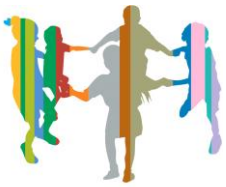


Bolton
Safeguarding
Children

BOLTON SAFEGUARDING CHILDREN BOARD

Serious Case Review

Baby D

Lead Reviewer: Maureen Noble

Published April 2018

CONTENTS

1. INTRODUCTION AND METHODOLOGY

The review offers condolences to the family of Baby D on his tragic death.

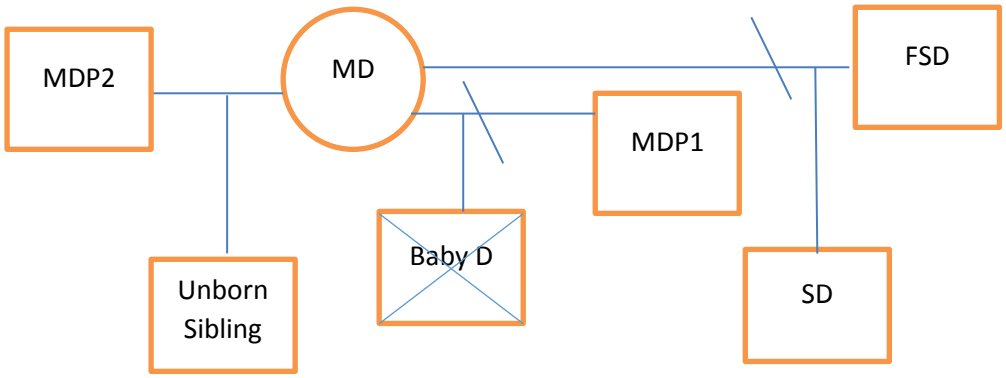
1.1 Key People

This Serious Case Review (SCR) relates to the death of Baby D, who sadly died in December 2016. Baby D lived with his mother (MD) and his older sibling (SD). He was below 3 months of age at the time of his death.

During the period under review MD had two consecutive relationships, MDP1 and MDP2. MDP1 was Baby D's father and lived at the family home with MD and SD. SD is said to have thought of MDP1 as his father. MDP1 was deported from the UK before Baby D was born.

MD's relationship with MDP2 appears to have begun a few weeks prior to Baby D's death. MDP2 was present in the family home when the incident leading to Baby D's death took place and was questioned under police caution following Baby D's death.

APPENDIX 1 – FAMILY GENOGRAM



1.2 Incident Leading to the SCR

On the date of Baby D's death the North West Ambulance Service (NWAS) received an emergency telephone call from MD saying that she had found Baby D 'not breathing'. MD said that Baby D had been unwell the day before and that she had taken him to see the GP.

Hospital staff informed police of Baby D's death. The SUDC (Sudden Unexpected Death of a Child) Paediatrician, Duty Social Worker and the Bereavement Team were also contacted in line with the local protocol.[1] At mother's request they also informed MDP1 by telephone. At this time MDP1 had been deported and was residing in another country.

Following notification police began a criminal investigation into Baby D's death. It was established that both MD and MDP2 were present in the home at the time of the incident. Both MD and MDP2 were voluntarily interviewed by police under caution.

[1] http://greatermanchesterscb.proceduresonline.com/pdfs/pr_gm_sudc.pdf

A post mortem was conducted following Baby D's death which established that he had injuries consistent with death resulting from overlay.[2] This was confirmed by a Home Office pathologist.

1.3 Review Process

A referral for consideration of a Case Review was received by the Bolton Safeguarding Children Board (BSCB) in February 2017. The Learning and Improvement Group recommended that a SCR take place in March 2017 and this was approved by the Chair of the BSCB.

An Independent Reviewer was sought and, following a commissioning process, Maureen Noble was appointed to undertake the review.

The BSCB commissioned a concise SCR using a blend of the SCIE Learning Together SCR Methodology[3] and the 'Welsh Model' for Serious Case Reviews.[4] The time period considered for the review was agreed as twelve months prior to the death; this is in accordance with recommendations from systems methodologies.

A combined chronology/timeline was compiled from agency records and individual conversations were held with practitioners; these resources were used to identify significant episodes of practice for analysis and learning.

A panel of professionals from relevant agencies was established as the review team and met on four occasions to oversee the review. Details of panel members are set out below:

Designation	**Agency**
Associate Director of Safeguarding / Interim Associate Director of Safeguarding	NHS Bolton Clinical Commissioning Group
Designated Doctor	Bolton NHS Foundation Trust
Named Nurse Safeguarding Children	Bolton NHS Foundation Trust
Detective Constable, SCR Team	Greater Manchester Police
Safeguarding Children Board Officer	Bolton Safeguarding Children Board

1.4 Research Questions to be addressed by the Review

The review team agreed the following areas for discussion with professionals involved in the case:

- Did agencies identify and respond to specific vulnerabilities and risks in relation to substance misuse and other 'lifestyle' factors?

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[2] file:///C:/Users/noble/Downloads/Sudden%20unexpected%20death%20in%20infancy%20and%20childhood%20(2e).pdf

[3] https://www.scie.org.uk/publications/ataglance/ataglance01.asp

[4] http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/Child_Practice_Review_Guidance_-_Welsh_Government.pdf

- Did professionals demonstrate an understanding of the daily lived experience of Baby D (and his older sibling)?
- Did professionals respond appropriately to MD's current and historical mental health issues?
- Did professionals discuss safe sleeping with MD? Are local policies, procedures and practice in relation to safe-sleeping robust and up to date; are there modifications that can be made to improve understanding and compliance?
- Has the review identified good practice?
- Has the review identified practice that could be modified to strengthen safeguarding?
- Has any additional learning been identified by the review?

The Lead Reviewer held one to one conversations with the following practitioners:

Family GP

Health Visitor

Nursery Nurse

A statement of involvement was received from Midwifery Services.

A learning event was held with professionals who were directly involved in the case prior to presentation of the report to the BSCB. A wider learning event was also held to share the learning from the case, promote good practice and discuss modifications to future policy and practice.

1.5 Criminal Proceedings

A police investigation into the death of Baby D took place. A police file was submitted to CPS in relation to prosecution. In December 2017 the review was informed that the Crown Prosecution Service advice was that there was no criminal case to pursue.

1.6 Coroner's Inquest

HM Coroner was informed in writing at the commencement of the SCR. A Coroner's Inquest was pended until the completion of criminal proceedings.

The Coroner's Inquest took place towards the end of 2017. The Lead Reviewer of the SCR was instructed to attend the inquest. The Coroner's findings were that the cause of Baby D's death was overlay; an open verdict was recorded[5].

1.7 Family Involvement in the Review

MD was informed of the Serious Case Review by her allocated social worker and confirmed in writing by the SCR Panel. MD was invited to participate in the review following completion of the criminal investigation. Prior to the Coroner's Inquest, a member of the review panel and the Independent Chair of Bolton Safeguarding Children Board met with

[5] There is not enough evidence to return a verdict. This is a rare verdict.

MD. The purpose of the meeting was to share the final draft of this report and to seek MD's views. MD's comments on the report and her views are included throughout the report and are shown in italics for ease of identification.

2. BACKGROUND TO BABY D AND PROFESSIONAL NARRATIVE

2.1 Background to Baby D

In February 2016 MD consulted her GP as she thought she may be pregnant with Baby D and 'booked' into maternity and midwifery services at around 8 weeks pregnant. She was said to be happy about the pregnancy and looking forward to a new baby.

MD had a history of anxiety and depression. In 2011 she had taken what she described as an impulsive overdose and was referred to Community Mental Health Services. She received ongoing treatment with anti-depressant medication from her GP.

MDP1, the father of Baby D, was deported in May 2016. This was difficult for MD although she remained positive about the relationship and had plans to visit father when Baby D was born.

Following father's deportation MD lived as a lone parent with SD (Baby D's older sibling). SD was a toddler during the period under review and attended a local nursery. During her pregnancy with Baby D, MD had noticed that SD's behaviour had become difficult; she said that he was demanding and naughty. She discussed this with the Health Visitor (HV) and sought support in helping with his behaviour. HV requested that a nursery nurse offer assessment and support.

MD received ante-natal services as set out in clinical guidance. Midwifery services were aware of MD's history and that she smoked cannabis. A discussion was held as to whether MD should be referred to the Outreach Midwife service (a service targeted to families with vulnerabilities) however this was discussed with MD and she said that she had stopped smoking cannabis so she didn't need the service.[6] MD attended her ante-natal appointments and, other than physical symptoms, the pregnancy was uneventful.

MD consulted her GP appropriately during pregnancy. When she was first booked as pregnant her GP decided to stop prescribing anti-depressants for the duration of the pregnancy. MD told professionals that she wanted to go back onto anti-depressants after Baby D was born as they helped her to manage daily life.

Baby D was born at full term with no complications and returned home with MD following discharge.

Baby D lived at home with MD and SD. He received care in line with expected practice from universal services under the national Healthy Child Programme[7]. The Community Midwife handed over care to a Health Visitor who conducted the first birth visit and Baby D's 8-10

[6] The local policy is that the Outreach Midwife and Community Team would continue to work closely together so that any emerging issues could be picked up and a re-referral made.

[7] https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

week check (conducted at 8 weeks). HV also saw MD in the mother and baby clinic and opportunistically in the local area.

Baby D was healthy other than minor health conditions for which he was taken to the GP. He was taken for all vaccinations and MD both welcomed professionals into the family home and attended appointments, although it was noted that she was sometimes reluctant to take on board the advice given to her by professionals who felt that MD had the view that she 'knew best'. In line with Bolton Safeguarding Children Board protocols both the Community Midwife and Health Visitor provided detailed information about safe sleeping on several occasions[8].

SD was seen by professionals and no concerns were noted. However, MD did state that since Baby D's birth, SD had become difficult to manage and naughty. The HV delegated a Nursery Nurse (NN) to see MD and SD at home to support with behaviour management.

NN found the visit to be difficult and observed that the relationship between MD and SD felt more like an adult to adult than parent to child interaction. NN did not observe any inappropriate behaviour from SD, however she did talk to MD about the support that could be offered and said that she would call again. She arranged to do this when SD was at nursery so that she could have a more open conversation with MD about her concerns regarding SD's behaviour. Following the second visit MD said that she did not want to take up the offer of behaviour support for SD.

The day before Baby D's death MD had presented with him to the GP practice. He was examined by the GP who noted MD's reports of vomiting after feeds. The GP advised MD regarding feeds and oral hydration, and that if vomiting persisted or became worse, MD should come back to the see the GP.

2.2 Professional Narrative

MD was described as being well known to local health agencies. She had been registered with a local General Practitioner for many years and had frequent contact with the practice.

Practitioners who met MD described her as an outgoing character who stood out as being gregarious. She was described as approachable, willing to contact services, capable as a parent although perceived by some 'not to be in control of her own behaviours'.

MD appeared to professionals to be honest and open about her lifestyle choices; she admitted that she used cannabis although she said at various times that she had stopped using or had cut down her use considerably. She was asked about alcohol use but said that she did not really drink alcohol.

In May 2016 her long term partner and father of Baby D had been deported due to a failed residency application. MD found this a stressful time; she did not want to separate from her partner and professionals were of the view that they were both looking forward to the birth of Baby D. Following deportation MD continued to have contact with the father and was hoping to arrange to visit him with Baby D for an extended stay after the birth.

[8] http://boltonsafeguardingchildren.org.uk/sleep-safe/

Professionals were aware of MD's historic and current mental health issues. She told professionals that she needed medication to manage her mental health and volunteered this information to all the professionals she had involvement with.

MD was perceived as a forceful character who was able to look after herself and SD. Professionals who visited MD at home observed home conditions that were acceptable and they had no safeguarding concerns about SD or Baby D until the event in August 2016 when MD told HV that she had resumed her cannabis use, was drinking alcohol and was sleeping with both children in bed with her. This was in addition to prescribed medication.

For the most part professionals did not perceive MD as a parent who was not meeting the needs of her children. There were no issues of neglect (although the review will highlight the professional view of the use of drugs and alcohol in this context). There was no historic or current involvement of Social Care and there had been no referrals made by any professional in relation to child protection concerns.

The professional mind-set in relation to MD was that she was capable of looking after SD and Baby D but that she did not always take on board the advice given to her by professionals. It was recognised by professionals that there were times at which MD needed additional support, particularly when she reported low mood and depression; when this happened she was offered 'listening visits'. On one occasion her GP gave her contact details for a local counselling service. Professionals were aware that MD did not appear to have a supportive network of family and or/friends.

3. SIGNIFICANT CONTACTS AND PRACTICE LEARNING EVENTS

The combined multi-agency chronology shows 30 separate contacts with MD during the period under review, these include face-to-face (clinics, hospital, surgery and home visits); contacts by telephone and opportunistic contacts in the local area).

The review panel has analysed all contacts and extracted those from which significant learning can be gained both in relation to good and modifiable practice. These are referred to below as **significant practice learning events (SPLE).**

In January 2016 MD presented to her GP saying that she felt depressed and suicidal and that, despite being prescribed anti-depressant medication, she was feeling worse. The GP enquired about MD's reference to suicide and assured himself that she had no plans to harm herself. MD said she did not feel she would actually 'do anything'; she was experiencing stress at home. The GP doubled the dose of anti-depressant medication and gave MD a contact number for the counselling service (it is a self-referral service). **SPLE**

Note: On reading the final draft report MD contested that she had told the GP that she was suicidal. However she did agree that she was depressed at this time. The GP record contains information that MD had reported she was suicidal; on that basis this information is included in the report.

The GP made enquiries about suicidal thinking to be assured that MD did not have plans to take her own life. The GP offered information regarding counselling services (the service is self-referral). The GP had considered a safety plan for MD.

The GP did not explore in any depth the reasons why MD was feeling in this way. Opportunities to discuss social issues were not taken nor was there discussion regarding the safety of SD.

MD had been prescribed the anti-depressant medication for some time; this would therefore have been a good opportunity to talk to MD about the effectiveness of prescribing given that she was feeling in low mood. Reviewing MD's general situation and well-being, as well as her medication, may have resulted in a better understanding of factors contributing to low mood and therefore better informed the treatment plan.

In mid-February MD presented to her GP and said she thought she was pregnant (she would have been around 7 weeks pregnant at this time). The GP recommended stopping the anti-depressant medication MD was taking. **SPLE**

This was a missed opportunity for the GP to make enquiries about home life, particularly given the earlier presentation about low mood and suicidal feelings. The recommendation to stop prescribing does not appear to take into account the long-term nature of prescribing or the impact of sudden cessation.

In early April MD booked for ante-natal care at 13 weeks pregnant. She told the midwife that she used Cannabis (up to five times a day) which MD said had helped her to manage extreme morning sickness in her last pregnancy. A referral was made to the Outreach Midwife (OM) as a potential high risk in pregnancy. MD had a number of other risk factors in her previous pregnancy including smoking and history of mental ill health.

The midwife advised regarding the health risks of cannabis use and also the risks in terms of safe sleeping. MD declined referral to the smoking cessation or substance misuse service. **SPLE**

Note: MD disputes that she was offered advice in relation to potential risk to Baby D resulting from her use of cannabis.

MD disclosed several risk factors to the Midwife which raised the Midwife's cause for concern.

The midwife demonstrated good practice by discussing each risk factor with MD and offered practical interventions such as referral to smoking cessation and substance misuse services, although these were declined. The midwife also made a referral to the outreach midwife.

In early May when she was 18 weeks pregnant MD asked her GP to re-start the anti-depressant medication which they did.[9] This was an opportunity to further explore MD's reasons for requesting to re-start anti-depressant medication.

[9] https://www.nice.org.uk/guidance/cg192/chapter/1-recommendations

In late May at an ante-natal clinic appointment MD informed the midwife that her partner was due to be deported. The midwife enquired about cannabis and MD said she no longer used it. **SPLE**

In June MD was admitted briefly to hospital. A few days after discharge she visited her GP and enquired about travel to another country as her partner had been deported there. It was noted that she would be unable to travel due to pregnancy.

At an antenatal visit in August MD reported that she had a history of depression and self-harm, the last episode being in 2014. She said her mood was low at present due to the deportation of her partner and that she was smoking five cigarettes per day. She was offered support to stop smoking but declined this. MD was offered listening visits. **SPLE**

In October Baby D was born at a local hospital with no complications. MD and Baby D were discharged to home five days later.

On the seventh day after discharge HV conducted a new birth home visit at which MD, Baby D and SD were present. Baby D was noted to be feeding well and gaining weight. No concerns were noted regarding Baby D. MD reported that her partner was still in another country due to a failed residency application. MD said she was coping 'OK' but wanted to increase the anti-depressant medication and would contact the GP. She reported little family support. MD declined the Edinburgh Postnatal Depression check and listening visits, she was given open access to HV. **SPLE**

MD reported at the visit that she was struggling with SD's behaviour and HV arranged a visit to be undertaken by a Nursery Nurse with a view to putting in place a six week behaviour management support intervention.

In November the NN made a home visit to discuss behaviour management support for SD. She found MD to be welcoming but noted that she did not appear to want advice or support in relation to managing SD's behaviour. NN observed that MD and SD's relationship was not like that of a parent/child but that MD treated SD as a companion and involved him in adult conversation and tasks; indeed NN observed SD holding and feeding Baby D, she also noted that MD used bad language in front of SD and advised her not to do this. NN left the home with some concerns around the family dynamic and with reservations about MD's willingness to put in place actions to change her behaviour in relation to managing SD. When NN returned to her office she spoke to a colleague about her concerns regarding the dynamic within the family. She did however observe that she had not witnessed any inappropriate behaviour on the part of SD. NN checked with the SD's nursery who said they had no concerns about him. This was good practice. **SPLE**

She made a note to review and return to visit at home again in two weeks' time when SD was at nursery.

At the end of November HV visited the family home to conduct the 6-8 week review of Baby D. HV administered the ages and stages questionnaire and noted that Baby D was not using both arms equally, this was noted for review in one month. There were no other concerns about Baby D's physical health.

MD told HV that she had ended her relationship with Baby D's father who was still in another country. She disclosed to HV that she had been sleeping in the same bed with SD and Baby D, that she was using cannabis and that she had started to consume alcohol before going to bed. HV talked to MD about safe sleeping and reinforced the messages about the safety of the environment and also the risks associated with using drugs and alcohol. HV offered to refer MD to the substance misuse service however this was declined. HV made a note to keep risk factors under review and planned to discuss with the GP. **SPLE**

The following day HV opportunistically encountered MD at the GP surgery. That same morning HV had left a message with reception staff at the surgery to share her concerns about MD's cannabis and alcohol use. HV spoke again to MD about drugs and alcohol and reinforced the messages regarding safe sleeping. She asked MD where the baby had slept last night and MD assured her that he had slept in his 'Moses' basket. HV was reassured by MD's response. **SPLE**

Six days later HV opportunistically encountered MD again at the Well Baby Clinic. HV took the opportunity to speak to MD and to remind her about safe sleeping. MD said that HV had 'scared her into' placing Baby D in his Moses basket to sleep, she also said that she had stopped drinking alcohol. **SPLE**

Two days later NN returned to the family home to speak to MD about SD's behaviour management. MD and Baby D were present in the home. MD welcomed NN into the home but made it clear that she had no intention of following her advice in relation to behaviour support and that she would not attend a 'drop in' session.

NN noticed that Baby D was asleep in a pushchair and was wearing outdoor clothing. NN advised MD to remove the clothing and take care that Baby D did not overheat however MD did not act on this advice. *Note: MD said that she did unbutton Baby D's coat but that he was asleep and she did not want to disturb him by removing his clothing.* NN noted that there was a faint smell of cannabis in the house, however she did not raise this with MD.

NN reported back to HV that MD had said she did not require any support with managing SD's behaviour and that she would not be taking up the offer of a six week programme. HV told the review she was surprised at this as MD had seemed keen. **SPLE.**

Note: MD commented that she believed that the appointment that had been made was for SD and not for her. She said she declined the appointment because it was in 'school time' and that she heard nothing from the service after that.

Two weeks later MD presented to the GP. The GP prescribed contraceptives for medical reasons; MD said she was not currently in a relationship. **SPLE**

The following day HV had a third opportunistic meeting with MD in the local area. HV was driving past and saw MD with Baby D. She enquired again whether Baby D was sleeping in his Moses basket and MD assured her that he was.

Two days after this, MD presented to the GP complaining of pain and was prescribed a higher dose of codeine based medication. **SPLE**

On the day before his death MD presented to the GP with Baby D complaining of a rash that had been present for 24 hours accompanied by vomiting. The GP thoroughly examined Baby D and advised re feeding and hydration. The GP asked MD to note if symptoms worsened and to contact the GP again.

The following day the events leading to Baby's D's death took place.

4. ANALYSIS OF PROFESSIONAL PRACTICE

The review analysed professional practice in relation to the research questions (set out in Section 1 of this report) and to the key practice episodes identified by the review. This forms the basis of the recommendations set out in Section 5 of the report.

The review has also gathered wider learning which will strengthen safeguarding practice which is set out in Section 5.

4.1 Good Practice Identified by the Review

The review has seen several examples of good practice particularly with regard to professional's efforts to engage MD. The Health Visitor built a good relationship with MD and maintained MD's confidence whilst also being tenacious and taking every opportunity to remind MD about safe sleeping. With hindsight MD was not always truthful with HV about aspects of her life but she did disclose to HV that she was using cannabis and that she had been sleeping with Baby D and SD in her bed.

The GP had also built up a good rapport with MD and knew her history well. He felt that she was open and honest. It appears that MD felt comfortable discussing a range of health issues with the GP; she also presented early in her pregnancy with Baby D suggesting that MD had confidence in engaging with the service. When MD presented to the GP in January 2016 she indicated low mood and suicidal feelings. The GP demonstrated good practice in exploring her current mood and intent. The GP also recommended to MD that she contact a counselling service and gave her details of a local service; the local service is self-referral only.

With hindsight it is clear that MD did not always discuss aspects of her life with her GP.

At 13 weeks pregnant MD booked with Midwifery Services and a history was taken. MD disclosed that she was a regular user of cannabis and that she had a history of mental ill health. The midwife demonstrated good practice in speaking to MD about the risks associated with cannabis use (as well as smoking) in pregnancy and suggested support services however these were declined by MD. The Community Midwife (CM) raised vulnerabilities and risk factors with MD and consulted with the Outreach Midwife. They communicated well in relation to MD's care, needs and vulnerabilities. Both practitioners continued to review MD's needs and had an arrangement whereby MD could be quickly referred back to the Outreach Midwife should a need be identified.

The Nursery Nurse had some concerns after her first home visit and raised these immediately with a colleague on return to the office. The Nursery Nurse also arranged a second home visit at a time when SD would not be present to assess the home situation and

to more freely discuss any difficulties that MD was having with SD. NN also observed the bond and relationship between MD and SD from SD's perspective; had MD agreed to behaviour support interventions NN planned to work with the family to establish boundaries. She observed that MD appeared to treat SD as an adult and as a friend.

Note: MD commented that this was the nature of her relationship with SD; that it was her style of parenting and that no professional ever raised this as a concern.

4.2 Modifiable Practice Identified by the Review

There are a number of areas in which practice could be modified to strengthen safeguarding as set out below. These will be explored in further detail in the learning section of this report.

The review concludes that there were a number of occasions when the GP could have taken the opportunity to further explore the reasons for MD's low mood. She disclosed that she was having problems in her relationship but these were not explored further. A proactive review of MD's treatment plan would be good practice, rather than reactive responses to requests for increased medication without further exploration of underlying factors.

MD presented to the GP in February saying that she thought she was pregnant. The GP's response was to refer MD for booking and to suggest that she cease taking the anti-depressant medication during pregnancy. During this consultation there is no indication of discussion regarding either the impact of ceasing anti-depressant medication or of any discussion regarding alternative medication or interventions. This would have been good practice.

When MD attended an antenatal appointment in August she disclosed that she had experienced low mood and depression and that she was currently experiencing low mood. She was offered listening visits however there is no indication that attempts were made to understand more about the disclosures.

Professionals were aware that Baby D's father had been deported and that SD had developed a close bond with him (it was reported to the review that SD thought of MDP1 as his father). The impact of the loss of MDP1 in such circumstances on both MD and SD does not appear to have been addressed by professionals.

Following the birth of Baby D MD received a home visit from HV to conduct the new birth visit. At this visit MD told HV that her partner had been deported and that this resulted in her feeling low. MD said she wanted to increase her anti-depressant medication. She also reported that she was struggling with SD's behaviour.

At the second home visit conducted at 8 weeks, MD also disclosed to HV that she had resumed her use of cannabis, that she was drinking alcohol before bed and that she had been sleeping in the same bed with SD and Baby D. HV spoke to MD about dangers and risks. She also reflected on whether or not she should make a referral to Children's Social Care however the following morning she saw MD opportunistically at the GP surgery and was reassured when MD told her that she had taken on board what HV had said and would

not put SD and Baby D into bed with her again. The review has concluded that professionals currently have options to discuss concerns through informal team working and with team leaders at weekly or monthly work allocation meetings. There are more formal options available to seek advice and guidance from other agencies (e.g. duty social worker) which is what HV intended to do at the next review which would have taken place at 12 weeks, sadly Baby D died at 11 weeks.

With regard to the disclosures of risk factors relating to drugs, alcohol and safe sleeping HV was sure that she had made the right decision in reminding MD about risks and that this would be effective. It appears that HV erred on the side of optimism with regard to MD's intentions or ability to change her behaviour in relation to cannabis use. It would have been good practice to revisit the issues with MD and to seek a peer or multi-agency discussion regarding risk factors.

At the birth visit HV introduced and offered the Edinburgh Postnatal Depression Scale (EPNDS); however MD said she did not want to complete it. HV might have considered following up with the GP at this stage although MD had previously completed the assessment following SD's birth and HV would have introduced it again at future visits as the opportunity arose.

When NN visited the family home for the first time she felt uncomfortable with the dynamic between MD and SD and expressed her concerns to a colleague. When she returned for the second visit NN noticed that Baby D was wrapped in outdoor clothing. She spoke to MD about the possibility of Baby D overheating but felt that this advice was not taken on board or acted on. NN also noticed a smell of cannabis in the room however she did not raise this with MD.

NN did not feel that her concerns warranted referral for early help; however it would have been good practice for NN and HV to have held a detailed discussion about NN's observations and concerns and for them to have agreed a plan to re-engage MD in relation to SD's behaviour management.

In the two weeks prior to Baby D's death it appears that MD had met a new partner (MDP2) and that he was staying at the family home. Professionals were not aware of this and MD did not disclose it to either the GP or HV.

There were two further occasions on which MD consulted her GP prior to Baby D's death. The GP could have taken the opportunity to discuss MD's day to day life at these consultations. The GP did ask about the need for contraception and was informed by MD that she was not sexually active. The GP could have explored this further with MD.

5. LEARNING FROM THE REVIEW – FINDINGS AND RECOMMENDATIONS

5.1 Findings

The review has concluded that the death of Baby D was neither predictable nor preventable by any of the agencies involved in his care.

The review has identified good practice and practice that can be modified to improve safeguarding as set out in the analysis of professional practice set out above.

Specific learning is summarised below and grouped under thematic headings linked to the research questions and key practice episodes.

5.1.1. Theme 1 – Responding to Current and Historic Mental Health

- NICE guidance in relation to management of mental health issues in pregnancy should be followed by practitioners in all settings.
- A multi-agency discussion in this case would have facilitated the sharing of historic and current information and enable joint care planning.

5.1.2. Theme 2 - Responses to Maternal Substance Misuse

- Professionals recognise the prevalence of cannabis use and require ongoing training in relation to its effects and impact on mental health and parenting.
- The offer from drug services in supporting long term cannabis users should be made widely available to all practitioners.[10]
- A brief assessment questionnaire similar to the one used some years ago developed by the Standing Conference on Drug Abuse (SCODA) would help professionals to assess levels of use and identify concerns.[11]
- Alcohol may have been used as a short term coping strategy by MD. Professionals should make routine enquiries into increased alcohol consumption alongside other lifestyle factors

5.1.3. Theme 3 - Disrupted relationships and hidden men

- The deportation of MD's partner was difficult for her and would have impacted on the lives of both SD and Baby D. Whilst the deportation is recorded by professionals there is no indication of this being seen as a significant event in MD's life.
- MD did not share information about her new partner with professionals. The review recognises that the daily lives of Baby D and SD would have been impacted by the introduction of a new partner to the household and identifies that support is needed for professionals in making enquiries about existing and new relationships.[12]

[10] https://www.boltondrinkanddrugs.org/about/services-menu/
[11] http://www.socialworkerstoolbox.com/scoda-risk-assessment-of-parental-drug-use-and-its-impact-on-childrentool/
[12] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

Note: MD disagreed that professionals should ask about personal relationships. Her view is that health visitors and other professionals are there for the child, not the adult.

5.1.4. Theme 4 - Understanding Baby D's Daily Lived Experience (and that of SD)

- Professionals were focused on the children and there are examples of professionals taking the opportunity to speak to SD.
- Although only a small number of agencies were involved at this time, a conversation triggered by MD's disclosures in August 2016 would have raised awareness regarding MD's vulnerabilities and risks and given a clearer picture of the daily lived experience of Baby D (who was unborn at this time) and SD
- The impact of MPD1's deportation could have been further explored by professionals in terms of impact on the day to day lives of Baby D and SD

5.1.5. Theme 5 - Safe sleeping

- Guidance in relation to safe-sleeping appears to be woven into the professional mind-set and professionals take every opportunity to give safe sleeping messages to new parents
- A professional consultation undertaken as part of this review has highlighted areas in which the current safe sleeping policy can be updated and strengthened.

5.1.6. Theme 6 - Resistant Parents

- With hindsight it is apparent that MD was not open and honest with all professionals about aspects of her life (although MD's GP felt that MD was open with him). On some occasions professionals observed an unwillingness to take professional advice although at the time this wasn't seen as being a cause for concern or reaching the threshold for further interventions.
  Note: MD's view is that she would take professional advice if necessary but that she would also use her own judgment in making decisions regarding her children.
- Professionals should have access to ongoing training, support and supervision to address their concerns regarding resistance and unwillingness to change risk behaviours.
  Note: MD contests that she was not open and honest with professionals. MD said that she told professionals about cannabis and alcohol use, but that she was not asked for any detailed information about her cannabis use or offered support to stop using cannabis.

5.1.7 Wider Learning

The panel noted that information sharing between health agencies is hampered by the lack of a single system for recording, storing and sharing information across agencies. This is reflective of a national problem with regard to health information systems.

6. Recommendations

The panel makes the following recommendations to the BSCB. A multi-agency action plan is attached at Appendix 2 setting out the BSCB's response to the recommendations and a plan for implementation.

Recommendation 1

The BSCB should be assured that the management of anxiety and depression in primary care settings complies with NICE guidance (both general guidance and guidance for managing mental health conditions in pregnancy).

Recommendation 2

The BSCB should be assured that all single agency early help assessment tools are aligned to ensure that:-

- there is no duplication of effort
- there is no disincentive to the completion of early help in relation to referral into social care services by any agency

Recommendation 3

BSCB should be assured that those practitioners who work directly with children and/or their parents/carers have access to the appropriate level of awareness raising and training in relation to working with parents who are resistant to change.

Recommendation 4

The BSCB should support the further development of local Safe Sleeping guidance based on the learning from this case. At the request of HM Coroner specific action is required to ensure that GPs receive advice in relation to specific concerns regarding safe sleeping and that they take opportunities to reinforce safe sleeping advice.

Recommendation 5

The BSCB should be assured that all relevant practitioners have access to good quality drug and alcohol training and are aware of the service offer from local drug and alcohol services.

7. BSCB RESPONSE TO RECOMMENDATIONS

SCR RECOMMENDATION	BSCB RESPONSE 2017-2018
The BSCB should be assured that the management of anxiety and depression in primary care settings complies with NICE guidance (both general guidance and guidance for managing mental health conditions in pregnancy).	Currently CCG governance and safety committee working with primary care directorate to perform initial audit of GP practice compliance with key outcome measures of NICE guidance; in particular frequency of reviews for patients with anxiety and depression and medication reviews for anti-depressants with enquiries made re: psychosocial factors impacting on these mental health conditions. The findings will be reported to Bolton Safeguarding Children Board Provide summary to GPs around NICE guidance, and also run an education session regarding best practice when treating a patient with anxiety and depression in primary care aligned to NICE guidance. Compliance will be re-audited to establish practice improvement and any areas for further development
The BSCB should be assured that all single agency early help assessment tools are aligned to ensure that:- • there is no duplication of effort • there is no disincentive to the completion of early help in relation to referral into social care services by any agency	Early Help processes have been part of Bolton's model to safeguard and promote the welfare of children for a significant number of years, and were most recently relaunched in 2014 in response to findings from an evaluation by Lancaster University; in that time there have been significant improvements in the number of Early Help Assessments and plans developed for children as well as an increase in the range of services using the process. During 2017-2018 the Early Help Strategy was redeveloped and the SCR recommendation is being addressed through the 'Embedding Early Help and Tackling the Barriers' strategic workstreams. The progress and implementation is being tracked through the Early Help Steering Group, which reports to BSCB. An annual assessment of effectiveness made in BSCB's annual report. A review of current referral processes to social care is planned for January to May 2018 – a multi-agency task and finish group is leading this and a report will be provided to BSCB on strengths and areas for development

SCR RECOMMENDATION	BSCB RESPONSE 2017-2018
BSCB should be assured that those practitioners who work directly with children and/or their parents/carers have access to the appropriate level of awareness raising and training in relation to working with parents who are resistant to change.	BSCB has previously published a learning brief on 'Recognising and Responding to Resistance' and this has been recirculated. BSCB has re-commissioned a revised training programme on this topic and it will be rolled out from January 2018 and impact evaluated during this period. Board members have been requested to provide assurance to BSCB on the their 'Resistant Parents/Families' offer
The BSCB should support the further development of local Safe Sleeping guidance based on the learning from this case. At the request of HM Coroner specific action is required to ensure that GPs receive advice in relation to specific concerns regarding safe sleeping and that they take opportunities to reinforce safe sleeping advice.	A task and finish group is currently reviewing local Sleep Safe guidance, publicity materials etc.; the group are also exploring a range of options for promoting sleep safe messages BSCB's Sleep Safe Guidance has been reviewed by the Regional Lead for the Lullaby Trust. The Regional Lead commented A multi-agency seminar was facilitated by the Lullaby Trust Regional Lead to share current sleep safe research and best practice. GPs have been reminded of the importance of safe sleeping guidance via GP practice bulletin. If the GP has or receives information giving rise to concerns about safe sleeping practices from other sources including the family of a 0-12 month old baby then reinforce the guidance at that contact and/or at subsequent contacts. Where concerned about sleeping practices within a family the GP will share this information with the health visitor. The recommendation will be further emphasised in a refresh of the current health visitor/GP communication pathway
The BSCB should be assured that all relevant practitioners have access to good quality drug and alcohol training and are aware of the service offer from local drug and alcohol services.	There is a multi-agency training programme on substance misuse delivered in Bolton and accessible by all partners. In 2018-2019 specific 'Cannabis And Its Impact' Workshops' are planned; these will be open to all partners working with children and adults. The impact of these sessions will be evaluated and reported to BSCB

Appendix 1

8. Abbreviation and Key

Abbreviations	Meaning
BSCB	Bolton Safeguarding Children Board
SCR	Serious Case Review
MD	Mother of Baby D
SD	Sibling of Baby D
MDP1	Mother of Baby D Partner 1
MDP2	Mother of Baby D Partner 2
SUDC	Sudden Unexpected Death of Children
GP	General Practitioner
HV	Health Visitor
NN	Nursery Nurse
SPLE	Significant Practice Learning Event