Serious Case Review

Overview Report

Child LR

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Introduction

This serious case review (SCR) was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) on 10/09/18. This decision was made following discussions at the LSCB Serious Case Review Sub Group and advice from the Serious Case Review National Panel that the criteria had been met for a serious case review to be commissioned.

The subject child who will be the focus of this SCR will be known as Child LR and was only 6 weeks old when the child sadly died.

The circumstances leading to the death of the child involved the child being placed in unsafe sleeping arrangements by the parents at a time when mother was known to be taking medication for depression and had been drinking alcohol on the night that the child died. A criminal investigation commenced in relation to concerns of neglect and after a full investigation police charges were withdrawn because of a lack of evidence and it was felt not to be in the public interest to pursue further.

At the time that Child LR sadly died the family were in receipt of local universal primary health care services but were not known to children social care in the area. The family were however well known to children social care in another area which borders on the place where the family lived.

Legal Context

A SCR was commissioned by LSCB following a recommendation by the LSCB SCR Sub Group that the sad death of Child LR had reached the threshold criteria under Working Together to Safeguard Children (2015) strategy guidance.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

- *(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.*

- *(2) For the purposes of paragraph (1) (e) a serious case is one where:*
  (a) abuse or neglect of a child is known or suspected; and
  (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The criteria for a SCR was met in this case because a child had sadly died and abuse or neglect was suspected.

Methodology

The methodology for this review was carried out using the system model approach to learning outlined in the Child Practice Review process provided by "*Protecting Children in Wales Guidance for Arranging Multiagency Practice Reviews"* (Welsh Government 2012).

The overall purpose of the SCR model was to consider what happened and explore why services were delivered as they were to consider how practice can be improved through changes to the system to improve outcomes for children. A Terms of Reference (TOR) (Appendix 1) was developed to identify the lines of enquiry for the review.

The process involved a Review Panel of representatives made up of senior managers and safeguarding leads who were from the organisations involved in providing services for the child and family. The role of the review panel was to provide relevant information and analysis of their organisation's involvement in order to capture service/practice issues and to agree the key learning themes and actions required for multiagency practice improvement.

There was good attendance at the panel meetings and participants were knowledgeable about their own areas and safeguarding arrangements. They were keen to submit and consider learning issues and to provide support for staff attending the practitioner event.

A composite timeline which included all agency interactions between 07/04/17 till 11/06/18 was scrutinised by both Review Panel and by the practitioners themselves at a Practitioner Learning Event to identify the key themes of learning.

The practitioner learning event was held to bring together those practitioners who were involved with the child and family and had personal experience of the family dynamics and care provided. The role of the practitioner event was to identify frontline challenges, good practice, consider why things happened as they did and to identify any gaps in the system.

The practitioners who attended the practitioner learning event were open, honest, articulate and had a good grasp of the issues identified within the review. The GP for the family was unable to attend but was available by telephone to answer questions raised at the learning event. The reviewer was able to clarify systems available at the GP practice during the period covered by this review.

Family involvement in the reviewing process is key to understanding the nature of services provided to individual families. This provides an understanding of how helpful practitioners / services were perceived by family members on a day to day basis.

The Reviewer and LSCB SCR Manager attend a meeting with father to hear and consider his views on what happened and his experience of services during the course of the timeline. It was unfortunate that mother was not able to attend this meeting. The views of Father will be discussed later in this report.

The Reviewer had access to a number of documents as follows:

- Referral for Serious Case Review Group minutes
- Joined multiagency timeline of significant events/analysis

- Timeline from cross boarder children social care
- Early Help Assessment information linking with half sibling
- Copy of original Family Social Need Assessment
- Copy of PHQ9 + GAD – 7 Assessment Tool
- Minutes of the Strategy Meeting following Child LR death
- All Pan-Lancashire Policies and guidelines were easily available via Lancashire Safeguarding Children Board website.

Research evidence and national statutory guidance was considered and used throughout this review.

Family composition and context at the time of the child's death.

All family members were white British. The family became known to health visiting services in the area in **April 2017.**

Child LR – Died age 6 weeks and 4 days. The child had been born naturally at 37 weeks gestation, weighting 2.40kg and was being breast fed. Breast feeding had initially been difficult to establish due to tongue tie which was surgically treated the week prior to the incident.

Full Sibling – Aged 5 years – there had been no developmental concerns and the child was reported as being well presented with immunisations being up to date. There had been some concern at school due to attendance issues which were at 87%. School identified that sibling had a slight stammer and there were some learning issues which had been put down to sibling being one of the youngest pupils in the school year resulting in immaturity when compared against peers.

Half Sibling – Age 14 years – child of father who was in regular contact with the family and visited every other weekend. The child lived in a different local authority area from the family and was seeing the school nurse and GP because of emotional health issues and family difficulties.

Mother – Age 27 years – had been working at a bakery prior to Child LR's birth. Mother was known to have moderate depression for which she was taking medication prescribed by the GP.

Father – Age 41 years – Worked full time as a lorry driver. Father was described as the authoritative figure in the household. He acted as spokesperson for the family including mother on several occasions.

Home – The family were described as a "standard middle-class family" by practitioners at the learning event. The home was described as a beautiful and well-kept detached house in a quiet cul-de-sac. The home was well furnished and there were toys and baby equipment available for the children.

Early Help Assessment also known as Common Assessment Framework (CAF) and is an early assessment and planning tool to facilitate coordinated multiagency support to improve outcomes for children and families.

Family Social Need Assessment is a social history checklist carried out by midwives at the first antenatal appointment. This is used to as part of their assessment process to identify any need for additional family support.

PHQ9 + GAD – 7 Assessment Tool which are national screening tools to facilitate the recognition for depressive disorders and anxiety disorders.

There were 2 small dogs in the home and there were no concerns about their welfare or their interaction with the family members. It was also known that Mother had a horse.

It was evident to the practitioners who knew the family that the children were being well cared for and were very much loved by both of their parents.

Circumstances and Significant Events (07/04/17 till 11/06/18)

Significant historical information prior to the SCR terms of reference (TOR) timeframe include that father was known to have had a criminal history from **2009** resulting in a criminal conviction in **2010,** this conviction was served and completed by **2015.**

In **November 2016,** which is just prior to the family transferring to the new area, a child protection referral was made by the school nurse in respect of the half sibling. The referral to children social care was with regard to a disclosure made by half sibling (then 12years) to the school nurse that when she went to stay with her father every other weekend, she was made to care for her 3-year-old half sibling whilst her father and partner stayed in bed. Half sibling had also witnessed step mother being physically attacked outside the house by another adult (not father) and having her head banged on the pavement.

Whilst concerns about half sibling were addressed at the time there was no evidence to demonstrate that anyone raised any concerns for sibling despite her young age (3 years).

Also, in **November 2016** it is recorded on the child health record that mother presented in A&E after being involved in a police chase in a stolen car. It was not thought that she had been driving the car but she was found to have been drinking heavily. A similar episode had occurred 5 days earlier.

Pre pregnancy period

The health visiting service became aware of the family in their area on **7 April 2017.** The focus at this time was in respect of the sibling who was now 3 ½ years old. The Health Visitor received the child health record which included historical information about the parents (as above) including that sibling had been subject to a child protection plan between **October 2014** and **January 2015**. Following the closure of the Child Protection Plan the child had been transferred to a child in need plan which ceased in **February 2015**. The receiving Health Visitor liaised with the previous Health Visitor for verbal handover of the information contained within the child health record to clarify any current concerns as would be expected.

There was a history of two “was not brought” appointments for siblings 2-year check-up, which were later attended in **July 2016** once it had been followed up by the Health Visitor.

There were no current safeguarding concerns identified by the Health Visitor although the Health Visitor did acknowledge an alert from children social care in the previous area that father could be aggressive to professionals which was noted.

The Health Visiting plan was to visit the child and family for a “transfer in visit”. The visit took place as planned at the family home on **21 April 2017** which was within the timescales expected. There

were no health or development concerns expressed regarding sibling and immunisations were up to date. Advice about the need to change to a more local GP was discussed.

On **28 July 2017,** mother who had not at this point changed her General Practitioner (GP) practice attended for an appointment reporting that she had increasing symptoms of depression since she had stopped taking anti-depressants a couple of months ago. Mother reported to the GP that father had lost his job. Mother was prescribed anti-depressants and later on **8 August 2017** mother requested a further script for anti-depressants having increased the dose on her own accord and a further script is issued.

All family members transfer to a new GP practice on **9 October 2017** and medical records were transferred from the previous GP practice in a timely manner.

The local police attended the home address of Paternal Grandmother (in a different area from the family) on **14 October 2017** due to a verbal argument between mother who was 10 weeks pregnant and maternal grandmother. This incident was risk assessed as "standard domestic abuse" and did not meet the threshold for sharing information with Children Social Care and Health Visiting Service.

Antenatal period

On **31 October** mother attended a midwifery booking appointment with father. Mother was approximately 12 weeks pregnant at this stage. The couple disclosed that father had an older child with a heart murmur which resolved spontaneously and mothers' previous child was thought to have been growth restricted at birth. Mother confirmed that she was taking anti-depressants for depression from her GP. In view of these indicators the midwife correctly made a referral for consultant led antenatal care at the hospital.

The couple did not share any details with the midwife about past involvement with children social care or the fact that half sibling was staying with them every other weekend despite being asked direct questions about these issues by the midwife.

On **7 November** 2017 mother had a dating scan at the hospital with father and sibling in attendance. A due date for baby was given as 18 May 2018.

Mother failed to attend appointments for consultant antenatal care on **27 November 2017** and **18 December 2018.**

Mother attended for anomaly scans to check for any heart abnormality in the baby on **3 January 2018** and **15 January 2018** both were unsuccessful due to baby position.

The scan booked for 1**8 January 2018** was cancelled by father due to the family being unwell. The scan then took place on **19 January 2018** which showed that baby heart appeared normal.

On **22 March 2018** mother had an appointment with the GP. It is recorded that mother had taken anti-depressants for the past 3 – 4 years following her first child and was advised about the risk of baby withdrawal the following birth. The GP was concerned that mother had not seen the midwife for 12 weeks however, this was due to shared care arrangements and hospital appointments would form part of this care.

On **27 March 2018** mother attended an antenatal appointment to see the midwife with sibling. Routine enquiry questioning about domestic abuse took place with a negative response given from mother.

On **10 April 2018** mother was seen by the community midwife at the GP practice where mother reported feeling stressed and taking anti-depressants. Mother declined a referral for "Mind Matters" which was a local team providing psychological therapies such as Cognitive Behavioural Therapy (CBT) and counselling.

On **16 April 2018** the Health Visitor visited the family home to provide antenatal assessment for post birth care. Mother suggested that she had not attended antenatal care till late in her pregnancy but scans were attended. The reason for this was not explored or explained.

Mother explained that she was taking antidepressants via her own GP and that her partner (father) was aware of her anxiety and that he was a good support. She reported that they had a secure and happy relationship and were supportive to each other.

In view of mothers' mental health concerns the Health Visitor conducted a PHQ9 + GAD assessment which found:

- Anxiety score 10 – moderate
- Depression score 4 – low

Support was offered via Mind Matters which was again discussed and declined the reason given was that the couple had already discussed mother's emotional health for when the baby was born and mother did not feel she needed extra support.

A routine safe sleep discussion took place during this visit and the Health Visitor visited the bedroom upstairs to see the crib which was a "next to me crib" and discussed the 6 steps for safer sleep. A room thermometer was given to mother which acts to remind parents of the 6 steps for safer sleep.

The outcome of the Health Visitor assessment was for "universal" provision of service, which is the minimum amount of service provided by the Health Visiting Service.

The final antenatal appointment took place with the consultant obstetrician on **25 April 2017**. Mother attended this appointment with father and sibling. Mother was still taking anti-depressant medication and her mood was descried as being "OK". A scan was performed due to static growth on palpation of the abdomen and a growth scan was booked in line with hospital policy.

The Birth

Child LR was born on **27 April 2018** at 37 weeks gestation with a birth weight of 2.40kg and made a good recovery following the birth. Both mother and Child LR were discharged home together on the same day.

Postnatal period

The midwife visited the home the following day on **28 April 2018** for routine postnatal checks. Mother reported that baby was finding it difficult to breastfeed due to having tongue tie. Information about tongue tie and treatment at frenulotomy clinic was provided for consideration by the parents.

On **30 April 2018** the midwife found that mother was still having trouble to breastfeed and a referral to frenotomy clinic was made with mothers' agreement.

On **2 May 2018** mother attended with Child LR for neonatal screening tests which were all normal, mother sees the nurse practitioner for antibiotics to treat mastitis.

Mother attended the local birth centre for breastfeeding support on **5 May 2018**. Mother was very keen to continue to breastfeed despite obvious difficulties.

On **10 May 2018** the midwife attended the home for a prearranged postnatal visit. There was no one at home and when the midwife called the father on his mobile phone, he was very angry about not having yet received an appointment for the frenulotomy clinic and declined an appointment for mother to be seen later that day.

Also, on **10 May 2018** the Health Visitor attended the family home to complete the Primary Contact Visit with both parents present. Emotional warmth and positive reciprocal interaction by the parents with both children were observed. The living area in the home was described as clean, tidy and warm.

Mother stated that she was suffering from anxiety and was taking anti-depressants. She reported that the situation with Child LR tongue tie was making breastfeeding difficult and was having a negative effect on her mental wellbeing. Child LR was weighted at this visit and was found to have returned to birth weight of 2.40kg. Mother stated that she felt like a failure and was worrying the bond between herself and Child LR would be affected. She reported that she was recovering well from the birth and she had the support of her partner and family.

Safer sleep guidance was discussed and the Health Visitor observed that the Child LR slept in a cot next to parents' bed at night and a Moses basket was being used throughout the day. The Health Visitor increased the intervention plan to "universal plus" to take account of support mother required due to breastfeeding problems and emotional well-being.

Tongue Tie occurs when the string of tissue under baby's tongue (frenulum) which is attaches the tongue to the floor of the mouth is too short. This can cause difficulties in the mechanics of sucking required for feeding.

Frenulotomy Clinic is were babies are treated for tongue tie. The procedure is painless and involves a tiny cut of the frenulum which instantly releases the tongue and resolves feeding difficulties.

Mastitis is a condition which causes breast tissue to become painful and inflamed. Most common in breastfeeding women

Primary Care Visit provided by the Health Visitor as part of the National Healthy Child Programme with a focus on child development, parenting and family matters.

Universal Plus describes the level of intervention being offered following assessment by the Health Visiting Service. The purpose is to promote the health and wellbeing of the child. "Universal Plus" denotes a single agency Health Visitor intervention at a slightly higher level than the standard "Universal" Healthy Child Programme offer.

The midwife visited on **11 May 2018** this was to discharge mother and child from the maternity service. A formal handover of care from Midwife to Health Visitor did not take place and is not expected practice. Child LR was reported to have gained weight at 2.40kg and the midwife discussed safer sleep at this visit. Mother stated that she was unhappy with the length of wait there has been for an appointment for the frenulotomy clinic. The midwife contacted the clinic and managed to get an early appointment for that day. The parents attended with Child LR but left after 2 hours without being seen because the clinic was running late.

On **16 May 2018** mother attended the GP with Child LR this was following a telephone call by father to the practice. Mother was concerned that Child LR was making funny noises when breast feeding and the whole family had upper respiratory infections. Child LR was examined and found to be satisfactory and mother was told to return with Child LR if there was no improvement.

On **21 May 2018** Child LR was taken to frenulotomy clinic again and the tongue tie was cut and stretched and Child LR was discharged from the clinic.

The GP received the notification of attendance and treatment of tongue tie on **25 May 2018**

The Incident

On **11 June 2018** at 11.07 hrs a 999-call made by mother that Child LR had been found unresponsive and not breathing. On arrival of the ambulance crew maternal grandfather opened the door and Child LR was found with no pulses, no respiratory effort and unresponsive. Child LR was found unresponsive and hypostasis was evident. Bruising was noted to the back of the child's head, back, elbow and blood was found in the nostrils. Life support was initiated and the decision to terminate resuscitation was made at 11.31 hours.

The ambulance service had referred the child emergency to the police on transit to the home address and the police informed children social care in line with the local sudden infant death protocol.

Child LR and mother was received at the hospital A&E department. The Forensic Medical Officer attending Child LR felt that mother was in such an emotionally distressed state that she did not have the capacity to consent to having blood samples taken to check for the presence of maternal drugs and alcohol.

A multiagency strategy meeting was held on **12 June 2018** and there was a unanimous decision to initiate a section 47 child protection investigation for sibling due to safeguarding concerns and the unknown cause of death of Child LR. A Police criminal investigation was also commenced in view of possible baby bruising and neglect issues.

The story provided to the police by the parents about events in the home the night before the incident differed slightly between mother and father. The parent's stories did however, confirm that half sibling had been visiting the family over the weekend. Before taking half sibling home, father had placed Child LR on the parental bed with pillows around the baby as was usual whilst mother was downstairs. Father then took half sibling home and returned after midnight.

Hypostasis is the accumulation of fluid or blood in the lower parts of the body or organs under the influence of gravity, as occurs in cases of poor circulation or after death.

Whilst father was out maternal grandfather (who was a known drug user) came around to the family home and mother stayed up late drinking alcohol with him. On return father went to bed and got up at 05.00 hrs to go to work and mother went to bed in the morning (time unclear) possibly between 03.00 and 05.00 hrs. Mother awoke around 11.00 hrs to find Child LR unresponsive.

The Local Authority applied to the Family Court for an Emergency Protection Order (EPO), parents attended court and put forward an appropriate adult to care for Child LR's sibling pending police and children social care investigation and risk assessment of the situation. This was accepted by the Family Court.

An initial post mortem found that the cause of death was unascertained and toxicology results were outstanding for several weeks. The initial concerns raised by the ambulance service of bruising on the baby were found to be hypostasis and not caused by non-accidental injuries as first suspected.

After several weeks the final conclusion of the pathologist was that Child LR death was unascertained and it was noted that there was a history of co-sleeping and that cocaine and fluoxetine (anti-depressant medication) were found in the child's blood. The pathologist view when asked for clarification on how these substances had entered the child's blood stream was that the toxicology findings may be as a result of breastfeeding and/or cross contamination from mother to child contact.

The criminal investigation was ongoing for ten months before the criminal case was closed by the police due to a lack of criminal evidence and it was felt to be not in the public interest to pursue further.

Family Perspective

The Reviewer and LSCB SCR Manager visited father at the family home to seek the parent's views on the services received by the family. Unfortunately, mother was not available to speak to us. Father explained that this had been a very stressful year and mother was still suffering anxiety and struggling to cope with meeting people and taking telephone calls.

Father was very helpful in explaining his views and those of his partner which has been much appreciated by the reviewer. Father's reflections were as follows:

- **About professionals** – All professionals had been respectful, kind and caring. However, father did feel that although professionals appear to want to help, they did not always know how to. This was particular in relation to concerns around mother's anxiety, poor feeding and lack of an appointment at the hospital frenulotomy clinic.

Emergency Protection Order is a court order used in serious situations to keep children safe. The order gives restrictive parental responsibility to whoever applies for the order and is often used to move children to a place of safety against parents' wishes.

Toxicology is the measurement and analysis of potential toxins, intoxicating or banned substances and prescription medications present in a person's body.

- Father did not see the difference between the Midwife and Health Visitor and did not understand their differing roles.

- Father expressed his gratitude for the way the police had collected him from work and had supported the family after the incident but was still angry about some aspects of the police investigation.

- **Division of tongue tie** - Father appreciated the help of the Community Midwife (father thought it was the Health Visitor) who he said at that point went out of her way 100% to sort out an early appointment for Child LR to have division of tongue tie at the hospital.

- Father felt strongly that the division of tongue tie should have been performed before Child LR left hospital following the birth. In the event it took 3 weeks to get the procedure done which father described as only taking a few seconds to complete. The delay of this procedure had been very stressful for the family and father felt that they had to wait too long whilst mother struggled to breastfeed and this had made mothers anxiety worse during this time. Father said that he had felt stressed and worried about the situation too and remembered getting angry with the community midwife on the telephone about the delay which he said was out of sheer frustration.

- **Mother's mental and emotional wellbeing** – Father felt that they were able to cope with mother's depression and anxiety without additional support. Mother apparently would have like to have reduced her anti-depressants during pregnancy but felt this would have made her depression worse.

- Mother had rejected support from Minds Matter because she felt father was best placed to support her. Father explained further that mother had tried to contact Minds Matter in the past but had found the self-referral process difficult to manage with poor communication and delay. This resulted in mother giving up on the process to be seen by them.

- Father was not able to recall any other suggestions around supporting mother's mental health. Based on this experience he felt that the support network for mothers with anxiety issues had been poor.

- **Information Sharing** – Father was of the view that professionals involved were aware of his past criminal background. He felt it would be "ludicrous" for staff not to be sharing information routinely about patients and families when they were all working with them at the same time.

- **6 Steps for Safer Sleeping** – Father could recall the Midwife and Health Visitor going up stairs into the bedroom to see the baby cot and viewed the Moses basket downstairs. Father did not remember all the messages from the discussion from Midwife and Health Visitor but he did remember telling the Midwife or Health Visitor (not sure which) that because of the tongue tie baby could not breastfeed properly which resulted in very regular feeding with baby becoming unsettled overnight. He said he had told the professional that the only way that baby and mother could get any sleep was to bed share. The reviewer found no evidence of this conversation in the timeline or records provided. Father was adamant that no one had ever told them that there would be an increased risk to baby if mother slept with baby whilst taking anti-depressants.

- **Safer Sleep Assessment** - When asked about the idea of an individual safer sleep assessment with parents so that parents could be clearly advised about their own situation and when it was not safe to co-sleep with baby father agreed that this would be a good idea.

Analysis of Practice and Organisational Learning

The following themes have been developed following discussions at two Review Panels and Practitioner Learning Event on 17/06/19 and with father of Child LR.

Learning Themes

There were 3 main learning themes identified through the discussion and analysis of the information presented at the Review Panel, Practitioner Event and Family perspective as follows:

- **Prevention of sudden infant death and management of unsafe sleeping arrangements**
- **Management of women with antenatal and postnatal mental health conditions**
- **Information sharing and assessment.**

Prevention of Sudden Infant Death and Management of Unsafe Sleeping Arrangements

There are clear national guidelines on safe sleeping arrangements for parents of new babies which are widely available. The NHS website, National Institute for Health and Care Excellence, UNICEF UK and Lullaby Trust which is a charity organisation for reducing infant death and supporting parents. All have clear guidance available to support professionals and public on the issue of safe sleeping arrangements for babies available on the internet. However, it is the case that despite good advice parents will co-sleep with their baby whether or not this is intentional or unintentional

Research in the Northeast of England into attitudes and experiences of co-sleeping showed that 65% of a yearlong sample of parents had actually co-slept with their baby. Parents with no previous intention to do so slept with their babies for a variety of reasons. 95% of the bed-sharing infants slept with both mother and father and breastfeeding was significantly associated with co-sleeping (Blair PS and Ball HL 2004).

It is important to highlight the serious risks of co-sleeping with a baby and the reason that co-sleeping has been linked with an increase in sudden infant death which are not completely clear. It is too simplistic to fully attribute infant deaths associated with co-sleeping to overlaying. In some cases, there may be evidence of overlaying but in the majority of cases the cause of death remains unknown (Blair, et al., 2014).

Health promotion advise about safe sleeping arrangements for babies such as encouraging babies sleeping on their back, on a firm clear surface, in a smoke free environment, with control of room temperature, encourage breastfeeding and baby sleeping in a cot in parents' room for the first six

months has all led to the reduction of overall sudden infant deaths rates nationally. However, it is not clear whether the overall co-sleeping rates for babies has changed over this same period.

A number of additional factors have been identified in research that appear to combine with co-sleeping to increase the risk of sudden infant death. These include co-sleeping on a sofa or arm chair, where either or both parents are smokers and in particular where the parent has consumed alcohol or drugs, this includes some prescribed drugs for medical purposes. The side effects of some prescribed medications may cause the parent to sleep more heavily with a higher risk of the parent (usually mothers) becoming unaware of baby's position in the bed leading to hazardous conditions for the baby and an increased risk of overlaying.

National advice on co-sleeping is clear as follows:

The safest place for a baby to sleep for the first 6 months is in a cot in the same room as the parents.

It is especially important not to share a bed with baby if any of the parents:

- are smokers (no matter where or when you smoke and even if you never smoke in bed)
- have recently drunk alcohol
- have taken medication or drugs that make you sleep more heavily
- never sleep with a baby on a sofa or armchair.
  (NHS website)

Lancashire, Blackburn with Darwen and Blackpool Safeguarding Children Boards have co-produced the "*Pan-Lancashire Safer Sleeping Guidelines for Children"* (March 2013 and updated in 2015 and 2018) – to provide local advice on co-sleeping and safer sleep guidance for front line staff. This is a fully comprehensive document of 17 pages setting out all aspects of evidence based safer sleeping advise for professionals to discuss with all parents/carers of babies.

The guidance on co-sleeping is in line with NICE guidance (2014) on Sudden Infant Death Syndrome (SIDS). There is a useful section which includes a list of factors to consider (as above) on when to advise not to bed-share or co-sleep with a baby because the risk is too great.

Pan-Lancashire Guidelines states that *"It is in no-one's interest to avoid this discussion (on safe sleeping) with the baby's carer either on the grounds that is it too complex or to wait until the mother reports that she has already slept with their baby in bed".*

UNICEF UK research on bed sharing, infant sleep and SIDs acknowledge the importance of "counselling" parents and care givers on safe sleep practice which suggests providing safer sleep guidance to parents beyond the provision of generalised safer sleep advice.

The Reviewer met with the Pan–Lancashire Co-ordinator for Child Death Overview Panel (CDOP) and Lead Nurse for Sudden Unexpected Deaths in Children (SUDC). Their experience when reviewing SIDs in the LSCB area has been that practitioners report that they still find asking parents if they can see where baby sleeps difficult. This view was reflected in the Practitioner Event

although in this case the Midwife and Health Visitor had carried out the inspection as recommended.

Although the Pan-Lancashire guidance is clear that Midwives and Health Visitor should inspect where babies sleep during the day and night there was no confidence in the process coming from the CDOP and SUDC leads spoken to that this was being carried out in the majority of cases they had been involved with.

Another observation was that Practitioners were finding it difficult to ask probing questions around parental lifestyle choices such as alcohol and drugs use. The linking up of these risk factors and discussion about the risk of infant death whilst co-sleeping was also felt to be an issue.

During local SIDs reviews it is usually the case that records show that it is noted that "safer sleep has been discussed" with the parents but the detail of any discussion is missing. Practitioners often have their own blanket conversation covering the aspects of safer sleep in general and this is not being applied to the personal circumstances of individual parents. There is no checklist or assessment to assist in discussions and no tailoring advice to the individual needs of parents. This will be addressed later.

The Reviewer has observed that the Pan-Lancashire Guidelines provide 3 useful appendices however, the reviewer found that the professionals at the practitioner event were unaware of these and the CDOP co-ordinator and SUDC lead nurse confirmed that these features were currently not being fully utilised. The appendix as follows:

1. Safer Sleep Legislation Guidelines - provided by Lancashire Constabulary
   This sets out situations when a person is liable to criminal prosecution when a child dies as a result of co sleeping under the influence of alcohol or drugs and include Wilful Neglect under section 1 (2) Children and Young People Act 1933 and Manslaughter under section of Offences against the Person Act 1861

2. Pathway for Multidisciplinary Workforce in relation to safer sleep arrangements which outlines who should do what and when. It is not known if these arrangements are currently included in the midwifery and 0-19 service Provider Service Specifications

3. Risk Assessment Tool – "Where might my baby sleep?" which is a self-help assessment for parents. There is no evidence available that this assessment tool is being used.

LSCB have actively promoted the Pan-Lancashire Guidelines (which were last updated in 2018) over a number of years. There has been funding from LSCB made available with Public Health to promote safer sleep for babies through training events and a number of public campaigns with the purchase of helpful materials. These have included room thermometers with the 6 steps to safer sleeping printed on to give to parents during the postnatal period.

It was evident at the Practitioner Learning Event and in the Review Timeline that in this case there had been discussions about safer sleep with both parents by the Midwife and Health Visitor. The Health Visitor asked to see where baby was going to sleep at night and during the day at both the antenatal visit and first postnatal visit and had been show an appropriate cot next to the bed in parents' bedroom and a Moses basket for the day. The 6 steps to safer sleeping was provided at the antenatal visit along with a room thermometer.

The Midwife had also discussed the 6 safer sleep steps at the discharge visit. Although discussion took place with the parents (in line with Pan-Lancashire Guidelines) this was a generalised overview of safer sleep for babies and there was no focus on the individual risk of co-sleeping for this particular baby. This was also confirmed by the father of Child LR who had been present at the visit.

Practitioners at the Learning Event demonstrated that they were very committed to promoting safer sleeping messages and it was clear that generalised safer sleep advice was being provided at family visits. There had been good practice around seeing where baby sleeps day and night and good record keeping in the child health record.

Practitioners reflected that they are not currently expected to actively engage parents to make individualised safer sleep risk management decisions around where baby sleeps and how to keep baby safe when sleeping. The participants at the Learning Event welcomed the suggestion of a safer sleep assessment tool to help professionals conduct an increased level of professional assessment and care planning to reduce the risk of SIDs.

What do the statistics tell us? Lancashire has a higher than national average rate of Sudden Unexpected Infant Deaths.

Child and Maternal Health – Public Health Profiles demonstrate:
Lancashire 2015- 17 - had a worse than average infant mortality rating.
Blackpool 2015 – 17- had the fourth worse figure for infant mortality rating.

Local SUDC statics for sudden unexpected infant deaths as follows:
2017-2018 = 6 baby deaths linked co-sleeping (data provided by CDOP based on cases reviews in 2017/18)
2018-2019 = 13 baby deaths in unsafe sleeping arrangements. Alcohol and substance misuse have been a modifiable factor in all cases. 11 of these cases involved co-sleeping. (Data provided by SUDC service)

These figures demonstrate a need for LSCB and its partner agencies to do more to try to reduce infant mortality rates in Pan-Lancashire.

A small local patient survey was carried out by the SUDC team in December 2016 to clarify if parents were receiving the Safer Sleep messages. This was a small study with only 49 responses as follows:

- *Have you had advised around bed sharing relating specifically to breast feeding?*
  YES = 31 NO = 8 No response = 10
- *Was the advice clear?*
  YES = 26 NO= 2 No response = 23
- *Have you had mixed messages about bed sharing?*
  YES = 31 NO = 8 No response = 10

The conclusion of this small study demonstrated that the messages given to parents about the risks of bed sharing /co-sleeping was not clear enough. However, it should be stated that there was no evidence of there being any mixed messages in this case.

What more can be done? To better inform parents of the risk of co-sleeping with babies to reduce the incidence of sudden infant death with links to co-sleeping.

Firstly, there should be consideration for the implementation of an individualised safer sleep assessment tool alongside current good practice. A joint assessment which is conducted by a trained professional from within the midwifery and or health visiting teams with both parents if possible or with mother to share information, on the lines already available in appendix 3 Risk Assessment Tool contained in the Pan- Lancashire Guidelines which was updated in 2018.

Both parents have a parental responsibility to protect baby from harm and both should understand the consequence of failing to protect their baby. The assessment would help professionals ask direct personal questions about the lifestyle choices of both parents. It is important to make an assessment of the risk factors in order to raise awareness with parents particularly about the risks of drinking alcohol, drug taking and smoking and the links these have to infant deaths and co-sleeping.

Parents need it to be made clear by professionals when the risk of co-sleeping is such that in their particular circumstance the parent should never co-sleep with their baby because the risk is too great. Even in cases where there are no risks identified the assessment framework would provide a conversational tool to enable professionals to identify risk in changing circumstances. For example, raising awareness to a breastfeeding mother who has no risk factors at all that even a couple of alcoholic drinks at a family wedding will increase the risk of infant death if they choose co-sleep that night.

In order to implement a Safer Sleep Assessment Tool as part of routine perinatal practice, the commissioning and provision of the assessment will need to be considered and discussed between commissioners for midwifery services (Clinical Commissioning Group) and with their providers and 0-19 children health services (Public Health) and their providers.

Further to implementing an individualised assessment, the Heads of Midwifery and Health Visiting need to work more closely together to ensure that there is a seamless and supportive programme of care for delivering the safer sleep programme which knits together a two-strand approach to the safer sleep programme which is already in place. Good handover arrangements and record keeping will be essential with a suggestion that the assessment tool could form part of the child health eRed Book.

Leadership of the local CDOP and SUDC team needs to be harnessed and information about local babies who die in unsafe sleeping situations need to be shared to continually inform front line practice. Regular anonymised “Alerts” from CDOP could be used.

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eRed Book – This is an electronic version of the personal child health record (PCHR) which is given to each child shortly before or after birth. The hard copy version has a red cover and hence known as the Red Book.

The views of parents are essential to ensure their perspective is recognised and considered to maximise the full potential of a safer sleep assessment tool. The father of Child LR agreed that an individual assessment which helps parents to understand their individual risk whilst co-sleeping is essential.

Parents expect to be asked personal questions about their lifestyle choices and it is the professional's responsibility to ask the questions no matter how difficult if feels. An assessment tool would help professionals to ask personal questions and improve the quality of the conversation they have with parents.

Secondly, there needs to be a stronger message around the legal consequence of co-sleeping and to raise awareness with parents about their parental responsibility to protect their baby or risk being criminalised in cases where neglect is proven following child death linked to co-sleeping. The consequence of criminal charges can have a devastating impact on family life at a time when the family are grieving the loss of a baby.

Thirdly, there needs to be a public campaign about when NOT to co-sleep with baby. Parents need to be aware of the need to risk assess every time they think about co-sleeping with their baby. This could be a nightly check list which can act as a quick aide memoire for parents. A good example of this is already available in appendix 3 of the Pan–Lancashire Safer Sleep guidelines.

Fourthly, the Pan- Lancashire Safer Sleep guidance needs to be strengthened to raise the importance of discussing safer sleep with fathers and include the use of the safer sleep assessment once agreed. Fathers can often be good supports in promoting safer sleep actions during the night.

LSCB has a key role in facilitating and bringing all the key agents together as discussed to consider and agree the validity of developing and implementing a safer sleep individualise assessment which is available to all families with new babies.

The reviewer recognises that a Safer Sleep Assessment Tool, whilst being very helpful in engaging and assessing parents in difficult conversations about their personal life and lifestyle choices, the assessment tool does not replace the effective building of a trusting relationship between professionals and parents. The assessment tool will however, empower professionals to be able to advise parents who feature risk factors e.g. alcohol and drug use NOT to sleep with their baby.

Recommendation 1
Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should with its partners review the Pan-Lancashire Safer Sleep Guidance to:

- Consider the potential for developing and implementing an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme and ensure that this is delivered.
- Consider strengthening the safer sleep messages for parents including being clear with parents about situations when they should NEVER sleep with their baby.
- Consider strengthening the message about the duty of the parents to protect their child and inform parents of the risks of infant death linked to co-sleeping with the possibility of criminal consequence should they ignore professional's advice.

Recommendation 2

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should request assurance from Public Health that work is systematically being undertaken to monitor and reduce local area infant mortality rates - which includes work associated with unsafe sleeping practices.

Management of Women with Antenatal and Postnatal Mental Health Conditions

The National Institute for Health and Care Excellence (NICE) published guidance on 17 December 2014 “Antenatal and postnatal mental health: clinical management and service guidance”. The guidelines cover recognising, assessing and treating mental health conditions in women who are planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year. The guidance promotes early detection and good management of mental health conditions to improve women’s quality of life during pregnancy and in the year after giving birth.

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point and many women experience both.

The management of mental health conditions during antenatal and postnatal periods is different than what is expected at other times during a woman’s life cycle due to the nature of needing to balance the needs of the woman to provide good enough parenting and that of the needs of her baby.

The mother of Child LR had a history of depression following the birth of sibling in 2013.
Pre pregnancy mother had an appointment with the GP in the originating area due to increasing symptoms of depression since stopping her medication over the past two months and she reported that her partner (father) had lost his job. In view of this the GP prescribed antidepressants which mother then increased on her own accord resulting in requesting an early repeat prescription which was agreed and provided by the GP. There was no assessment of the root causes of mother’s depression and no reflection on mother’s alcohol misuse which had resulted in her attendances at A&E. This omission of an assessment to better understand mother’s mental health and alcohol misuse was below the levels of expected best practice.

At the time when mother attended for her booking appointment with the midwife the arrangements for taking into account NICE guidance on perinatal mental health had not been fully established. No mental health assessment by the midwife took place, but on questioning by the Midwife Child LRs Mother reported that she was being treated by her GP for depression and was taking antidepressants.

It was explained at the Learning Event that midwifery practice had changed and now as part of the Midwife’s mental health clinical pathway (in line with NICE guidance) the Midwife would conduct a Patient Health Questionnaire (PHQ) and Generalised Anxiety Disorder (GAD) assessment with advice to see the GP if the assessment was positive. A referral to the perinatal mental health team would also be made if the threshold is met as part of the clinical pathway.

The perinatal mental health team are a specialist team of Nurses and Midwives who are led by a Consultant Psychiatrist with a special interest in perinatal mental health. The professionals in this

service are specialist trained to work with mothers to provide mental health support and to help mothers to gain optimal mental health and emotional wellbeing in order for them to be able to take best care of themselves and their baby.

When Child LRs mother attended her GP appointment at 33 weeks pregnant, she reported that she was still depressed and antidepressants were continued. The GP gave advice about baby who may need support for drug withdrawal following the birth which would be expected practice. Again, the GP did not take the opportunity to formally assess mother's mental and emotional health and did not consider mother's past history of excessive alcohol use as would be expected.

The Midwife met with mother 2 weeks later and offered a referral to “Minds Matter” which is a local service providing psychological services such as Cognitive Behavioural Therapy and counselling but this was declined. Mother remained of the view that her partner was supporting her and she did not require any other support.

At the Health Visitor antenatal visit, the PHQ and GAD assessments took place as appropriate when mother reported that she was feeling anxious. Mother was found to have moderate anxiety score and low depression score. Again, the services of Minds Matter were offered and again rejected by mother who stated that she had good support from her partner (father).

The members of the Review Panel clarified that the Mother’s PHQ and GAD score at this time would not have met the threshold for a referral to be made to the Perinatal Mental Health Team and that the Health Visitor had acted within expected practice guidelines.

Following Child LRs birth the Health Visitor made a primary visit to the family home (baby is 13 days old) and mother reported that she was still feeling anxious and depressed and that the impact of baby’s difficulty with feeding was having a negative impact on her emotional wellbeing. Mother reported that she was feeling a failure and was worried about the effect this was having on the bond she had with her baby. No formal mental health assessment took place at this point and no advice was given about seeing her GP as would have been be expected.

The Health Visitor gave appropriate reassurance about her feelings for baby and although it is not recorded in the record the Health Visitor remembers offering extra “listening visits” but these were declined. Again, Mother stated that she had support from her partner and the Health Visitor did not take the opportunity to challenge this decision and to reassure mother of the benefits of additional Heath Visiting visits.

The impact on mother’s mental health and emotional wellbeing linking to baby having tongue tie and mother finding it difficult to breastfeed does not appear to be well understood by professionals. Father told the reviewer that it was very stressful for mother and it was frustrating waiting to hear about an appointment for the frenulotomy clinic from the hospital which never arrived. The midwife rightly assessed the urgency of the situation and contacted the frenulotomy clinic and arranged an appointment for the same day. Unfortunately, the parents attended the clinic but were unable to wait over the 2 hours they were left waiting because they needed to pick sibling up from school. Father said the clinic were apologetic and rearranged an appointment for the following week which is when the procedure took place.

The impact of difficult feeding not only increased mothers' anxiety but it resulted in mother developing mastitis which was very uncomfortable and painful. This would have added further to mother's stress and anxiety.

Mother clearly had depression and anxiety and consistently rejected all offers of support beyond prescribed medication from the GP. NICE guidance recognises that women who have mental health problems may be:

- Unwilling to disclose or discuss their problems because they fear stigma, negative perceptions of them as a mother or fear that their baby might be taken into care.
- Reluctant to engage, or have difficulty in engaging, in treatment because of avoidance associated with their mental health problem or dependence on alcohol or drugs.

Mother stated throughout the time period of the review that her partner was supporting her emotional health. Whilst Mother had a history of irresponsible drinking which was known to the Health Visitor, the Midwife was not aware of this and mother had not disclosed any past history of alcohol misuse when asked by the Midwife at the booking appointment. This will be addressed under Information Sharing.

Communication and discussion between Midwives and Health Visitors did not take place but is essential when postnatal mothers have a known mental health condition and are rejecting helping services. Communication in these situations gives professionals the opportunity to consider each other's perspective and to form a clear view and hypothesis of the bigger picture. This joint multidisciplinary assessment would enable a coordinated approach to considering concerns and supporting ongoing care plans.

The Reviewer has been told that since the time of this review, NICE guidance has been fully implemented in the area and a Perinatal Mental Health Service has been established to improve the management and support of women with antenatal and postnatal mental health conditions in the future.

Recommendation 3
Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should be assured that there are robust clinical pathways in place for the management of antenatal and postnatal mental health in women across Pan-Lancashire.

Information Sharing and Assessment

Information sharing is an area which comes up time and time again in serious case reviews. Sharing information is an intrinsic part of any frontline practitioner role when working with children and families. The decision to share information, with whom and when presents a difficult dilemma for practitioners but is essential for effective collaboration and to ensure the best outcomes for children. Without the right information an effective assessment cannot take place. Good communication and information sharing enable professionals to effectively assess the needs of children and families in order to effectively delivery of the right services at the right time and to prevent situations becoming more acute and difficult to manage.

Professor Munro's review of child protection systems concluded that there should be a move towards allowing frontline practitioners to make decisions about when to share information away

from centralised bureaucracy and to support practitioners to share relevant information with practitioners working in the same organisation and those working in other organisations in the best interest of children and families.

There was clear guidance available for practitioners published by HM Government in March 2015 and updated in 2018, *Information sharing: guidance for practitioners and managers* available which highlights the key principles of information sharing and when and how to share information.

In this case there were a number of examples of good information sharing and communication. However, there were a number of information sharing gaps identified which need to be addressed in order for health services to provide a seamless web of care for effective service delivery and for the safeguarding of children and their families as follows:

- **Information sharing across the primary health care team during antenatal and postnatal period.**

The primary health care team for antenatal and postnatal women and their families includes the GP, Midwife and Health Visitor. However, not all practitioners in the "team" were aware of all the relevant information about the family which would have provided a clearer picture about the nature and vulnerability of the family. A better understanding of the history of the family may have helped frontline practitioners to ask the right questions to improve assessment and service provision.

Areas to be addressed as follows:

Midwifery services – when the Midwife in this case was situated in the GP practice the Midwife could get onto EMIS which is the GP electronic medical record (this is not the case for all Midwives and GPs in the area) and see each individual family member's medical records. The Midwife can also record information onto patients' medical records for the GP to take into account when making an assessment of a patient.

Although the midwife had access to EMIS in the GP practice, it was reported that the Summary Care Notes from the medical records for the family were not on the GP EMIS system and therefore no information was available for the midwife. The reason for this was that at the time of the midwifery booking appointment there was a significant backlog of Summary Care Notes which were waiting to be put on the system.

The midwifery pathway requires the midwife to obtain historical medical information about the mother at the Booking Clinic. This is routinely done through self-reporting from the mother unless this information can be triangulated through accessing the GPs record. In this case the information was not found on the GP system and was not explored further at a later occasion.

The GP safeguarding lead for the practice explained to the Reviewer that following this case the practice employed additional administration resource to ensure that the Summary Care Note backlog was cleared and EMIS is now kept up to date. The GP safeguarding lead explained that the practice merged on 1 April 2018 and now had 15,000 patients and it was a continual challenge to maintain up to date Summary Care Notes.

The community Midwife uses a "patient held record" which is commenced at the first Booking appointment and available to the Health Visitor on request to mother. This is a paper record which is held by the mother and is removed for filing once the Midwife discharges the mother.

It was evident at the Practitioner Learning Event that the Midwifery service was totally unaware of any of the family history prior to the family moving into the area. The midwife was not aware of the Health Visitor alert about father's past history of aggression towards professionals which could have placed the Midwife at risk. The historical information which was available was essential for the midwife to fully assess, understand and address any family vulnerabilities.

The Midwife at the learning event felt that had the Midwife been aware of previous children social care involvement they would have contacted the organisations safeguarding team for advice. In some safeguarding cases families are put onto a Midwifery case load which means that the mother would have been seen by the same Midwife at each appointment which helps to build a more trusting relationship and extra home visits would have been undertaken. This would have led to a better exploration and understanding of the family's vulnerabilities and dynamics.

Discussions at the Review Panel acknowledged that since there were no current child protection concerns that it was unlikely that the safeguarding team would have advised for Child LRs mother to be placed on a Midwifery case load.

Learning more about the family and developing a trusting relationship was not helped by the fact that mother was seen by at least 5 different Midwives over the course of her maternity care. A lack of opportunity to provide continuity of care needs effective collaboration and communication with other professionals involved in antenatal and postnatal care and this appears to be lacking in this case.

Following the Midwifery Booking appointment, a paper copy of the Family Social Needs Assessment was sent to the Health Visitor and GP for their information. On review of the completed form it was revealed that the midwife was aware of mothers' depression but was not aware of past involvement with social services or that another child (half sibling) was staying at the house on a regular basis.

It was not clear at the learning event why the Health Visiting team had not communicated with the Midwife at that stage to alert her to inaccuracies in the information which the Midwife had obtained directly from the parents.

This was a missed opportunity and the reviewer has reflected that this communication arrangement was not robust enough. The process is heavy reliant on the Health Visitor or GP to read the information and to make a judgement about how correct the form is. The Health Visiting service did not appear to use the information form other than to be informed that the woman is pregnant.

Parents do not always divulge accurate information for whatever reason. In most cases it is to cover something up. Father said that he thought that the health professionals would have all the information anyway and he suggested that it was "ludicrous" that they didn't.

Had the midwife been aware of the historical information this would have given the midwife the opportunity to respectfully challenge the parents to develop insight into how the past alcohol use,

family dynamics and mothers' depression were impacting on family life and may have led to the offer of Common Assessment Framework (CAF) and/or additional support.

The Midwife cannot see the Health Visitor record and the only information from the Health Visitor is available to the Midwife is via the Red Book which is given to parents following the birth of the child. The Midwife did not have the assessment opportunity to consider what impact the new baby would have on the family and this is also a missed opportunity.

The next formal communication from the midwifery team to the health visiting team was following the 20-week scan confirming the pregnancy and expected date of delivery. This was sent to the health visiting team via email. There is no other communication made between the two services despite the fact that they are both working with the family at the same time.

There was no formal handover of care either written or verbal between Midwife and Health Visitor following the Midwife discharge visit and therefore no opportunity for these professionals to have a joint review of the needs of the child and family.

The reviewer is of the opinion that the lack of an effective formal handover of care between Midwives and Health Visitors. This needs to be addressed by local Health partners to ensure that practice is consistent with Nursing and Midwifery Council (NMC) Codes of Conduct section 8 on working co-operatively.

Following Child LR death, the safeguarding team who cover the midwifery services were informed of the child's death and a safeguarding team member attended the multiagency strategy meeting. The midwives who had been personally involved in mothers and baby's care (there were 5 or 6) were not aware of the death of Child LR until seeing it in the local news. The safeguarding team should consider the effectiveness of their communication pathways to ensure midwifery teams are informed when one of their patients die in the local area in order to raise awareness and provide support.

Mother's records have been flagged as a high-risk individual for future pregnancies and to offer the Care of Next Infant programme (CONI) following the child death review meeting which was good practice. The Health Visitor and GP were requested to do the same.

Health visiting service – the Health Visitor received the electronic Child Health Record from the cross-border health visiting team and was aware of the family history including when and why sibling was involvement with children social care. The Health Visitor made contact with the cross-border health visiting team to discuss the family in more detail and alerted the child health record about father's attitude to professionals as would be expected.

Following the Health Visitor assessment there was an option for the Health Visitor to discuss the case with the safeguarding team to consider future service delivery. This option was not taken and no further consideration of the siblings past child protection concern was acknowledged or taken account of.

Once the health visiting team became aware that mother was pregnant a further assessment of the impact that a new baby would have on the family would have been relevant. A discussion at this stage to share information with the midwife and GP would have been appropriate and consideration of the need for additional support may have been facilitated.

The Health Visitor record keeping electronic system at the time was ECR but this did not have a shared arrangement to allow the Health Visitor to see the GP EMIS medical record for further information. Since the Health Visiting service transferred over to a new organisation, they are now on EMIS electronic system which is the same system as the GPs. It would therefore make obvious good sense for there to be an electronic system "share" to allow routine sharing of relevant healthcare information.

Routine communication from the Midwife to the Health Visitor has previously been discussed and the lack of a formal handover from the midwife to the Health Visitor needs to be addressed.

The reviewer was told by those at the Practitioner Learning event and by the GP safeguarding lead that the GP and Health Visitor have regular face to face meetings (at least monthly) and weekly phone calls in between to discuss vulnerable families on roll with the GP practice. The midwife is not party to these meetings because not all vulnerable families have pregnant mothers in them. The Health Visitor is expected to contact the midwife if there is anything relevant. It may be useful to consider if this arrangement is working.

The routine information sharing and communication between Health Visitors and Midwives does not appear robust enough. Both professionals' groups appear to be working in silos and given that they are both serving the same clients at the same time more needs to be done to ensure effective collaboration.

GP Practice – the GP practice admitted that at the time the midwife went to view the child and family medical records they had not been put on the system. This was due to a backlog of records in the practice. Since this case they have made improvements in keeping Summary Care Notes up to date on EMIS. The midwife has access to this information when visiting the practice, this is not the same for all other GP practices. The reviewer was told about the flagging system which places a safeguarding icon on the front of the patients record (for the whole family) to raise awareness of a safeguarding concern to improve assessment of patients' needs and help identify risk.

There are regular Safeguarding Review Meetings between GP and Health Visitor on a monthly basis and weekly catch ups by telephone which reflect good practice.

In conclusion, there are gaps in routine information sharing for pregnant women and their families to be addressed in the following areas:

- Health Visitors and GPs require an appropriate level of record sharing between the services to improve assessment, service provision and to strengthen local safeguarding arrangements. – The solution for this could be addressed through an Information Sharing Agreement to promote an electronic share arrangement via EMIS.

- The midwifery service, family social need assessment form and email notification of the pregnancy which is sent to the Health Visiting service appears to be the only routine information shared between the two professional services. This level of communication does not appear to be very comprehensive or very useful. – The commissioners of midwifery and 0-19 services and their providers should review routine communication and information sharing arrangements between the services to ensure they are robust and complement each other.

- Midwifery handover of care should be formalised to ensure that a summary of midwifery care and findings form part of the child health record for future consideration.

- Commissioners should consider contracts and service specifications for Midwifery and Health Visiting to consider how the two services can develop closer links to prevent silos working. Clarity around roles and collaboration would reduce duplication of effort and enhance child and family care planning and support.

Recommendation 4
Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should request that the local clinical commissioning groups and public health services engage with the LMS Better Births programme to promote information sharing and professional collaboration between GP's, midwifery and health visiting at all levels of family need. This should be evidenced by providers through embedding meaningful integrated practice and associated measures.

- **Information sharing and school**

School have a duty of care for children placed on their roll. Sibling was a pupil in year 1 at the local primary school. There were no safeguarding concerns identified at school although there were concerns around poor attendance.

School had no knowledge of any past history of social care involvement with the sibling in another area and were surprised that this was the case. There is an expectation that school nurses should share relevant safeguarding information with School and there are Information Sharing Agreements in place to support this.

It is known that in this case, the sibling was assessed as requiring "Universal" services which meant that a verbal handover between Health Visitor and School Nurse was not required on school entry in line with the 0 – 19 services policy. Only children requiring a more intensive multiagency approach to intervention such as those assessed as "Universal Partnership Plus" receive verbal handover. The rational for this is that there are high numbers of children starting school for the first time at the beginning of each school year and it would not be possible due to time constraints or relevant to discuss each child.

Good Practice

There were a number of areas of good practice in this review as follows:

- Safer Sleep guidance – both midwife and health visitor followed the safer sleep pathway giving expected advise and seeing where baby sleeps at night and during the day
- The GP practice have robust flagging for safeguarding which includes all family members.
- The GP recognised the delay in uploading Care Summary Notes on EMIS and engaged additional admin support to rectify the situation.
- Development of a local perinatal mental health team to better support antenatal and postnatal women is now in place.
- Good record keeping by Midwives and Health Visitor which identified who was present at all appointments.

- Home visits by the Midwives who usually request mothers to attend clinic to be seen postnatally.
- Midwives went the extra mile to get an early appointment for the frenulotomy clinic.

Practice Issues

Practice issues include those areas which already have a good process in place and needs to be strengthened as follows:

- When there has been previous historical child protection concerns in a new family transferring into the local area, a discussion with the safeguarding team should take place to consider any current safeguarding issues for the child and family.
- GP and Health Visitor safeguarding meetings take place on a monthly basis. Practice should be reviewed locally to ensure that Midwives are being informed about vulnerable families which include pregnant women and new-born babies.
- GPs should ensure the formal assessment of mental and emotional health and maintain a clear record of the patient's alcohol/drug use which may affect the patient's mood when managing mild/moderate mental health conditions.
- GPs should review their arrangements for sharing safeguarding concerns about pregnant women with health visitors and midwives to ensure these are robust.
- The safeguarding team should consider the effectiveness of their communication pathways to ensure midwifery teams are informed when one of their patients die in the local area in order to raise awareness and provide support.

Conclusion

During the time this SCR has been in progress Lancashire Safeguarding Children Board has been decommissioned and is now part of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership.

This SCR highlights a number of opportunities for Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and its partners, particularly health care partners, to review and develop a number of practice areas to improve outcomes for local children.

This review should be shared to promote learning across the safeguarding partnership.

Recommendations

These recommendations are for the consideration of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and its partners.

Recommendation 1
Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should with its partners review the Pan-Lancashire Safer Sleep Guidance to:

- Consider the potential for developing and implementing an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme and ensure that this is delivered.

- Consider strengthening the safer sleep messages for parents including being clear with parents about situations when they should NEVER sleep with their baby.
- Consider strengthening the message about the duty of the parents to protect their child and inform parents of the risks of infant death linked to co-sleeping with the possibility of criminal consequence should they ignore professional's advice.

Intended outcome: *To improve professional advice about co-sleeping in unsafe situations and reduce SIDs*

Recommendation 2

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should request assurance from Public Health that work is systematically being undertaken to monitor and reduce local area infant mortality rates - which includes work associated with unsafe sleeping practices.

Intended outcome: *To improve the focus and understanding of infant mortality rates in the local area.*

Recommendation 3

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and partners should be assured that there are robust clinical pathways in place for the management of antenatal and postnatal mental health in women across Pan-Lancashire.

Intended outcome: *Effective perinatal mental health services available across pan-Lancashire*

Recommendation 4

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership should request that the local clinical commissioning groups and public health services engage with the LMS Better Births programme to promote information sharing and professional collaboration between GP's, midwifery and health visiting at all levels of family need. This should be evidenced by providers through embedding meaningful integrated practice and associated measures.

Intended outcome: *To ensure adequate levels of information sharing between health partners when caring for children and families at the same time*

Terms of Reference Serious Case Review Child LR

Introduction

This Review is being commissioned by the Chair of Lancashire Local Safeguarding Children Board (LSCB) in accordance with the learning and improvement framework for LSCBs described in Working Together to Safeguard Children guidance (HM Government 2015). The Serious Case Review will be undertaken as a concise Child Practice Review in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSCB will conduct the review and report progress to the Board through its Chair.

Membership will include an independent Lead Reviewer and representatives from key agencies with involvement.

Organisation	Role
Independent / Lancashire Safeguarding Business Unit	Chair / Business Co-ordinator
Independent	Independent Reviewer
East Lancashire CCG	Panel Member
East Lancashire Hospital Trust	Panel Member
Lancashire Children's Social Care	Panel Member
Lancashire Children's Social Care	Panel Member
LCFT	Panel Member
Lancashire Constabulary	Panel Member
CAFCASS	Panel Member
Rochdale Children's Social Care	Panel Member
Lancashire Safeguarding Business Unit	Business Support Officer

Timeframe for the review

The review will cover the timeframe of **07/04/17 to 11/06/2018**. Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

The purpose of the review is to

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB;

- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;

- Examine the effectiveness of case handovers/transfers, information sharing and working relationships across borders;

- Examine the involvement of other significant family members in the life of the child, and family support provided to the subject family;

- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;

- Identify any actions required by the LSCB to promote learning to support and improve systems and practice.

- Establish the robustness of the Pan -Lancashire Safer Sleeping Guidance for Children (March 2018) and consider learning to improve future arrangements and practice

- Consider the impact of any drug misuse (including cannabis), alcohol use and potential domestic abuse (including coercive control) and the level of professional curiosity used to assess and understand the needs of the children and family.

- Examine the effectiveness of the local safeguarding children arrangements including CAF/ early help processes and arrangements for managing difference of opinion.

Tasks specific to the review panel:

1. To set the time frame for the review, see above;

2. Agencies that have been involved with the child and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;

6. A full and accurate genogram of the subject family will be prepared for the panel and to assist the learning event;

7. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

8. The Panel will plan with the Lead Reviewer a learning event for practitioners to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

9. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice. This will be a joint event with practitioners from Child LP SCR which is a very similar case.
10. The Panel will receive and consider the draft Joint SCR Overview Report (Child LP and Child LR) report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial hypotheses addressed and any additional learning is identified and included in the final report;

11. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;

12. The Panel will plan arrangements for feedback to the family and the practitioners in attendance at the learning event and share the contents of the report following the conclusion of the review, and before publication;

13. The Panel will take account of any criminal investigations or proceedings related to the case;

14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SCR report for publication.

References

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http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0107799

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

Statement by the Independent Reviewer

The reviewer, Kathy Webster is independent of the case and of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and its partner agencies.

Prior to my involvement with this Serious Case Review;

- I have not been directly concerned with the child or any of the family members or professions involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigours analysis and evaluation of the issues as set out in the Terms of Reference.

Signature: K. Webster

Name: Kathy Webster – Independent Reviewer

Date: 7th November 2019