**Case Study 4**

This is not a real case but contains some elements from different cases that have been part of a Rapid Review carried out in Telford and Wrekin.

**Background information**

Archie is a 3 week old baby born in November 2020.

Archie does have older siblings, however they were removed from his mother’s care before she was pregnant with Archie.

Archie’s mother has a history of drugs misuse and mental health problems, however there has been no evidence of drugs misuse whilst she was pregnant with Archie.

Archie’s mother lived in Telford previously, however she temporarily went to live in Wolverhampton where she became pregnant with Archie. His mother moved back to Telford at 36 weeks gestation to be closer to her family network, she was living with Archie’s maternal grandmother for the end of her pregnancy and when Archie was born.

**Incident**

The Midwife and Health Visitor completed their statutory home visits to Archie at his maternal grandmother’s address as this is where he was registered to be living with his mother. During one of the visits completed by the Health Visitor, mother’s mood was observed to be erratic and she appears to be having a drastic mood swing compared to when the Health Visitor had visited previously. The Health Visitor made a referral for Early Help support based on this home visit which mother consented to, however whilst waiting for this support to be reviewed and implemented, Archie sadly died.

Archie died at an address which was unknown to professionals. It later transpired that this address was mother’s new partner’s address. Mother’s new partner was known to the police for several offences. The address was also a House of Multiple Occupation (HMO) and unsuitable for babies and children to be living there. Archie was discovered by mother’s new partner as he was not breathing and had turned blue. The partner called an ambulance, both paramedics and police attended. Archie was pronounced dead. This then triggered the SUDIC process.

Both Archie’s mother and her new partner were arrested. His mother admitted to being asleep at the time of the incident as she had also been taking drugs with her partner. The partner later admitted to police that he had become intolerant of Archie as he was always crying and he admitted to shaking him aggressively to try and get him to stop crying because Archie’s mother was ‘passed out’.

When all services shared information about this case, the Midwife had recorded on their last home visit that maternal grandmother mentioned a new partner and that Archie’s mother would visit there sometimes. This case record was passed on to the Health Visitor however it was never fully explored.

Family Connect had also received a referral from maternal grandmother as she was concerned about Archie’s mother’s mental health after giving birth. Family Connect could see that the Health Visitor did make a request for Early Help which was in process and Family Connect also gave some information on mental health services which mother could self-refer to. There is no record if Archie’s mother did make any self-referral to any mental health service in Telford.

**Outcome**

This incident met the criteria for a Rapid Review.

Please use the criteria for Rapid Reviews and the resources available (as well as any additional resources you may use in your service) to identify the learning from this case and how this could be implemented into practice.