Nottinghamshire SAFEGUARDING CHILDREN Board

LEARNING AND IMPROVEMENT BULLETIN – JN15

SUMMARY:

The subject of this review is JN15, a 5 month old boy who died in 2013. The cause of death was unascertained. At the time of the baby's death JN15 was in the care of his mother who had a previously unrecognized or diagnosed mental health illness.

The review was conducted using a Significant Incident Learning Process (SILP) led by an independent reviewer. The review identified many examples of good practice by universal services provided to the family. Indeed there was nothing professionals could do to prevent the death as they were not alerted to the deterioration in mother's mental health on the day that JN15 died. Had they been, there is an established process of caring for the mother and child in such cases, and it is likely they would have been followed.

GOOD PRACTICE IDENTIFIED

- The family received a good universal health service from all of the professionals involved.
- Additional support was offered when issues were identified, for example when sibling was losing weight and was a difficult feeder the health visitor provided additional support.
- Following a report of domestic abuse and despite mother calling the police to say she no longer required them to visit in April 2013, an officer went to the home and spoke to mother. This was followed by a risk assessment.
- There was appropriate information sharing between the hospital and community health colleagues.
- All of the relevant professionals asked mother how she was after the birth of JN15. She replied that she was well and this was clearly recorded in agency records.
- The health visitor clearly knew the family well and provided a sensitive and appropriate service to them.
- The record keeping was good across agencies.

KEY LEARNING

Lessons are limited as no professional working with the family was aware of the deterioration in mother's mental health. The mother was not 'at risk' of this condition and mother's post natal depression was not identified on completion of standard assessments. The family appeared to be coping well. However lessons about the sharing of information about reports of domestic abuse have been identified.

ACTIONS TAKEN

1. NSCB is to review information sharing of domestic abuse notifications which are assessed as "standard risk" and particularly in relation to pregnant women.