Portsmouth Safeguarding Children Partnership

Rapid Child Safeguarding Practice Review – Freya

By Graham Bartlett

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1. Introduction

1.1 Applying Working Together to Safeguard Children (2018)[1], on 16 November 2020, the Portsmouth Safeguarding Children Partnership (PSCP) determined it was appropriate to conduct a Rapid Child Safeguarding Practice Review examining agency involvement with a sixteen-week-old infant and her parents, who for the purposes of this report will be known as Freya[2].

1.2 Freya died having spent the first eight weeks of her life in hospital following a prenatal diagnosis of gastroschisis and health concerns arising from that. The cause of death was unascertained, however she was found in an unsafe sleeping position co-sleeping with her parents, who are now under criminal investigation on matters connected with her death.

1.3 The aim of the review is to capture areas of learning to inform service improvements around interagency working, information sharing, and practice in raising awareness of babies at heightened risk from unsafe sleeping.

2. Review Arrangements

2.1 The PSCP appointed Graham Bartlett to lead the review, drawing from the combined scoping to which all agencies contributed, additional material requested, a learning event and the considerations of the Learning from Cases subgroup, acting as the Panel

2.2 Graham Bartlett is the Director of South Downs Leadership and Management Services Ltd. He independently chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and was previously the Independent Chair of the Brighton and Hove Local Safeguarding Children Board. He has significant experience of chairing and writing Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adults multi agency reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for Brighton and Hove. He had previously been the Detective Superintendent for Public Protection. He retired in March 2013. He has had no involvement or responsibility for any policing or safeguarding services in Portsmouth or Southampton.

2.3 The agencies contributing to the review were

- Portsmouth Children and Families Services
- Hampshire Constabulary
- Portsmouth Clinical Commissioning Group
- Portsmouth Hospital NHS Trust
- Solent NHS Trust
- University Hospitals Southampton NHS Foundation Trust
- Freya's General Practitioner

2.4 The specific terms of reference for the review were established as:

- To examine the effectiveness of information sharing arrangements between all agencies and professionals (including whether PPN1 forms are used accurately and effectively) and whether these could have been improved
- To explore the arrangements which support handover of care during the ante and

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] 'Freya', 'Hannah' and 'Ryan' are pseudonyms.

post-natal periods between NHS trusts, especially when one or more trust is out of the Portsmouth area.

- To examine the effectiveness of new birth and post-natal visiting and care arrangements, especially when one or more on the trusts involved is out of the Portsmouth area
- To examine the Portsmouth safeguarding referral arrangements and the threshold for Multi Agency Safeguarding Hub (MASH) decision making
- To explore the effectiveness of policies and protocols related to patients who 'do not attend', children who 'were not brought' to health appointments and around disguised compliance during the ante and post-natal periods.
- To examine the Healthy Child Programme Health Visiting thresholds in operation in Portsmouth, the status' of 'Universal / Universal +' as used by Health Visitors (including the criteria for escalation or step down through these), what they mean in practice and whether partners have a good understanding of what this looks like.
- To explore the knowledge and understanding of Sudden Unexpected Death in Infants (SUDI) risk factors among professionals and how these influence assessment and decision making
- To examine the nature, range and effectiveness of information and support provided to parents and carers, by health and social care agencies, around co-sleeping and reducing the risk of SUDI
- To examine the impact of organisational and operational change as a consequence of the Coronavirus pandemic on the provision of health and social care in the ante and post-natal periods
- To examine the nature and quality of bereavement support offered and/or provided to parents in the period following a SUDI, including in cases when parents are under investigation for alleged criminal offences
- To consider any equality and diversity issues (e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) that appear pertinent to the family and any consequent service provision.

2.5 The timeframe under review was from 1 January 2020 - 23 October 2020 (the day of Freya's death) although for the purposes of examining bereavement support, this period was extended.

2.6 It was not possible to involve the parents in this review for some time as they were under police investigation. They no longer are and many efforts have been made by the lead reviewer and their social worker to encourage them to contribute to and review the report but, other than to one text message confirming an email address, they did not reply. It was felt by the lead reviewer and the Safeguarding Partnership that the review should take this as them not wishing to be involved so this report is written without their direct perspective. As a result the pseudonyms used have been chose by the lead reviewer rather than the parents.

3. Practice Episodes

7 January 2020 – 1 July 2020 – Ante Natal Period

3.1 On the 7 January 2020, Hannah – Freya's mother –, accompanied by Ryan (Freya's father) –, presented at Queen Alexandra Hospital (QAH), Portsmouth (part of Portsmouth Hospitals University NHS Trust [PHUT]) for maternity care and was booked by an allocated midwife. During this she disclosed a history of pre-pregnancy alcohol use (20 units per week) and cocaine use, two years previously.

3.2 Hannah's GP did not become aware of the pregnancy until early April as women are able to self-refer directly online by completing an online booking form. On receiving the completed form, the usual process is that PHUT Maternity Services contact the GP by letter informing them their patient is pregnant and has presented for maternity care, requesting any relevant health related and social information be returned. The GP surgery has no record of receiving this notification until after Hannah's sixteen-week scan.

3.3 Hannah attended QAH for a routine ultrasound scan on 23 January 2020 and gastroschisis[3] was identified in the unborn baby so Maternity Services contacted the Fetal Medicine Unit (FMU) at Princess Anne Hospital (PAH) in Southampton (part of University Hospital Southampton NHS Foundation Trust [UHSFT]) for Hannah to be reviewed. A Parental Substance Misuse Assessment was completed by the midwife four weeks later and no ongoing support was identified as necessary.

3.4 It is unclear whether any of the history known to PHUT Midwives was shared with UHSFT as, initially, the referral was for a fetal medicine opinion rather than a booking.

3.5 On 7 February 2020, at fourteen weeks gestation, Hannah was reviewed in FMU Outpatients at PAH. The investigations confirmed prenatal gastroschisis, a complex diagnosis requiring the baby at birth to have surgical input in a specialist FMU in the immediate postnatal period. A plan for this was established and Hannah's antenatal care and birth was then to be led by the FMU at PAH.

3.6 On 20 February 2020, Hannah attended a PHUT community midwife antenatal appointment. A PRAM (substance misuse proforma) was completed due to her previous self-disclosed alcohol consumption, however she reported she had ceased drinking in pregnancy. The PRAM revealed a low risk score and it was planned to be revisited later in the pregnancy.

3.7 The same day, during a PHUT maternity safeguarding supervision around this case, domestic abuse and mental health were discussed and there was no evidence of either, but it was decided to re-visit Hannah's lifestyle and drinking at subsequent appointments. There was also a discussion regarding Hannah's attendance at antenatal appointments.

3.8 On 14 April 2020, during a routine ultrasound at PAH, it was noted that the baby was small for her gestational age and had shortened long bones. Clinicians discussed with Hannah whether she would consent for an amniocentesis but there appeared to be no further discussion regarding this, therefore it is unclear if she declined it or, clinically, it was decided against.

3.9 The same day Hannah was booked for pregnancy care and birth at Princess Anne Hospital by the FMU midwife. Routine enquiry was made during regarding substance misuse, mental health, previous social care involvement and domestic abuse. Hannah responded that there were no such issues. FMU remained unaware of the history reported to PHUT.

3.10 On 23 April 2020, Hannah was due to attend a PHUT midwife appointment but did not. The midwife made two calls and left messages on each. It seems PHUT maternity services did not know that Hannah had been booked in to UHSFT for pregnancy care and birth.

3.11 On 30 April 2020, again Hannah did not attend a PHUT midwife appointment. Two telephone messages were left on Hannah's answerphone, and a letter sent to her home. Within the letter, a new appointment date was provided and Hannah was informed if she did not attend the third appointment a referral to children's social care would be made. Again, it seems PHUT did not know that Hannah had been booked in to UHSFT for pregnancy care and birth.

3.12 Hannah attended PAH for ultrasounds on seven further occasions between 28 April

[3] An abdominal wall defect whereby a child's abdomen does not develop fully while in the womb causing the intestines to develop outside the abdominal wall

2020 and 29 June 2020. At this last appointment, due to continued concerns over the baby's growth and gastroschisis, a decision was made to induce labour.

3.13 In addition to the ultrasound appointments, given concerns around fetal growth which remained on the 5th centile, there was a plan for the baby's heart to be regularly monitored by a non-invasive continuous cardio-tocograph (CTG). The frequency of these increased from twice weekly to alternate days.

3.14 On 14 May 2020, for the third time Hannah did not attend a PHUT midwife appointment. A telephone call was again made and message left together with a letter being hand delivered to her address.

3.15 On 21 May 2020, PHUT made a MASH referral due to her missing the midwifery appointments. The referral contained information relating to alcohol and cocaine use (including information from the PRAM of 20 February 2020) and adverse childhood experiences. The referral stated that no mental health or domestic abuse issues had been reported.

3.16 Given the referral did not meet threshold it was returned to PHUT Maternity Services for more information. It seems that it was from this that PHUT safeguarding first became aware that Hannah was receiving her care in Southampton and that some appointments there clashed with theirs. UHSFT were satisfied that Hannah was engaging well with them and had no concerns regarding her keeping appointments. This was also the first time that PHUT Maternity Services discovered Hannah's ante natal and birthing care would be delivered by UHSFT.

3.17 As a result of this information, on 2 June 2020 the case was reviewed by PHUT Safeguarding Team resulting in a request to the community midwife that all relevant information and the maternity hand-held record be sent to PAH and to formally hand over care. The Community Midwife confirmed this had already been done.

3.18 On the same day a health visitor attempted a remote (due to Covid) antenatal home visit but there was no reply. The health visitor left a voicemail asking for a call back.

3.19 Given the referral did not meet threshold and was returned, the fact that Hannah had been a victim of domestic harassment from a previous partner and that Ryan had been subject of three Multi Agency Risk Assessment Conferences (MARAC) between 2013 and 2015 in respect of another partner, was not highlighted. The police held this information but it would not have been expected for PHUT to enquire of them once the referral had been returned.

3.20 On 8 June 2020 Solent NHS undertook a remote antenatal health visit and noted that Hannah would require additional post-delivery support for maternal mental health due to her anxiety. She was given comprehensive safe sleeping advice and signposted to electronic resources. The health visitor also discussed domestic abuse with her but no immediate action was required. They did discuss the frequent appointments at PAH but Hannah said her wider family friends were very supportive.

3.21 On 10 June 2020, a maternity safeguarding liaison form was raised and reviewed by maternity safeguarding at UHSFT in response to the earlier MASH decision as it seems this was the first time PAH were aware of the previous alcohol and cocaine misuse as Hannah had not reported that to them.

3.22 Hannah did miss two consecutive CTG appointments in the week commencing 8 June 2020 and advice was given to continue to monitor and review if further appointments were missed.

2 July 2020 – 28 August 2020 – Birth and Post-Natal Hospital Care

3.23 On 2 July 2020, due to a delay in the first stage of labour, Freya was born by Emergency Caesarean Section at thirty-five weeks. Her birth weight was 1.585kg, she was in good condition and needed no neonatal life support. She was transferred to the Neonatal Unit

(NNU) to allow immediate treatment for her gastroschisis. She required some support with breathing but was weaned off this quickly and was self-ventilating by eight hours old.

3.24 During the initial postnatal period Hannah made a routine recovery and was keen to mobilise and visit her daughter. There is no documentation regarding her partner during this period but Hannah visited her daughter regularly. Due to Covid restrictions, visiting by partners was severely restricted.

3.25 The following day, Hannah was discharged to midwifery-led care. Ordinarily she could have lodged at the Ronald Macdonald House but as this was closed due to Covid, she was discharged to Bramshaw ward to enable her to spend time with Freya.

3.26 Following birth, the gastroschisis was confirmed and the bowel was gradually reduced back inside and the abdominal opening was closed. She was fed intravenously until her bowel started to work and she was able to establish full breast feeds, then she transitioned to a prescription formula because of poor growth. She also had symptoms of gastro-oesophageal reflux disease There were no family concerns noted during the inpatient stay.

3.27 Having been notified of the birth on the 3 July 2020, the health visitor congratulated Hannah by text. She asked to make a home visit in July but as Hannah was still in hospital this was delayed. During this time, Freya was under Universal Plus health visiting.

3.28 On 6 July 2020 the health visitor text Hannah to set an appointment for 13 July 2020. Hannah text back to say that that Freya will not be with her so it was agreed they would talk over the phone then and plan a subsequent face to face appointment. This conversation happened as planned and communication was maintained regarding Freya's hospital stay and to discuss discharge.

3.29 In the early hours of 19 July 2020 police were called to a report that a drunk driver had crashed into a fence in Portsmouth. When they arrived, witnesses described to police how the driver had driven off from the scene. Before doing so the driver had assaulted a security guard who had challenged him.

3.30 Police went to the owner of the vehicle, Ryan's, address and found him and a woman (believed to be Hannah, as comments were made about her breastfeeding and having a baby in hospital) in the address. Both were described as drunk. Ryan refused to come to the door and threatened the officers himself and with two dogs who were in the house. Whilst officers spoke with him he barricaded the door and screwed it shut. A senior police officer declined permission for officers to force entry to make an arrest or to 'save life or limb' under Section 17 Police and Criminal Evidence Act 1984. This incident was not reported to other agencies through the police PPN1 referral form.

3.31 Later in July 2020, Hannah was in Neonatal Intensive Care Unit (NICU) with sickness. The health visitor advised Hannah to liaise with the GP regarding contraception and to let her know when Freya was discharged.

3.32 By 10 August 2020, Hannah was becoming frustrated with Freya's hospital stay. She sent her health visitor a text saying she wanted to take Freya home as some of the staff do not listen when Freya has got wind and do things that are making her vomit which doesn't happen when she feeds her. The health visitor quickly replied, offering to complete weekly weight checks but said Freya should stay in hospital to be monitored. The health visitor offered to liaise with the hospital but it is unclear whether she did.

3.33 On 18 August 2020, Freya's weight was 2.7kg and she was discharged home. Her discharge medication was Omeprazole, Iron and Vitamin supplements. The discharge checklist was completed which included a one to one discussion regarding ICON[4] and safe sleep and a pack containing information[5] covering these risks. Because of Covid it was not

[4] A method to avoid abusive head trauma in babies. https://iconcope.org/for-professionals/
[5] https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-for-babies-a-guide-for-parents-web.pdf

possible to discuss these with Ryan at the same time and no steps were taken to do so subsequently.

3.34 As well as seemingly not being notified of Hannah's booking, the GP surgery maintain they did not receive a discharge summary or birth notification from Southampton regarding Freya, despite UHSFT records showing they were sent. After being registered with the surgery on 21 August 2020 she was never seen in the surgery. She did not have a 6-8 week check, nor did she attend for either her first or second immunizations.

3.35 On 24 August 2020, Hannah contacted the surgery following discharge from UHSFT to re-prescribe Alfamino powder for Freya. The missed child immunizations were picked up from the child health report and, after being unsuccessful in contacting Hannah by phone, the surgery sent a text message in October asking her to contact them to arrange an appointment.

3.36 On 25 August 2020 Hannah took Freya for a NNU routine post-discharge review. The surgical nurse specialist noted some concerns regarding Freya's physical health so, in accordance with protocol, sought advice from the consultant in charge of Freya's care and arranged for her to be reviewed by the paediatric surgical team in based in the Emergency Department (ED). Staff escorted Hannah and Freya to ED where Freya was initially reviewed by a consultant paediatric surgeon who recommended an overnight stay on PAW for observation and monitoring of input and output as she was mildly dehydrated.

3.37 That evening a surgical register further reviewed Freya as Hannah wanted to go home. They explained the risk of Freya deteriorating and offered a referral to the Paediatric Unit at QAH. Hannah declined this and told the surgical registrar she had a health visitor appointment the next day. This was not checked. A plan was made for Freya to be discharged home with a follow up call the next day, a review by the health visitor and a ward review on the 27 August 2020.

3.38 The paediatric surgeons would have preferred not to have discharged Freya but did so given the plan they put in place. As UHSFT paediatricians do not have access to maternity liaison forms they would not have been aware of the parental history and therefore any additional vulnerabilities. They only access maternal records in cases regarding children open to Children's Services where they have concerns and with maternal consent.

3.39 Hannah had cancelled the appointment with the health visitor. It is unclear whether this was before or after she took the decision to self-discharge. In either case, she would have known before or shortly after the discharge plan was set that she would not be seeing the health visitor before 8 September 2020.

3.40 On 27 August 2020, following a review by a surgical registrar, when the fact of the cancelled health visiting appointment was realised, Freya was admitted to the children's surgical ward. Hannah completed and signed the nursing assessment form stating there was no current or historical alcohol misuse, drug misuse, domestic violence or mental health issues with anyone living in home. Hannah remained with Freya during her stay.

3.41 The following morning, after a gastroenterology opinion and review, Freya's feeds were changed to a high energy formula, with paediatric dietetic supervision. During the review, a plan was made to discharge that day. There is no record of whether a discussion took place regarding the potential risk of early discharge or the impact on Freya. It is noted on the discharge paperwork that 'mother would like to go home.' A period of observation to see if the change in formula improved feeding and reduced vomiting episodes had been requested, but this appears to have been changed, probably as there was no evidence of vomiting at the time of discharge. A discharge letter was sent to primary care but seems not have been received. Following discharge from UHS, Hannah had ongoing telephone support with the paediatric dietician.

4 September 2020 – 23 October 2020 Post Discharge Period in Community

3.42 On 4 September 2020 an outpatient review with the Neonatal Dietician revealed that

Freya was gaining weight and was now 3.02kg. Hannah had no other concerns and said she had a review with the health visitor planned for the following week.

3.43 On 8 September 2020 the health visitor tried to contact Hannah to arrange a visit. Her call and text were returned the following day when Hannah said Freya was gaining weight with the new milk. A plan was made for a home visit on the 21 September 2020.

3.44 On 21 September 2020, Hannah text the health visitor to cancel the appointment as she had too much on. The health visitor text back offering to weigh Freya but Hannah did not reply. The health visitor waited for Hannah to rebook an appointment.

3.45 On 30 September 2020 during an outpatient review with a consultant paediatric gastroenterologist, there were no clinical concerns and Freya's weight was now 4.05kg. She was reported to be on no medications and the plan was to review her in 4 months.

3.46 On 1 October 2020, the health visitor tried to call Hannah and sent her a text but received no reply. By now Freya had been stepped down to Universal Health Visiting. That was the last contact attempted between the health visitor and Hannah. The effect of this is that Freya was not seen for a new birth visit since her discharge from hospital on 18 August 2020.

3.47 On 15 October 2020, Hannah's MATB1 (Statutory Maternity Pay form) was collected from the GP surgery, the same day the surgery sent her a reminder to book Freya's immunisations.

3.48 At 06:00 on 23 October 2020, Hannah awoke to find Ryan asleep on top of Freya in their double bed. Ryan was on his side partially covering Freya with his body. Hannah woke Ryan and picked up Freya who was cold to touch and her body felt stiff. Hannah commenced CPR however she could not open Freya's mouth fully. At 06:08 Hannah contacted the ambulance who were dispatched immediately, arriving within seven minutes of the call. When they arrived Freya was unresponsive and pale.

3.49 She was taken straight to QAH but sadly pronounced dead at 07:10. Given the circumstances, Hannah and Ryan were arrested on suspicion of causing or allowing the death of a child. During the search of their house a number of cannabis plants were found in the loft. Subsequently, both parents were further arrested for cultivation of cannabis.

3.50 The house was described as cluttered and untidy – indicating that some level of support required due to a degree of neglect. There was baby equipment present in the house, although not being used. There was evidence of old food in the kitchen, compost in the house as well as cannabis and drugs paraphernalia. There was a cot present in the parents' room but appeared to be used for storage and had some evidence of posseting and animal hair on the sheet. There was blood on the sheets in the bed.

3.51 There were appropriate clean bottles and clothes in the house and a Calpol bottle which indicated minimal use. Freya's red book was found, but there were no written contacts inside, and safe sleep information was found in a wardrobe. The pet dogs and fish appeared well cared for

3.52 The Child Death Review Process[6] was instigated straightaway.

3.53 During interview, Hannah confirmed that she drank four pint cans and a small can of Heineken the previous evening. She drank the first one at around 8pm and the rest over a three to four hour period. Eight empty cans were found. She said when she went to bed she was drunk but not 'wasted.' She also said she had 'two tokes' of cannabis at about 9pm.

3.54 Hannah confirmed Ryan drank about the same amount as her and maybe a few extra smaller cans of Heineken. He also had 'two tokes' of cannabis. She said she went alone to bed about midnight, leaving Ryan alone with Freya. The last time she saw Freya alive, she

[6] https://hipsprocedures.org.uk/assets/clients/7/HIPS%20Child%20Death%20Review%20Process.pdf

was asleep in her highchair.

3.55 At 06:00 she awoke and Ryan was lying on his side facing the wall away from Hannah. Freya was under him just below his shoulder blades with her face in his back. Hannah could see one side of her face, one arm and a leg. The rest of her, including her face, was squashed against Ryan's back.

3.56 Hannah said Freya would normally co-sleep with them despite knowing that they should not. She admitted to being aware of safe sleep guidance and was told not to co-sleep but her friends did it so she thought it would be OK. Hannah said Freya usually slept on her side of the bed, up by her face between her and Ryan, and she moves a pillow to allow room.

3.57 During his interview, Ryan said he and Hannah drank two pints cans of Heineken each. He said he did not consume any other alcohol nor had he smoked cannabis or taken any other illegal substance.

3.58 He said he, Hannah and Freya went to bed together at midnight and that 80% of the time Freya sleeps in her cot. He said that she was in her cot when they all went to bed and the first time he knew she was in the bed was the following morning when Hannah woke him shouting. He then saw Hannah pick Freya up from the centre of the bed and confirmed that Freya had been tucked under his back. He had not known she was there and at no time did he feel her.

3.59 He added that Freya was being given Calpol as she was teething and that he and Hannah had not discussed co-sleeping but had been given leaflets on safe sleep.

3.60 Freya and Ryan are still under investigation.

4. Analysis

4.1 This review has highlighted a number of learning opportunities and areas of good practice. The learning opportunities, good practice points and the recommendations they lead to are organised by the terms of reference they refer to.

To examine the effectiveness of information sharing arrangements between all agencies and professionals (including whether PPN1 forms are used accurately and effectively) and whether these could have been improved.

4.2 There were a number of examples where information broke down in this case, specifically:

4.3 Hannah's care was transferred from PHUT to UHSFT given the fetal abnormality which was discovered in January 2020. A decision was made shortly after that all Hannah's ante natal care, and the birth, would be led by UHSFT. UHSFT's monitoring regime of Hannah was intense and, by and large, she engaged with it.

4.4 However, despite the referral the communication between PHUT and UHSFT was poor. The midwifery service seemed unaware Hannah was being looked after in Southampton and made many attempts to see her during the period she was making the forty five mile round trip for fetal scans. In accordance with their policy[7], they were tenacious in following up what they considered to be episodes of non-engagement, to the point that they made a MASH referral under the safeguarding arrangements. Had they been aware that Hannah's care had been transferred, they say they would have realised she was engaging elsewhere and not considered her missing their appointments a safeguarding issue.

4.5 The MASH referral, which was not accepted, was not discussed with the Named Midwife for Safeguarding nor shared with the GP, which reduced the opportunity for fuller information to be considered. Had the referral met threshold, Ryan's and Freya's domestic

[7] Missed Antenatal and Postnatal Appointments – Guideline – PHUT 2020

violence history with previous partners would have been revealed as police information would have been requested. However, as it did not, PHUT were asked to gather more information which led them to realise that Hannah was being treated at Southampton. This exercise would not reasonably have included a request for police information.

4.6 Practitioners explained that the initial referral to FMU was for a review only and made over the telephone. When that became a booking to manage the gastroschisis, the FMU did not communicate that with PHUT Maternity Services so they remained oblivious. The review was told that routinely FMUs communicate with each other and then expect the recipient to cascade the information to their wider teams as appropriate. The PHUT Antenatal Transfers Out to External Trusts Standard Operating Procedure (SOP)[8] does not explicitly cater for these transfers as it is more focused on transfers consequential to mothers' choice. Since these events, the review has been told that the practices have been addressed and now FMUs would ensure they refer to the originating maternity services department.

4.7 The review understands the introduction of Badgernet[9], a perinatal data management system, across all the trusts involved in this review will significantly improve the information sharing in these situations. As it is new to many trusts, its efficacy in this region has yet to be shown but the Child Death Overview Panel co-ordinator reports promising improvements already. Access to this system will not only be by maternity services but FMUs too. Although the signs are good, its important that professionals review records otherwise, despite the information being available, they may remain unaware of key events.

Recommendation 1

That PHUT and UHSFT assure themselves that the introduction, roll out and use of Badgernet supports and promotes information sharing so that referrals are documented, visible and communicated to appropriate professionals. Also that the outcome is available to the referring department, and any other clinical services the patient is currently under, so that continuity of care is clear and primary responsibility assured.

4.8 When the FMU referral was made, the relevant information around Hannah's increased vulnerability, primarily to do with her self-reported historical alcohol and substance misuse, was not included so the receiving hospital were unaware of these factors. Also, information regarding Ryan having a history of domestic violence with a previous partner, and Freya previously being a victim was unknown to all health professionals so, in respect of any future risk, all they had to rely on was Hannah's self-report that domestic abuse was not an issue. There is nothing to suggest there was domestic abuse between her and Ryan, but the previous history combined with her alcohol/ substance misuse disclosure would have highlighted an increased vulnerability around her and her unborn child than was assumed.

Recommendation 2

PHUT ensure that when referring patients to any service, whether within or out of the Trust, they include all information regarding that patient, especially such that might suggest an increase safeguarding risk or heightened vulnerability for the child or parent(s).

4.9 The police did not share the details of the road traffic collision during which it was revealed that Freya, who was in the house that Ryan barricaded, was breast feeding. This oversight meant that critical information was kept from other agencies and, particularly around the time Freya was seeking to discharge Hannah from hospital, might have prompted a stronger response to safeguard her. The police acknowledge they should have shared, and

[8] Antenatal Transfers Out To External Trusts Standard Operating Procedure (SOP) – PHUT 2020
[9] https://www.badgernotes.net/

this was an oversight by the officers concerned.

4.10 Had they shared this event, they would have identified the previous domestic history Hannah and Ryan had with previous partners and this would have been significant in assessing risk, especially with a new born baby adding to the family pressures.

4.11 Hampshire Constabulary have recently launched a major initiative, 'Child Centred Policing[10]', a program to embed six key principles of taking a Child Centred approach to all aspects of policing so as to improve the quality of policing for children and young people by acknowledging their differences, recognising their vulnerabilities and meeting their needs**.**

4.12 The oversight in this case was an individual error but it is intended the principles of Child Centred Policing will reduce such occurrences in the future.

Recommendation 3

Hampshire Constabulary, as part of the Child Centred Policing programme, ensure all officers understand the purpose and importance of sharing information through the PPN/1 process which might indicate that children or vulnerable people are, or could be, at risk especially when that information indicates substance misuse or violent behaviour by parents and/ or carers.

4.13 The communication between the UHSFT and the health visitor could have been improved. Hannah voiced frustrations to the health visitor about the way NNU were treating Freya and the health visitor said they would speak with the ward yet there is no evidence they did. Then, against medical preference, Hannah wanted to discharge Freya from PAW. One of the factors that seemed to reassure the registrar that discharge was safe was Hannah saying she had a health visitor appointment the following day, but she had cancelled it. Given this conversation took place in the evening it might have been difficult for the registrar to check, but had they been able to, they would have discovered the truth, a truth that was only realised subsequently upon which Hannah returned Freya to hospital for a pre-arranged appointment. However, as UHSFT were unaware of any concerns, as they had not been shared, there were no concerns regarding Freya's safety.

Recommendation 4

Solent NHS Trust and UHSFT should assure themselves that the communication pathway between acute and community services in respect of babies under one year who are being treated in an acute setting is effective. This should ensure improved information exchanges regarding shared patients/ service users so as to provide better continuity of care and ensure that the parents' voice is heard regarding their child's treatment.

4.14 Greater access to maternity liaison forms might have allowed the clinicians to better understand the risk and vulnerability of a child under their care. Whilst UHSFT did not know the domestic violence background, nor Ryan's recent alcohol related offending, they would have known of the historic substance misuse concerns which would have painted a fuller picture than Freya's disclosure offered. The introduction on Badgernet should improve this, as well enabling inter-trust maternity information sharing. The effectiveness of this should be reviewed when the system is established and operating.

[10] https://www.safe4me.co.uk/wp-content/uploads/2018/10/CYP-strategy-2017-01-update.pdf

Recommendation 5

UHSFT should ensure that paediatric clinicians have access to parental information, such as maternity liaison forms, so they can properly assess children's vulnerability when making clinical decisions or decisions to discharge.

4.15 Hannah's GP have no record of hearing about the pregnancy, birth and discharge. The discharge letter is on the hospital system as being sent but it remains unclear why it was not received by the GP.

Recommendation 6

The GP surgery, PHUT and UHSFT should review their systems to ensure notifications of pregnancies, births and discharges are sent and received as expected and to establish whether this is a case specific issue or whether other patients are affected too.

To explore the arrangements which support handover of care during the ante and post-natal periods between NHS trusts, especially when one or more trust is out of the Portsmouth area.

4.16 The referral from PHUT to UHSFT was clinically appropriate given Freya's gastroschisis but it does not seem to be underpinned by any holistic process to ensure that all the relevant information about expectant mothers and their unborn babies is shared.

4.17 For example, in this case the historical information regarding Hannah's previous alcohol and drug misuse, which was captured at her midwifery booking, was not passed on to the UHSFT and were only picked up by UHSFT when they responded following the rejected MASH referral. They then raised their own Maternity Safeguarding Liaison form but this was not subsequently passed on to the clinicians. This meant that when Freya was admitted to PAW and the surgical ward in late August, Hannah's assertion that there was no current or historical substance misuse was accepted as there was nothing to cross check this against. These concerns are addressed by Recommendations 1, 2 and 5 and should be resolved by Badgernet.

4.18 It appears also that Solent NHS were similarly not informed of the previous substance misuse until the rejected MASH referral was followed up. This is also addressed by Recommendation 2.

4.19 Despite PHT referring Hannah to UHSFT for Freya's gastroschisis to be managed, it seems PHT midwifery were unaware as they escalated Did Not Attend (DNA) episodes to safeguarding. They also did not know that her antenatal care and the birth would be led by UHSFT. They were oblivious that Hannah was attending PAH very regularly and that they had no concerns.

4.20 There did not seem to be any protocols between the two trusts to ensure relevant information was shared when patients are referred for tertiary treatment. The review was told that there are arrangements when a formal referral is made but not, it seems, when transfers of care happen through these less formal routes. Badgernet should ensure that all relevant information is shared and all those previously providing services notified. This is also addressed by Recommendation 1.

To examine the effectiveness of new birth and post-natal visiting and care arrangements, especially when one or more on the trusts involved is out of the Portsmouth area.

4.21 From the information provided, Solent NHS, who provide the Health Visiting Service in Portsmouth were aware of Hannah as the health visitor was quick to congratulate her on Freya's birth and was in regular phone and text contact with her during the hospital stay.

4.22 It was not possible for PHUT to undertake a new birth visit as is standard, given that Freya was still in hospital for the first six and a half weeks of her life. Given that, responsibility fell on Solent NHS to undertake the new birth visit. This was very much on the health visitor's radar while Freya was in hospital with attempts to predict when she might be discharged and therefore a visit possible. When she was discharged various appointments were made with the health visitor and cancelled by Hannah. The effect of this was that the health visitor never did visit Freya and therefore never saw her or Hannah in their home setting.

4.23 After the neonatal contact the HV was not afforded the opportunity to discuss previous or current concerns with Freya, the conversations being of a more general nature to arrange a birth visit. Despite efforts, there was no appropriate opportunity to continue conversations around safe sleep after discharge from hospital.

4.24 Whilst it would be easy to point to the Covid pandemic for the reasons the post-natal care was not as continuous as it would otherwise be, it seems it was more connected with Freya's extended hospital stay coupled with Hannah cancelling appointments or not returning calls. Every effort was made but thwarted.

Good Practice Point 1

The tenacity of the health visitor on keeping in touch with Hannah while in hospital and seeking to visit her on discharge was impressive. Whilst she did not have all the information regarding Freya's vulnerability, the health visitor was determined to keep in touch, notwithstanding less enthusiasm from Hannah.

To examine the Portsmouth safeguarding referral arrangements and the threshold for MASH decision making.

4.25 The PSCP Safeguarding Children Procedures[11] are accessible, clear and compliant with national standards and expectations. They are easy to use and have clear appendices on Threshold Guidance[12] and the Inter Agency Referral Form[13].

4.26 Section 3.2 of the procedures links to "Principles and Guidance for Secondary and Tertiary Health Care When a Child Is Not Brought or Misses an Appointment.[14]" This relates to missed ante-natal appointments (DNAs), as well as post-birth consultations.

4.27 This document suggests that referring episodes of "Was Not Brought" (WNB) to social care through the Inter Agency Referral Form should be in cases where there is "high concern due to a persistent pattern of non-attendance or non-engagement, on-going medical or mental health condition and/ or known parental mental ill health, drug or alcohol misuse or domestic abuse or known looked after child or subject to child in need (CIN) or child protection (CP) plan." There are a number of suggested steps for the professional to go through before making the referral including discussing with the health visitor, school nurse, or other professionals.

4.28 Unsurprisingly the MASH referral was returned for the referrer (in this case PHUT midwifery) to undertake further enquiries as to the reasons for the DNA. It was at this point they became aware that Hannah had been attending her appointments in Southampton. Had they been aware of this the situation would have been better understood, professionals' time saved and the impact of multiple clashing appointments on Freya and her unborn baby considered in a more appropriate fashion. PHUT acknowledge that they would not have made the referral had they have known this.

4.29 The previous domestic abuse history was not revealed during the PHUT information

[11] https://hipsprocedures.org.uk/
[12] https://hipsprocedures.org.uk/assets/clients/7/PSCP%20Threshold%20Document%20v5%20March%202021.pdf
[13] https://hipsprocedures.org.uk/okyyzl/appendices/threshold-documents-and-inter-agency-referral-forms
[14] https://hipsprocedures.org.uk/assets/clients/7/Child%20and%20Family%20Engagement%20Guidance%20for%20secondary%20and%20tertiary%20care%20March%202017.pdf

gathering process following the referral nor was the GP informed. The former is understandable as the referral was not at the threshold which would have permitted wider information sharing. The latter is more concerning as, in all cases, information should be sought from primary care. The GP might have had health or social information that would add to the safeguarding considerations. They did not but that was not known nor checked.

Recommendation 7

The PSCP should assure itself that the information gathering and sharing processes between partners, when completing a referral, are thorough and inclusive so, where permitted, relevant information is gleaned and shared with others following each and every request so that risk-based decisions and interventions can be considered, backed by all available information.

To explore the effectiveness of policies and protocols related to patients who 'do not attend', children who 'were not brought' to health appointments and around disguised compliance during the ante and post-natal periods.

4.30 The PHUT process for prospective mothers who miss midwifery appointments is clear and escalates effectively from telephone calls through to hand delivered letters. This was followed but notification of the third DNA to the GP and to the Named Midwife, as set out in the Safeguarding Procedures for Safeguarding, did not happen. This suggests that staff are unfamiliar with the process and the levels of information gathering expected before onward referrals are made. Engaging the Named Midwife for Safeguarding and the GP might have highlighted more opportunities and possibly even that Hannah's care had been transferred.

Recommendation 8

PHUT should ensure all professionals understand the maternity DNA escalation procedure for mothers who miss midwifery appointments so they engage with appropriate safeguarding and primary care colleagues before making a MASH referral.

4.31 In terms of Hannah's disengagement from health visiting, Solent NHS Trust's Guideline[15] is clear and seems to have been broadly followed. The difficulties the health visitor had in engaging Hannah were discussed at regular supervision. As it was clear Hannah was taking Freya to regular appointments in Southampton, the Guideline did not need to be instigated.

4.32 Health visiting is not a mandatory service so if Hannah said she did not want it or a home visit, the health visitor would have strived to make other arrangements such as meeting in a family hub, albeit these were closed due to Covid. Hannah's refusal might have triggered some concern but as it is not statutory to engage; ultimately the choice lies with the parents. The Guideline has been updated around new birth visits now, so if the health visitor has not been able to engage or visit they would escalate their concerns.

To examine the Healthy Child Programme Health Visiting thresholds in operation in Portsmouth, the status' of 'Universal / Universal +' as used by health visitors (including the criteria for escalation or step down through these), what they mean in practice and whether partners have a good understanding of what this looks like.

4.33 The Healthy Child Programme[16] has four stages: Universal, Universal Plus, Universal Partnership Plus and Enhanced Health Visiting Offer (ECHO).

4.34 At birth, due to her medical condition, Freya was under Universal Plus, which is defined as *short term targeted response for specific concerns and provides:*

[15] Guideline for Family Disengagement & Children Not Brought for Appointments - Children's Service Solent NHS Trust
[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

- Extra support with breast feeding
- Evidence based programmes for behaviour, post-natal depression, attachment, sleep programmes, healthy eating and exercise
- Targeted parenting programmes such as Parent Child Game
- Lifestyle interventions such as for smoking or oral health
- Additional interventions for infants and children with developmental delays
- Help to access other support or information to reduce social isolation and improve interactions for children

4.35 By the 1 October 2020, Freya had been stepped down to Universal, which is defined as *routine family health assessment and delivery of the core healthy child programme and provides:*

- Antenatal visit
- New birth visit
- 6-8 week maternal mood screen
- 9 – 12 month developmental review
- 2 – 2.5 developmental review
- Offer to attend child health clinic and breast-feeding groups
- Text messaging and website access to service

4.36 The health visitor had yet to see Freya by this point, and she had relatively recently been discharged from hospital having been readmitted following what appears to have been a discharge against clinical preference, and with incomplete information.

4.37 Freya was on Universal Plus due to being in hospital for her gastroschisis and Hannah requiring additional support. When Freya was discharged, she was moved to Universal seemingly for that reason, although the rationale was not documented. The new Guideline says that if the health visitor cannot visit the family in their home for a new birth visit they cannot now be stepped down. In this case Covid would have prevented the visit but Hannah was not engaging anyway. The review was told that she should not have been stepped down and would not in the future. It was suggested that had the health visitor been able to visit then Freya may have been escalated rather than stepped down, given what is now known.

To explore the knowledge and understanding of Sudden Unexpected Death in Infants (SUDI) risk factors among professionals and how these influence assessment and decision making.

To examine the nature, range and effectiveness of information and support provided to parents and carers, by health and social care agencies, around co-sleeping and reducing the risk of SUDI.

4.38 In the Child Safeguarding Practice Review Panel thematic report, 'Out of Routine: A Review of Sudden Unexpected Death in Infancy (SUDI) in Families Where the Children are Considered at Risk of Significant Harm (2020)[17]', a range of pre-disposing risk factors were identified in the forty notified cases. These are in keeping with the well-established evidence base for the risk factors associated with SUDI:

- Unsafe sleep position (prone or side)

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

- Unsafe sleep environment: –co-sleeping in the presence of other risks (including bed sharing), overwrapping, soft sleep surfaces
- Tobacco exposure
- Alcohol and drugs (during pregnancy and when co sleeping)
- Poor post-natal care - late booking and poor ante natal attendance
- Low birth weight (< 2.5kg) and preterm birth <37 weeks' gestation)

4.39 Whilst this case involved all of these factors, professionals were aware of just the final two as, so far as they knew, Freya no longer drank, did not smoke or take drugs and did not co-sleep or expressed a desire to do so. As previously explained, it was not possible for the health visitor to see the home environment and therefore get a sense of whether Hannah and Ryan smoked, drank, took drugs and what the sleeping arrangements were, although she would have seen a cot (albeit cluttered) had she been able to access. She was also unable to have detailed remote conversations around this too as the bulk of the phone calls were to do with planning for Freya's discharge to arrange the new birth visit.

4.40 During a remote ante natal visit by the health visitor in June 2020, Hannah was anxious about post-delivery and they advised her on the best sleeping position for the baby and that the safest place was for the baby to sleep in a room with their parent/carer for the first six months. They also spelt out the risks associated with co-sleeping, advised around no hats in the house as the baby would overheat and on bedding. The notes also say she was signposted to electronic resources, but it does not indicate which.

4.41 When Freya was discharged in August 2020, UHSFT recorded they discussed safe sleep in some detail with Hannah. Both the Neo Natal ward and the health visiting service say that the notes reflect that Freya's heightened vulnerability was recognised, hence the detailed discussions they had. They also say that professionals impressed on Hannah that Freya was in a higher risk category than the general population so the advice they were giving was particularly pertinent.

4.42 Applying Figure 1, further information would have placed the family in the middle category (Predisposing vulnerability and risk) and on the night Hannah died, into the bottom category (Situation risks and out-of-routine incidents). Applying the proposed 'prevent and protect practice model for reducing the risk of SUDI (Figure 2), there are a range of recommendations for working with parents of children with heightened risk. These seem to have been applied in this case.

Figure 1 Source - Child Safeguarding Practice Review Panel Report, 'Out of Routine' (2020).

Level of risk	Families affected	Risk factors identified in the fieldwork cases[14]
Background context	All families	• General recognised risk factors for SUDI • Variations in access to and range of preventive services • Fragmentation between providers
Predisposing vulnerability and risk	Families with additional needs	• Socio-economic deprivation • Poor or overcrowded accommodation • Adverse childhood experience of parents impacting on inability to detect harm in interpersonal relationships • Parental mental health problems • Alcohol or substance misuse • Ongoing and cumulative neglect • Parental criminal behaviours • Relationship breakdown and/or new partners • Limited engagement with services, including late ante-natal booking and mistrust of professionals • Prematurity or other vulnerabilities in the infant
Situational risks and out-of-routine incidents	Families with children at risk of significant harm	• Temporary housing • Change of partner • Altered sleeping arrangements • Alcohol or drug use on the night in question

Good Practice Point 2

The recognition of SUDI risk factors that were known (accepting some had not been shared) was strong and the bespoke advice and guidance given to the mother was clear to the extent that she could recall it when interviewed by the police.

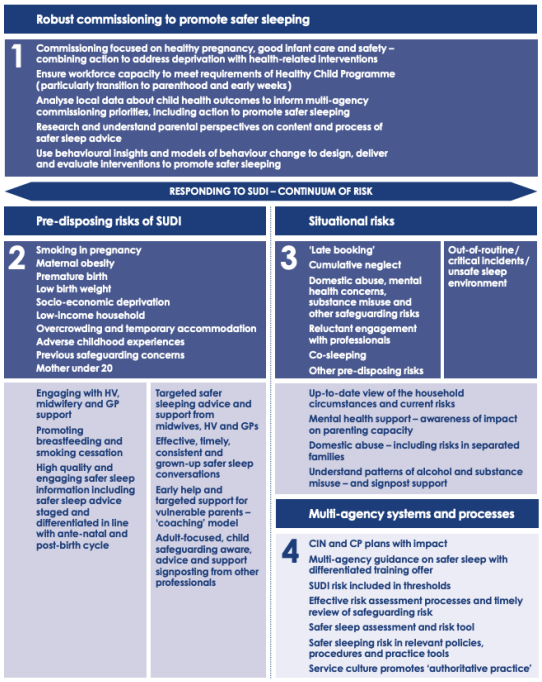
4.43 In 2019, Southampton LSCB (now Safeguarding Children Partnership) published a thematic review on co sleeping deaths[18]. This examined four deaths, two of which were also reported as serious case reviews. In that review, the four deaths were compared against recognised risk factors similar to the Out of Routine Report (Figure 3). Freya is added for comparison.

4.44 This shows Freya to be more vulnerable on the night she died than the other babies, the difference being that given the lack of information, social care and non-universal provision in this case many of those factors or risks were unknown in this case.

4.45 Hannah said that she was aware of the risks of co-sleeping and had been told not to do it but as her friends did, so did she. She described how she would usually sleep with Freya. Ryan said, as far as he was aware Freya was in her cot and it was rare for them to co-sleep. Hannah admitted consuming alcohol and cannabis on the night. Ryan said their alcohol consumption was modest and neither consumed drugs. Despite the varying accounts, what is clear is that Hannah heard and understood the safe sleep messaging and chose to co sleep anyway.

4.46 The Southampton review noted from a 2017 US study[19] that all mothers in one focus group admitted to bedsharing even though they knew the risks. In this study they cited exhaustion as being the reason but equally there could be other drivers for parents to make this choice in the face of advice.

Figure 2 Source - Child Safeguarding Practice Review Panel Report, 'Out of Routine' (2020).



[18] Southampton LSCB Thematic Review on Co Sleeping Deaths (2019)
[19] https://web.wpi.edu/Pubs/E-project/Available/E-project-121217-163202/unrestricted/WPI_Infant_Sleep_Safety_CPSC_17_Report.pdf

Figure 3. Source Southampton LSCB Thematic Review on Co Sleeping Deaths (2019)

Risk Factor	Reece	Child A	Child B	Billy	Freya
Not in a cot by parents' bed	X	X	X	X	X
Sleeping with baby on a sofa				X	
Sharing with a smoker	X		X	X	X
Sharing with person who has consumed alcohol					X
Sharing with person who has taken drugs (legal or illegal)					X
Parents in low socio-economic groups	X			X	X
Parents currently abuse alcohol or drugs					X
Young mothers with more than one child	X				
Premature infants and those with low birthweight		X	X	X	X

4.47 Co-sleeping is common-place, even widespread in many cultures, so the universal message regarding safe sleeping should reflect unsafe co-sleeping rather than co-sleeping per se. In the Out of Routine report, all the cases reviewed unsurprisingly involved co-sleeping but nearly all also involved drugs or alcohol. The risk factors are episodic and contextual so while in this case, Hannah's friends had reported co-sleeping and presumably did so with no adverse effects on their babies, unlike Hannah they may not have had any predisposed or situational risks. If the messaging is universal and does not focus on heightened risks, parents could compare their sleeping arrangements with others and see no problem, not recognising the differences.

4.48 It seems that in this case the extra risk was recognised hence the more focused guidance. The Safeguarding Children Procedures gives clear messages too[20]. Given the Covid restrictions on visiting, UHSFT did not give the same messages to Ryan and did not seek to do so subsequently. On reflection it would have been better if they had so there would be a common understanding between both parents of the risk and how to avoid them so they could support and regulate each other.

To examine the impact of organisational and operational change as a consequence of the Coronavirus pandemic on the provision of health and social care in the ante and post-natal periods.

4.49 All but the first two months of the period under review took place during Covid restrictions, most of it during the first lockdown when services and the whole population were coming to terms with an unprecedented pandemic and the arrangements to stem its spread.

[20] https://hipsprocedures.org.uk/qkypxo/children-in-specific-circumstances/safe-sleep-for-babies-and-infants.

4.50 Surprisingly, the organisational impact this brought was not considered to have affected Hannah's and Freya's services in any significant way. There were staffing shortages across all sectors due to shielding but, in the main, the services Hannah accessed operated as normal. The only exceptions were that staff were unable to see parents together, so missed the opportunity to observe the dynamic they would normally see and health visits were remote, but as Hannah stopped engaging this was not a factor. Portsmouth had closed all family hubs so there were no drop-ins but, again, Hannah had disengaged so probably would not have used them in any case.

To examine the nature and quality of bereavement support offered and/or provided to parents in the period following a SUDI, including in cases when parents are under investigation for alleged criminal offences.

4.51 Given Hannah and Ryan did not wish to engage with the review, it was not possible to speak to them around the bereavement support they received following Freya's death. Whatever their suspected criminal culpability, Hannah and Ryan have suffered an unimaginable loss and their grief may well be aggravated by a real sense of guilt given the police investigation, necessary as it was.

4.52 The Joint Agency Response minutes of 23 October 2020 and 9 November 2020 reveal a decision that the police Family Liaison Officer[21] (FLO) act as the Keyworker for the family. The SIO confirms that contact has been maintained but at this stage, how that has been received by the parents cannot be judged. The GP had also written offering support but received no reply.

4.53 The Bereavement Support Manager at PHUT says they have had no contact from Hannah and Ryan and she was barred from contacting them due to the investigation.

4.54 The Child I Serious Case Review (PSCP 2020)[22] highlights the lack of clarity over staff contacting parents under investigation to provide them bereavement support. The Lullaby Trust provides advice on how to offer support[23] but not where there is a criminal investigation ongoing. There appears to be no guidance on this so parents are left in limbo to grieve alone with no professional support other than through the FLO whose independence they might doubt.

Recommendation 9

Hampshire Constabulary and NHS providers involved in the Joint Agency Response Procedures should develop guidance to allow parents of children who have died unexpectedly to receive appropriate independent bereavement support in a way that does not adversely affect the criminal justice processes but also recognises their need for support.

To consider any equality and diversity issues (e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) that appear pertinent to the family and any consequent service provision.

[21] https://profdev.college.police.uk/professional-profile/family-liaison-officer-flo/
[22] https://www.portsmouthscp.org.uk/wp-content/uploads/2020/07/Child-I-report-V8-Final-for-publication-1.pdf
[23] https://www.lullabytrust.org.uk/bereavement-support/family-and-friends/

4.55 Throughout the analysis for this review there was nothing identified to indicate that Freya, Hannah or Ryan received a differential or detrimental service based on any equality factors. Unfortunately, as Hannah and Ryan chose not to speak with the review, their perspective on this remains unknown.

5. Conclusion

5.1 It is clear from this tragedy that health providers recognised Freya's increased risk of SUDI and provided enhanced one to one guidance to Hannah to impress on her the heightened vulnerability.

5.2 However, the information sharing arrangements between and within acute trusts and from the police had shortcomings which meant there was confusion as to who was leading on services for Hannah, a lack of information about her alcohol and substance misuse and incidents of alcohol related violence and domestic abuse not being shared. Had the information sharing arrangements been clearer and applied, professionals elsewhere in the system would have had a fuller understanding of the environment Freya was being discharged into and might have engendered additional support to safeguard her.

5.3 The impact of Covid restrictions meant that only Hannah, not Ryan, was given safe sleep guidance, and that was regrettable, but given she understood it there were no omissions or errors which had they not have occurred, would have prevented Freya dying. However, had agencies worked together there *might* have increased vigilance which *might* have encouraged safer sleeping arrangements, which *might* have led to a less tragic outcome.

Appendix A – Schedule of Recommendations

Recommendation 10

That PHUT and UHSFT assure themselves that the introduction, roll out and use of Badgernet supports and promotes information sharing so that referrals are documented, visible and communicated to appropriate professionals. Also that the outcome is available to the referring department, and any other clinical services the patient is currently under, so that continuity of care is clear and primary responsibility assured.

Recommendation 11

PHUT ensure that when referring patients to any service, whether within or out of the Trust, they include all information regarding that patient, especially such that might suggest an increase safeguarding risk or heightened vulnerability for the child or parent(s).

Recommendation 12

Hampshire Constabulary, as part of the Child Centred Policing programme, ensure all officers understand the purpose and importance of sharing information through the PPN/1 process which might indicate that children or vulnerable people are, or could be, at risk especially when that information indicates substance misuse or violent behaviour by parents and/ or carers.

Recommendation 13

Solent NHS Trust and UHSFT should assure themselves that the communication pathway between acute and community services in respect of babies under one year who are being treated in an acute setting is effective. This should ensure improved information exchanges regarding shared patients/ service users so as to provide better continuity of care and ensure that the parents' voice is heard regarding their child's treatment.

Recommendation 14

UHSFT should ensure that paediatric clinicians have access to parental information, such as maternity liaison forms, so they can properly assess children's vulnerability when making clinical decisions or decisions to discharge.

Recommendation 15

The GP surgery, PHUT and UHSFT should review their systems to ensure notifications of pregnancies, births and discharges are sent and received as expected and to establish whether this is a case specific issue or whether other patients are affected too.

Recommendation 16

The PSCP should assure itself that the information gathering and sharing processes between partners, when completing a referral, are thorough and inclusive so, where permitted, relevant information is gleaned and shared with others following each and every request so that risk-based decisions and interventions can be considered, backed by all available information.

Recommendation 17

PHUT should remind professionals of the maternity DNA escalation procedure for mothers who miss midwifery appointments so they engage with appropriate safeguarding and primary care colleagues before making a MASH referral.

Recommendation 18

Hampshire Constabulary and NHS providers involved in the Joint Agency Response Procedures should develop guidance to allow parents of children who have died unexpectedly to receive appropriate independent bereavement support in a way that does not adversely affect the criminal justice processes but also recognises their need for support.

Appendix B – Schedule of Good Practice

Good Practice Point 3

The tenacity of the health visitor on keeping in touch with Hannah while in hospital and seeking to visit her on discharge was impressive. Whilst she did not have all the information regarding Freya's vulnerability, the health visitor was determined to keep in touch, notwithstanding less enthusiasm from Hannah.

Good Practice Point 4

The recognition of SUDI risk factors that were known (accepting some had not been shared) was strong and the bespoke advice and guidance given to the mother was clear to the extent that she could recall it when interviewed by the police.