Hampshire Safeguarding Children Board

Serious Case Review

Child U

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1) The reason for the serious case review

1.1 A Serious Case Review is one of a number of reviews and audits within a Local Safeguarding Children Board's learning and improvement framework. These aim to drive improvements to work to safeguard and promote the welfare of children (*Working Together 2015 p.72)* - learning about and consolidating good practice but also learning from situations where the review has been prompted by a serious incident or tragedy. An opportunity is provided to open a 'window

on the system' and any learning, perhaps especially from a situation with the most tragic of outcomes, must be used to continue to strengthen the development of the various strands (individual practice, each agency and inter agency organisation, management, governance of quality assurance etc) of a 'safety net' comprising the multi-agency professional response with and for all children, young people and families.

1.2 Child U, a seven-week old baby, died in hospital in June 2015 following an emergency admission, transfer to a specialist unit and a decision to withdraw life support care necessitated as a result of significant injury including swelling and bruising to the brain and a fracture to the skull. Child U's father was arrested at the time on suspicion of grievous bodily harm, was charged with murder and subsequently, at trial, found guilty of manslaughter.

1.3 Several health and social care services' teams and professionals had involvement with Child U's parents from early in the mother's pregnancy. Work with the family following Child U's birth was managed under a Child in Need plan (*section 17, Children Act 1989; Working Together 2013 and then 2015 version*) following a pre-birth referral to the Children's Services Department in March 2015 and subsequent assessment.

1.4 Hampshire Safeguarding Children Board considered that the criteria had been met for a serious case review (under regulation 5 (2) and (b) (i) of the Local Safeguarding Children Boards' Regulations 2006) due to the tragic death of Child U, a serious case[1] where abuse was suspected. The time period that the review would cover was agreed as comprising the months during Child U's mother's pregnancy, when services had pre-natal involvement, up until the time of Child U's death - and focusing on learning that will help continue to develop the way that agencies work together to protect children from harm.

2) The review process

2.1 A review panel was appointed consisting of appropriate senior designated professionals from health, the local authority and the police to plan and manage the review. The panel was led by Phil Heasman an independent consultant who has had no previous involvement with the case or the specific local agencies and services involved. Further details of the review panel membership are included in Appendix A.

2.2 The process of the review included:

- preparation of agency reports by senior staff within each relevant agency including, variously: an indication of its roles and responsibilities; a detailed chronology: a narrative of events outlining the contact, involvement and work with the family; a consideration of emerging key practice issues and an analysis of learning and recommendations;
- compilation of a full, integrated chronology;
- meetings of the panel to review the information provided by relevant agencies; to identify themes and issues; to identify key personnel who could assist with developing an understanding of what professionals did in their work with the family and the

[1] NB: the term 'case' is used not as a description of a specific child but rather the whole situation and circumstance, people and processes relating to work with a child, young person and their family.

management and systems supporting it; to consider the information and circumstances of the case and identify learning and recommendations;

- meetings by the lead reviewer and a panel member with relevant practitioners who had been involved with the family both individually and then as a full group together - in order to understand the case from their perspective, including factors affecting practice and its management at the time;
- consultations with managers as appropriate;
- drafting of a review report for consideration by the Hampshire serious case review sub-committee before submission to the Hampshire Safeguarding Children Board.

2.3 Child U's parents were informed that a review was taking place and an invitation offered to meet with the lead reviewer and panel members.

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3) Names used in the report and agencies in contact with Child U and her family

Names used in the report

Child U – also referred to as Unborn baby U up until date of birth.

Unborn baby U's mother or Child U's mother / mother

Unborn baby U's father or Child U's father / father

Maternal grandmother – Child U's grandmother on her mother's side

Agencies in contact with Child U and family

3.1 Several agencies, services and professionals had contact with Child U, the parents and Child U's maternal grandmother and wider family members (both before and after Child U's birth) and the following may be referred to in the report:

- GP surgery and practice
- Local hospital NHS Trust (1):
    - Emergency Department
    - Early Pregnancy Unit
    - Ante-natal Midwifery services
- Local hospital NHS Trust (2):
    - Teenage Pregnancy Community Midwife service
    - Maternity unit
    - Hospital midwifery service and antenatal ward
    - Emergency Department
    - Gynaecology ward
- Regional community health provider:
    - Adult Mental Health Team (intensive support team*)*
    - Perinatal Mental Health Community Service
    - Health Visiting Service

- Local hospital NHS Trust (3):
    - Accident and Emergency Services
    - Midwifery service
    - Maternity Unit
- Local Authority Children's Services Department:
    - Children's Reception Team (CRT)/ multi-agency safeguarding hub (MASH)
    - local Referral and Assessment Team (R&A)
    - local Children in Need Team
- Hampshire Constabulary
- The Ambulance Service
- Tertiary hospital service

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4) Summary of events, practice and its management during the review period

4.1 Outline and introduction

4.1.1 The review covers the ten months from August 2014 when Child's U's mother was supported in her pregnancy up until the time of Child U's admission to hospital with the injuries that led to Child U's death in June 2015.

4.1.2 This part of the report aims to set out what happened and professionals' response to the presenting circumstances relating to the family and to Child U in particular. It is divided chronologically into five sections or phases of involvement with the family by various agencies and professionals during the period covered by this review. The information is drawn from the agency reports submitted to the review panel and from meetings with practitioners and managers from key agencies and services. Therefore, it includes some additional information that may not have been known by all or any of the practitioners involved directly with the family during the period covered by the review. This in itself may potentially be an issue of note when seeking to understand the response to the circumstances of Child U's mother's pregnancy, Child U's life and that of the family as a whole and especially the parents.

4.2 Early months of Unborn baby U's mother's pregnancy to late December 2014

4.2.1 Unborn baby U's mother became pregnant shortly after the start of her relationship with the baby's father and sought medical help in September from her GP and through an unscheduled attendance at an Emergency Department for matters relating to her pregnancy. Mother was booked for maternity care with the Teenage Pregnancy Community Midwifery service due to her age; the pregnancy was noted to be of 'low risk', no mental health difficulties were disclosed and 'no safeguarding concerns' noted.

4.2.2 During October, November and December 2014 Unborn baby U's mother had several planned and unplanned contacts with health professionals and services due to a number of difficulties relating to her pregnancy: - with a GP in the practice with which she was registered, the GP out of hours' service, two hospitals' emergency departments, admissions to the

gynaecological ward, contact with midwifery service staff and ambulance personnel. By fifteen weeks into the pregnancy the ambulance service report highlights that Child U's mother had been to hospital on five occasions.

4.3 December 2014 to referral to Children's Services March 2015

4.3.1 In mid-December mother, father and maternal grandmother attended a GP's appointment with Unborn baby U's mother presenting with hyperemesis gravida. The GP was concerned at mother's low mood, she was tearful and reported thoughts of self-harm and suicidal ideation, poor sleep and not eating; her partner (Unborn baby U's father) and mother appeared supportive and concerned. The GP made a referral to the mental health crisis team for support over the weekend and to the Adult Mental Health Service in the light of concerns for mother and the implications for her pregnancy and the unborn baby.

4.3.2 The Community Mental Health Team assessment, undertaken within a few days, led to information being shared by mother of her longstanding mental health difficulties apparently associated with bereavement, family separation, trauma (personal and within the wider family) and psychological difficulties.

4.3.3 However, no safeguarding issues were raised with reference to Unborn baby U or her mother but it was suggested that pregnancy had affected mother's mood, sense of self-esteem and increased her anxiety (including having nightmares about her baby being still-born and fears that her partner would leave her; fear of being sick and dying and fear of hospitals). The pregnancy and Unborn baby U was identified at the time as a protective factor by the mother.

4.3.4 Over the immediate Christmas and New Year period, Unborn baby U's mother was seen by several different adult mental health workers. A referral was made to the Perinatal Mental Health Team and a care planning meeting was held. By this time the parents had moved together into their own flat, with the father off from work for two weeks.

4.3.5 In mid-January, responsibility as lead mental health team was transferred from the Adult Mental Health Team to the Perinatal Mental Health Team after a joint visit. The handover of support included a plan for a weekly visit by a community mental health nurse from the Perinatal Mental Health Team one week and the team's nursery nurse the next. The GP was informed of this plan via a discharge summary from the AMHT detailing transfer of mother's care to the Perinatal Mental Health Team. It was noted that mother had had ten hospital admissions relating to her physical health and was reporting distressing dreams, intrusive thoughts and images, with extreme emotions easily triggered and with mother not eating. Suicidal thoughts were reported as having reduced and the unborn baby was identified as a protective factor. Unborn Baby U's mother was considered to be of moderate risk of harm to herself but low risk of harm to others with the risk reducing by the third visit.

4.3.6 Information from the relevant agency report from visits in late January and February suggest that mother's levels of physical and mental well-being fluctuated including reports of: pain and hip problems prompting a referral to physiotherapy and use of a wheelchair at one stage; instances of fainting; sickness continuing; expressed fears about becoming a mother and her inexperience; panic attacks and being unable to leave the flat. Antidepressant medication was prescribed though it would seem that this was not taken due to worries about side effects;

an appointment for counselling support was made, linked to the apparently continuing impact of bereavement and loss of contact with mother's grandfather. At times, Unborn baby U's mother reported and presented with improved mood and feeling positive – looking forward to the future with the baby.

4.3.7 A 'multidisciplinary safeguarding meeting' was held at the GP surgery in mid-February attended by the health visitor, GPs in the practice and the practice nurses. Concerns were noted about the potential impact that mother's mental health may have on her unborn child and potential vulnerability as a young first time parent. The health visitors agreed to offer the new parents extra support once the baby was born.

4.3.8 Mother's physical health continued to be of concern with further admission to the hospital maternity unit in early March due to suspected ruptured membranes and pre-term labour. Medication was given for pain relief, to mature the baby's lungs and to try to prevent pre-term labour. Unborn baby U's mother discharged herself from the antenatal ward against medical advice and declined an appointment for a second dose of medication (steroids) to mature the baby's lungs. Re-admission to the maternity unit by ambulance the next day enabled the second dose of steroids to be given; this was followed by an afternoon discharge home but a further admission in the evening, again by ambulance. Unborn baby U's mother discharged herself again the next day against medical advice. Mother's mental health was considered as a possible underlying reason for the multiple hospital attendances and admissions.

4.3.9 During a home visit in March, the PNMHT nursery nurse undertook preparation discussions including practical parenting skills' development, giving advice and information in relation to breast-feeding etc. Advice was given in relation to the level of tidiness of the flat. It was reported that mother seemed open about her ability to deal with her emotions and the possible effect on the baby, feelings of insecurity in the relationship with her partner/Unborn baby U's father and arguments they had had. Mother reported that Unborn baby U's father could get angry when they argue – but that neither had hit each other. Mother reported experiencing violence in previous relationships – but that the relationship with Unborn baby U's father was not like that.

4.3.10 An antenatal visit was undertaken by the allocated health visitor with a second visit planned, linked to a designation of 'universal plus' care provision as a result of the vulnerabilities highlighted.

4.3.11 Episodes of collapse and fainting were reported by mother to her GP (at 29 weeks of her pregnancy). At this time mother requested a transfer of antenatal care to an alternative hospital; this was arranged. As a result of a further planned appointment at the GP surgery a week later, Unborn baby U's mother was admitted to the hospital (at which she was now registered for the birth) as a result of the fainting episodes and the need for cardiac investigations.

4.3.12 Following admission to the high dependency unit and disclosure overnight to the midwives about her past experiences and circumstances - and following a telephone discussion with the Perinatal Mental Health Team mental health nurse, the safeguarding midwife at the hospital made a referral by email to the Children's Reception Team of Hampshire Children's Services Department because of concerns about potential safeguarding risk to Unborn baby U.

4.4 From referral to Children's Services to Child U's birth (March 2015 to May 2015)

4.4.1 On the basis of the referral information, the Children's Reception Team progressed the case to the Multi Agency Safeguarding Hub (MASH) for further assessment checks though these appear to be limited to health records, databases and to checks relating to the mother alone.

4.4.2 Well within expected timescales for a response and within a day of the referral being made, the case was transferred to the appropriate Referral and Assessment Team (geographically determined by the home address of Unborn baby's mother and father) and allocated by the team manager to a social worker for assessment, noting that details of family relationships and other professionals who may be working with or have knowledge of family members needed recording and appropriate checks made.

4.4.3 The allocated social worker contacted the parents by 'phone and visited them at home as mother was no longer in hospital. This visit was undertaken within the locally expected timescale from referral for assessment visits by Children's Services in such circumstances. Both prospective parents were seen together and the visit formed the basis of the assessment record and the decision to continue involvement with the family under a 'child in need' designation. The social worker also contacted the hospital safeguarding midwifery team that initiated the referral.

4.4.4 In the seven weeks from the referral until Child U's birth, there was liaison between the hospital and midwifery services and teams: the Teenage Pregnancy community midwife, the safeguarding midwife at the hospital and the midwifery team that would provide community ante- and post-natal care). Routine planned antenatal contact with mother continued and included discussion of the birth arrangements and breast-feeding and some discussion about mother's worries about the seizures that she was having and her feelings of being unwell.

4.4.5 During this period the PNMHT community mental health nurse and nursery nurse also continued to visit in accordance with that team's plan. During a visit by the community mental health nurse at the end of March, mother openly shared information about her past experiences (and the possibility of counselling support was discussed), the referral to children's services and visit by the social worker. Mother reported that she understood that the baby would be 'placed on a child in need plan' but was tearful at discussing children's services involvement and said that she had not been able to tell her mother about it, that it is causing arguments between her and the baby's father leading to Unborn baby U's mother spending a couple of nights at her mother's home. The transfer of mother's midwifery care and plans for the baby's birth were discussed as were mother's physical health difficulties (pain and mobility and the proposed investigative tests in relation to the seizures and results of blood tests) and her general mental well-being, including commencing medication due to her low mood; no current suicidal ideation was reported.

4.4.6 During home visits by the PNMHT nursery nurse in April, there were discussions about how mother was feeling about the arrival of the baby and how the pregnancy was progressing with mother saying that she was excited but also slightly nervous. Unborn baby U's mother reported being sick again in the mornings and had stopped taking her medication as a result. The home visit at the end of April was with both prospective parents and father expressed being a little

worried about Unborn baby U's mother and the baby; these worries were discussed. Mother was reported as being talkative and happy, feeling that she does not need her medication at present. She said that she felt prepared for the arrival of the baby and appropriate nursery furniture was being put together. The prospect of accessing community support through the local children's centre was discussed; the PNMHT nursery nurse had no concerns arising from the visit.

4.5 From Child U's birth to the Child in Need meeting (May 2015)

4.5.1 Child U was born in May 2015 and plans for discharge from hospital included discussion with the allocated children's services team assistant manager (to seek agreement for the discharge of baby and mother, with advice given by the assistant team manager regarding the need for the hospital midwives to liaise with the PNMHT for current information of their involvement and whether they had any concerns) and routine assessment of care provision for the baby and advice. Postnatal care was transferred from the hospital ward and midwifery team to the postnatal coordinator of the community midwifery service.

4.5.2 A plan of care for daily visits by midwives was made with the postnatal coordinator and information was shared with the community midwife due to visit (which included a hand held note that *mother* was a 'child in need'). There was continued involvement by the PNMHT including a home visit by the community mental health nurse three days after Child U's birth (following her and her mother's discharge from hospital the day before) at which both mother and father were present - with father reporting that he was taking paternity leave. Sleeping, feeding, plans for the nursery nurse to visit and to continue to offer support were discussed as well as mother's emotional well-being. Some difficulties with breastfeeding were talked about but no other concerns or issues noted. Similarly, no concerns were reported or recorded by the midwives involved in home visits and postnatal clinic appointments; physical care and breastfeeding advice was given.

4.5.3 The allocated social worker from the Referral and Assessment Team visited for a second time (the first being the assessment-related visit in March) seeing Child U's mother and with her father joining later in the visit. Mother was reported as being tearful, with the 'baby blues'; concerns were expressed at the cluttered conditions of the home. The parents were invited to attend a 'child in need' planning meeting to be held at Children's Services Department offices some distance from the family home. Child U's parents expressed keenness to attend but raised practical concerns given financial difficulties, the lack of transport and the proposed venue of the meeting.

4.5.4 A week after Child U's birth the health visitor learned of Child U's birth through a coincidental meeting with the parents and baby at the local hospital where the parents were attending a midwifery appointment; the parents told the health visitor about the planned 'child in need' meeting.

4.5.5 The 'child in need' planning meeting was held ten days after Child U's birth with the health visitor, the Referral and Assessment Team social worker and the social worker from the children's services team that would take over longer term work with the family (under the 'child in need' plan) in attendance – along with the chair of the meeting. Background information gathered regarding issues and concerns were shared at the meeting. Information from the PNMHT staff was sent by email as they were unable to attend due to the short notice given. The

information provided included positive up-to-date information about both parents and the care of Child U from recent contact and details of the PNMHT proposed plan to monitor for three months and, if things are going well, to discharge the mother and baby from the service.

4.5.6 The 'child in need' plan included: health visitor to arrange a routine 'new birth' visit and liaise with the PNMHT and the GP regarding medication and mother's seizures and discuss with mother a referral for outreach support from the local children's centre; the newly allocated social worker to visit and this visit to include a discussion about the family's financial situation, income and benefits; mother to continue to engage with support from PNMHT who will monitor; parents to make a self-referral to substance misuse team or seek support from GP if there is a risk of relapse given reported previous use and recent abstinence (c. one year) – with associated planned outcomes noted.

4.5.7 The nursery nurse from the Perinatal Mental Health Team visited the family on the day of the 'child in need' meeting. Mother reported being emotional at times, but this could be due to over doing things as she had gone out most days since she came home from the hospital. It was recorded that mother appeared bright and chatty and was cuddling Child U with good interaction; saying that she feels her bond is good. Both parents shared feeding Child U with a bottle. Mother said that the reason for not attending the 'child in need' meeting was that she had not been feeling well, that Child U had been a little unsettled, that Child U's father had an appointment with his GP, that mother did not feel that she could get on the bus with Child U and because of the cost of the travel.

4.5.8 According to the records, Child U was seen with *both* her mother and father on four occasions all within eleven days of her birth – twice by staff from the Perinatal Mental Health Team and once by the social worker on an unplanned visit to inform the parents of the forthcoming 'child in need' meeting. Child U's father was also recorded as being present during the midwife's 'day eleven' visit. After that appointment subsequent meetings and visits appear to be with Child U and her mother only.

4.6 From the Child in Need meeting to Child U's hospital admission (28.6.2015) and subsequent death (29.6.2015)

4.6.1 Over the next five weeks there was direct contact with Baby U and her mother: by midwives, by the health visitor, by the community mental health nurse and the nursery nurse and by the newly allocated social worker jointly with the Perinatal Mental Health Team nursery nurse.

4.6.2 In accordance with the postnatal support plan, appointments and visits were made with the community midwives, though one contact (day 17) was by telephone as a follow up call as Child U reportedly had not had her bowels open for 24 hours. One planned meeting with the midwife was missed (day 20) but Child U and her mother were seen the next day (day 21) and all physical checks were noted as being within normal limits; Child U and mother were discharged from midwifery care as planned.

4.6.3 The health visitor visited on two occasions, noting on the first (the new birth contact visit a fortnight after Child U's birth) that Child U had a little weight loss from records two day before

and that Child U had a faint red mark at the bottom of her neck that the health visitor was confident was a birthmark.

4.6.4 The community mental health nurse also visited separately on the same day: just with Child U and mother as the baby's father was back at work. It was reported by the community mental health nurse on that occasion that baby U's mother appeared bright in mood, interacting well with her baby, chatting with Child U in an appropriate warm tone and with good eye contact. Mother said that she was feeling really well mentally, her mood was good and she was enjoying being a mum. Mother explained why she and Child U's father had not attended the 'child in need' meeting and said that she had tried to ring the social worker and had told the social worker, during the visit to tell them about the meeting, that they would be unlikely to be able to attend. Mother reported that the health visitor had told her that, from the meeting, additional support would be provided, but mother said that she was unaware of any other outcome or of the plan.

4.6.5 Mother told the PNMHT nurse that she and the baby were going out every day and that she planned to go to the local children's centre within walking distance to meet other mothers – encouraging Child U's father also to attend on a Saturday to meet other dads. Mother reported that she had bathed Child U twice and thinks that she has managed this well. After the visit the community mental health nurse contacted the social worker (still allocated within the R&A team before transfer) by email providing positive information from the visit and asking for information from the 'child in need' meeting for herself and passing on mother's request for the date of the next meeting and whether it could be held nearer to home so that she could attend.

4.6.6 A joint visit was made by the PNMHT nursery nurse and the newly allocated social worker in early June to see Child U and her mother after the social worker had initially been unable to contact the family to arrange a home visit. Prior to the visit it was reported to the social worker by the community mental health worker that the family seemed to be doing really well with mother's mood and mental state good, not on any medication and eliciting no concerns.

4.6.7 During the joint home visit, concerns were raised by the social worker about the untidiness of the flat which could cause a tripping hazard. Child U was observed being fed and winded by her mother who was considered to have positive attachment, good interaction (eye contact, attuned to sounds and movements, chatting to the baby in a warm tone) with both appearing comfortable with one another and mother considered to be appropriately responsive to her baby's needs. Mother said that she feels well-supported by her family and that she and baby U's father are working well as a couple. Again it was recorded that mother appeared bright in mood, interacted well with Child U and said that she was feeling really well mentally and she enjoyed being a mother.

4.6.8 The 'child in need' plan was explained with some changes proposed. The social worker suggested that she would like to see the bedroom and front room tidied (clutter and clothes on the floor causing worries about tripping) and it was both parents' responsibility to do this. The social worker planned to visit again in two weeks' time.

4.6.9 During a visit by the PNMHT mental health nurse five days later, it was noted that the bedroom was cleared, neat and tidy. Child U's mother needed prompting to support the baby's head better but otherwise there were no concerns, with good interaction between mother and

baby. The plan was for the community mental health nurse to see Child U and mother in a month's time as it was deemed that her mental health was greatly improved; the PNMHT nursery nurse would visit between then.

4.6.10 The second home visit by the health visitor, accompanied by a student nurse, was at the start of the fourth week of June. Mother reported feeling tired a lot of the time and with stomach pains. The flat was considered very untidy and cluttered and mother said that she felt a lack of support from Child U's father, suggesting that she was not happy all the time with him – not helping with the flat or with the baby. It was reported by mother that the father said that he believed that his work was harder than looking after a baby and that they argued sometimes. Concerns were raised again at how formula feeds were being made up for the baby (advised to reduce the volume, make feeds up when needed and to measure the water before the powder). Advice was given about holding Child U more securely when feeding, keeping her head upright after feeds. It was noted that Child U appeared alert and responsive and watched her mother during feeding and had good head control. Both baby and mother were dressed appropriately. The possibility of a children's centre referral was discussed again and mother said that she may go to a toddler group with a friend.

4.6.11 A further home visit planned by the social worker in mid-June was missed by the parents as no-one was at home and when the social worker met the health visitor coincidentally, the day after the health visitor's second visit, the social worker reported that Child U and her parents had not been at home at the time of two arranged home visits. The health visitor said that she would encourage mother to keep appointments or to contact the social worker if she was not going to be available.

4.6.12 Child U and her mother and maternal grandmother were also seen during the week by the GP for the baby's six week check where it was noted that Child U was alert and interacting. No physical abnormalities were noted (Child U's nappy was removed for weighing), weight development was consistent (9^{th} centile) though Child U appeared small. It was reported that bottle-feeding was good. Mother reported that she felt happy being a mum and appeared to be more positive than in previous visits. Mother said that further appointments with the health visitor and perinatal mental health team were planned.

4.6.13 On the Friday of that week, the PNMHT nursery nurse rang Child U's mother to arrange an appointment for the Monday and mother reported that all was going well with herself and the baby, that she had forgotten about the social worker's visit and would give the social worker a call. Mother said that she looked forward to the visit planned with the PNMHT nursery nurse after the weekend.

4.6.14 On the Sunday following a telephone call to 111, the call was passed on to the ambulance service as an emergency. The attending community first responder resuscitated Child U who was choking; she had experienced cardiac arrest.

4.6.15 Child U was first taken in an emergency to the local hospital and later transferred for specialist paediatric intensive care in another hospital in the early hours of the next morning. Child U was admitted with apparent clinical signs consistent with brain death but with a beating heart; in the evening a decision to withdraw life support was made because of the extensive brain injury.

5) Analysis of involvement with Child U and her family; its organisation and management and related recommendations

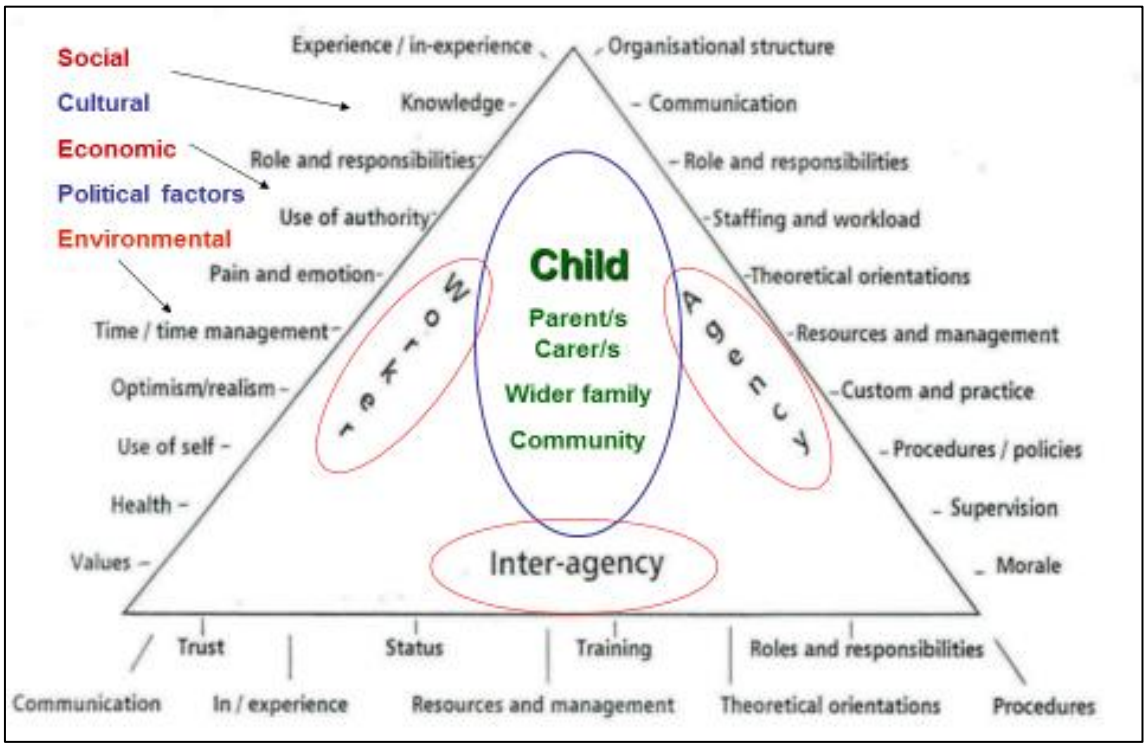
5.1 Introduction

5.1.1 During the process of reviewing agency reports and the comprehensive chronology, of meeting with practitioners and throughout the discussions of the review panel, a number of themes relating to involvement with Child U have emerged as relevant for learning and development of practice by individual agencies, the agencies' collaborative work and the work of individual professionals and its organisation and management. This section of the report is organised in relation to broad themes with additional consideration of relevant related issues and learning points within each theme. It includes analysis, discussion and recommendations for the Hampshire Safeguarding Children Board and its constituent agencies to consider in the expectation that the relevant lessons and practice improvements already identified within individual agencies and both the wider issues considered here and specific recommendations will help contribute to effective practice with and for other children.

5.1.2 Throughout the review process it has been helpful to adopt a systemic, holistic perspective in relation to aspects of practice; recognising that there may be several domains and dimensions that interact to comprise the professional component in any case. The practice of individuals can be seen in the context of the service and agency for whom they work and the dynamic of inter-agency and multi-professional work: all may play a part individually and dynamically together in contributing to the overall effectiveness of safeguarding and promoting the well-being of children, young people and families.

5.1.3 The following model was shared with the panel and practitioners to help consider practice and the arrangements and systems for its organisation and management within and between agencies. The dimensions within the three professional domains are informed by various sources but include areas of practice identified as perhaps pivotal to the effectiveness of practice from past Serious Case Reviews and public inquiries.

Fig. 1: The professional component: domains and dimensions – a model to assist analysis (in Calder et



al; RHP, 2008)

5.1.4 As may perhaps be expected from a process that has taken a systemic approach, many of the themes that have been identified would seem to be linked - with a degree of dynamic overlap or common elements. They may also resonate with themes in other serious case reviews published by the Hampshire Safeguarding Children Board and in national overview reports such as the recent 'Pathways to harm, pathways to protection' report (Brandon et al; DfE May 2016). The review panel are confident that the Hampshire LSCB is committed to identifying lessons of common relevance and using these to help further develop effective services to children, young people and families.

5.2 Working with children and families: vulnerability; think family, think fathers; participation; promoting positive parenting

a) Vulnerable parents, vulnerable unborn babies and children

5.2.1 From early in Unborn baby U's mother's pregnancy it was identified that there were a number of potential vulnerabilities, initially relating to the young age of the parents (leading to the initial involvement of the Teenage Pregnancy Community Midwife) and then relating to presenting issues including mother's physical health and emotional well-being especially with the referral by the GP to adult mental health services to assess and support Unborn baby U's mother some five months before Child U was born. Information about both parents' personal and familial histories and experiences, shared or identified at various times, suggested additional levels of vulnerability and need.

5.2.2 Several of the practitioners met during the course of the review suggested that it was unfortunate that the Family Nurse Partnership programme supporting new parents did not cover the area of the parents' home address and that this service might have provided additional support for Child U's parents; it may also have added to an understanding of the parents' capacity to meet Child U's needs.

5.2.3 The vulnerabilities, needs and the potential legacy of past experiences led to the designation of this as a 'vulnerable pregnancy' but understanding the point at which these vulnerabilities are then seen as potentially impacting on the health and development of an unborn baby is perhaps an important one. The status of an unborn baby may be complex legally and ethically but some of the agency reports presented to the panel suggest that early opportunities to appreciate the potential impact on the unborn baby of the parents' circumstances and history may have been missed. However, the GP's concern about mother's health and emotional well-being in late December 2014 leading to the referral to and involvement of mental health services included clear and appropriate concerns about the unborn baby. The referral to the Children's Services by the hospital safeguarding midwife, some two months before Child U's birth, was a referral in the name of Unborn baby U in her own right.

b) Think family, think fathers and partners

5.2.4 The encouragement to 'think family' for professionals who work primarily with children and young people, and to 'think children' for professionals who work primarily with adults has emerged in previous serious case reviews nationally and in policy proposals, as has an encouragement to 'think fathers'.

5.2.5 It appears that there was good engagement by the GP and the PNMHT staff with Unborn baby U's father at times during the mother's pregnancy with both his concerns and positive supporting role being noted. However, no professional apparently had any contact with Child U's father after eleven days from Child U's birth and it does not appear that there was an opportunity to observe Baby U's father with her after this, or to discuss with him the pattern of respective care and parenting responsibilities or the family's circumstances. Details about the full practical provision and pattern of twenty-four-hour care within and outside the home by mother, father, wider family and friends seem limited, including evidence of discussions with Child U's mother about this.

5.2.6 It is important to note, however, that those who visited and had contact with Child U's mother after the second week following Child U's birth did not identify concerns that they considered significant to prompt a review of service levels or an escalation in the formal response or multi-agency provision.

c) Participation

5.2.7 It is unfortunate that the parents did not attend the 'child in need' meeting held some ten days after Child U's birth. This would seem to represent a missed opportunity to directly involve the parents and all the professionals in a formal, fully informed consideration of: the concerns that had been identified during the months before Child U's birth, the parents response to support and services and of 'how things are going now'; an updated assessment of Child U's well-being and development and of the realities of meeting Child U's needs; a shared discussion of the resources, strengths and positive capacity of the parents individually and together; and in the development of an agreed, co-ordinated 'child in need' plan with the full engagement of the family

5.2.8 There are many examples of the professionals' involved developing good relationships with Baby U's mother (in particular) that enabled effective support and help to be offered and services accessed: by the GP in facilitating referral to mental health support services and hospital care; by health professionals within the ambulance service and emergency departments in the early stages of Child U's mother's pregnancy; by the adult mental health team professionals and the perinatal community mental health nurse and nursery nurse; by the hospital midwifery team that referred Unborn Baby U to Children's Services and delivered Baby U; by the community midwives caring for Child U and her mother; by the health visitor and as far as was possible, by the social worker following the 'child in need' meeting in May 2015.

5.2.9 In particular, it is important to note that the period following Baby U's admission for emergency treatment on June 28th would appear to have been handled by staff in the two hospitals involved and by the police personnel in attendance with sensitivity despite the very great difficulties involved.

d) Promoting positive parenting

5.2.10 A further theme relating to working with families is that of parents and carers' understanding of what might be considered 'positive parenting', the awareness and skills required to meet the needs of children physically and emotionally.

5.2.11 Various professionals provided support and advice to the parents with an emphasis on working with Child U's mother both before and after Child U's birth. This included information and discussion about feeding (the subject of discussion on several occasions after Child U's birth); physical care (though it was noted that mother reported bathing Child U only twice during the first two weeks after her birth but it is not known whether the adequacy of this was discussed); holding and attachment and bonding with positive interaction between mother and Child U noted; the tidiness and safety of the home. During discussion with the professionals who worked with the family, examples of the type of information routinely given was provided including information about safe sleeping and handling.

5.2.12 This review has raised a discussion about the degree of consensus and consistency in the content (or 'curriculum') and the details of advice and guidance that might be given by anyone involved in promoting positive parenting and assessing parenting capacity which in this case included the PNMHT nursery nurse, midwives, health visitor and two social workers. The recently published *Pathways to harm, pathways to protection: triennial analysis of serious case reviews 2011 to 2014 (DoE may 2016)* notes (p.54) that of the 293 SCRs reviewed, 197 related to fatalities with fatal physical abuse accounting for the largest single category of fatalities and 'In the majority of cases, where specified, the cause of death was a severe non-accidental head injury' which 'appear, on first inspection as 'arising out of the blue'.' It would seem important to be assured that any advice and guidance includes direct information about the potential vulnerability of babies and the dangers from inappropriate handling or being shaken.

5.3 Professional practice and its organisation and management: information; assessment and analysis; co-ordinating multi-agency work; policies, procedures and protocols

5.3.1 Whilst many of the themes emerging from this review would seem to be linked, it may be helpful to consider four specific areas relating to professional practice and its organisation and management.

a) Information: gathering, analysing, recording, managing and sharing

5.3.2 This is a recurring issue in serious case reviews, part 8 report and public inquiries going back decades (see Galilee 2005, a report for the Scottish Parliament) and highlighted again in the recent 'triennial publication' (Brandon et al 2016).

5.3.3 In this case there are many examples of collaborative work facilitated by good communication and information sharing for example between the GP and mental health services; from adult to perinatal mental health services; transfer of case responsibility with the Children's Services Department; joint visits by health and social care.

5.3.4 However, during the course of mother's pregnancy and after Child U's birth only *some* information was shared at *some* points with and by *some* professionals and services about mother's and father's history, experiences and previous involvement by various services including children's services and the police. Similarly, information was apparently not collated in relation to current circumstances including regarding what mother had said to various professionals about her emotional well-being and information about self-harm, suicidal thoughts and actions, or behaviour during the pregnancy that could have had a direct impact on the well-

being of her unborn baby. Missing, partial, unavailable, unshared information can potentially compromise the quality of an analysis of need, risk and vulnerability (in particular), as well as strengths and protective factors - and then also have an impact on the decisions and plans based upon the information and analysis. It may also have an unquantifiable potential effect on the more micro moments and focus of engagement, discussion, questioning and appraisal of 'how things are'.

5.3.5 No one professional held all the information or had a full picture of the individuals' and family circumstances past and present; it was through the compiling of a comprehensive chronology and sharing information during the review process that some professionals later learned of significant information relating to both parents' personal and familial experiences in the past as well as during the period of the review which may have had an impact on perceptions and assessment of vulnerability relating to the parents or Child U and on interactions between professionals and with the family.

5.3.6 The Current Hampshire Children's Trust *Information Sharing and Confidentiality Policy (May 2010)* cites the following rationale for effective practice in relation to information management:

> 'Effective communication and sharing of information are vital. Recording information and communicating information in a clear and timely manner, and systematically gathering information from a range of sources, improves identification of children and young people in need or risk of harm. Sharing information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child… and will inform effective assessments of children's needs.'
>
> *The Children's Plan: Building Brighter Futures (*DCS&F Dec 2007)
>
> 'Clear and accurate records are essential to track an agency or practitioner's involvement with a child/family to ensure sound decision making.'
>
> *Integrated working newsletter* Every Child Matters/CWDC

5.3.7 Agency reports prepared for the review and information from meetings with the professionals highlight several areas where practice in relation to information gathering, recording, management, transfer and sharing - and the systems that support it in a complex network of services – could have been more effective within arrangements and expectations existing at the time. The areas of concern identified included:

- multiple recording systems that not everyone has access to especially within what might be seen as an integrated service, e.g: hospital records linking from Emergency Department, gynaecological unit to maternity services;
- difficulties at the point of formal transfer from apparently similar services provided by different organisations, e.g: between midwifery services with a recognition that a standardised handover of care record is required when a woman moves area or transfers care; from hospital to community safeguarding midwifery; from centrally-based co-ordinators to locally-based practitioners
- hand-held or paper-based records or notes; informal recording of partial information for individual practitioner use; notes kept for understandable reasons in locked cupboards but with limited access or 'read' alerts;

- information either not recorded that was later shared with an agency report writer; information not available to other staff members as a result of being on the system within expected time periods – sometimes compounded by mobile or remote working and computer log-in difficulties away from base, or with difficulties associated with the use of centralised or shared business support arrangements.

5.3.8 The many suggestions and recommendations in the individual agency reports relating to the management of information and the issues above suggest that there is a clear recognition of the substantial challenges but also a strong commitment to continually improve this vital area of professional practice.

b) Assessment and analysis – likelihood, in theory and in practice

5.3.9 A second professional practice theme and linked to the issues above, relates to assessment and analysis.

5.3.10 Following the referral to Children Services in March 2015 by the hospital safeguarding midwife, children's services responded well within the appropriate and required timescales to undertake an initial assessment and progress involvement to the local Referral and Assessment Team and allocation to a social worker for a full *Child and Family Assessment*.

5.3.11 There were delays in completing the write-up and dissemination of the assessment and whilst the assessment process included a home visit (March 2015) with both Child U's parents prior to Child U's birth, the assessment did not apparently include gathering of full information about both of Child U's parents or wider family as appropriate or from all available sources (including from children's services records and from all professionals who had recently worked with or were currently working with or had contact with the family).

5.3.12 The formal assessment that led to designating Unborn baby U as a 'child in need' (and identifying that work with the family would be co-ordinated within the 'child in need' level of service provision) was undertaken prior to Child U's birth essentially through a one off visit.

5.3.13 The assessment report included references to research in support of the proposed decision and plan. Information from research studies relating to 'vulnerability' and of potential protective and resilience factors and risk and harm factors (see, for example, Jones in Ward and Brown 2012, the research summarised in Bentovim et al 2009 and, most recently, the information about 'pathways to harm' in the recent triennial analysis of serious case reviews, Brandon et al 2016) could help in an analysis of 'likelihood' of well-being or indeed harm where known predisposing indicators of potential risk of harm are identified and to then be used to inform decision-making. It would be interesting to know the source of the research drawn upon in the assessment report, the process of its selection for inclusion and whether there is agency guidance about the use of research and the degree to which key messages from research (especially about likelihood of well-being or harm) are shared and applied by practitioners.

5.3.14 At all levels of work (early help, targeted early help and when children's social care are involved through the designation that a child is a 'child in need' or there are 'child protection' considerations) the expectation in statutory guidance and local procedures is that a comprehensive assessment and analysis of a child's health and development, related needs and

the capacity of parents and carers to meet those needs – along with a consideration of wider family and environmental factors impacting on the child and parents – will form the foundation of decisions and plans.

5.3.15 Issues raised during the review included a consideration of how appropriate a pre-birth assessment is as a basis for deciding appropriate levels of need and level of service provision expressed in a plan *after* a baby is born; how is *theoretical* 'likelihood' and *potential* parenting capacity tested in practice? The Hampshire Children's Services Child and Family Assessment form requires information about family details, of parents and other significant persons and the assessment format expects a detailed consideration of parenting capacity – essentially an analysis of the capacity of those involved in the care of a child to meet her or his needs. A consideration of 'Each child and young person's day' provides an opportunity to explore the role of any person involved in a child's life on a regular basis or comprising part of the household. Knowing 'who is who' in a child's life and who might be included in an assessment and analysis of the sum of the 'parenting capacity' across everyone who may be involved in day-to-day care is an important part of making decisions about well-being and safety, and this can only be fully understood following a baby's birth.

5.3.16 National guidance is clear that assessments are a process not an event[2] and plans must be based on an up to date analysis; following the birth of the baby, the assessment, the analysis and the plan need to be reviewed and updated.

5.3.17 It is important to note that, in this case, no substantial additional concerns were identified by any professional after Child U's birth to suggest that she was suffering or likely to suffer significant harm.

c) Co-ordinating multi-agency work

5.3.18 A final theme relating to professional practice concerns the more general co-ordination of multi-agency work.

5.3.19 *Working together to safeguard children* (with the 2013 and March 2015 versions covering the period of this review) sets out the expectations in statutory guidance for work with all children and families across four levels of need and concern relating to a child's health and development. It includes clear guidance on the respective processes relating to assessment, decision-making and response by individuals, individual agencies and agencies working together including expectations, where there are several services and agencies involved, of the identification of a lead professional and a co-ordinated plan ('early help'; 'child in need'; 'child in need of protection'). These expectations are set out and might have been met through the arrangements in either the *Maternity and Children's Services Unborn Babies Safeguarding Protocol* or the expectations in the *Protocol For Multi Agency Child In Need Planning*. The newly announced additional arrangements in Hampshire (July 2016) for co-ordinating early help services are indeed welcome but it is important that all agencies, services and professionals understand the expectations and roles within this model and within the procedures and processes guiding action at all level of involvement.

[2] Working Together to Safeguard Children (2015) para 35.

5.3.20 As noted, in the agency reports and the information provided by the practitioners during the review, there are many good examples of effective multi-professional work in this case by individuals including contact, discussion, joint visiting and complementary activity to offer support, advice and services.

d) Policies, procedures and protocols

5.3.21 Perhaps effective work to promote and safeguard children and young people's health, development and well-being requires the construction and maintaining of a multi-professional and multi-agency 'safety net' that has both fixed 'warp' strands: policies, procedures, guidance, structures and systems in place generically to manage work for all children, young people and families - as well as 'weft' threads, woven in the potential complexity of the daily professional practice with a specific child, young person or family by professionals and their agencies working individually and coming together as a unique 'team' around *this particular* child or young person and family.

5.3.22 A shared legislative framework and related national statutory guidance documents (such as *Working Together* in various editions since 1988) and shared local policies and procedures seek to ensure consistent and coherent best practice and that best practice is standard practice. The four local safeguarding children boards' *Maternity and Children's Services Unborn Babies Safeguarding Protocol* (mentioned above) was in place before the period of time covered by this review. This protocol sets out clearly a number of indicators, presenting features and circumstances or 'risk factors' that should trigger its use. The protocol includes guidance about: information sharing, the early co-ordination of services, the expectation that a formal multi-agency safeguarding meeting will be held, along with the establishment of a 'team around the child' or 'common assessment framework' process to include the engagement of parents and carers and all professionals involved. The protocol provides a framework for the formal co-ordination of an early, coherent multi-agency response including assessment, decision-making, planning, work and review of work with the parents of an unborn baby where there are circumstances past and present that suggest vulnerability or need. Guidance is also included about the development of a 'safeguarding birth plan' where there are concerns about a family 'irrespective of an unborn baby being subject to a child protection plan' with a list, in an appendix, of issues to be considered in such a plan and addressed where necessary.

5.3.23 A number of professionals involved with Unborn baby U's mother and father almost from the beginning of the period covered by this review might have recognised the role of the protocol in assisting, guiding and co-ordinating multi-agency practice including the sharing of information. Whilst the use of the protocol could have been considered at an early stage in mother's pregnancy, the 'multidisciplinary safeguarding meeting' held at the GP surgery in mid-February attended by the health visitor, GPs in the practice and the practice nurses could also have provided an opportunity to manage wider involvement with Unborn Baby U's mother and father – and involve other agencies – within the structure, authority and arrangements in the protocol.

5.3.24 During the course of the review, questions arose about the degree to which practitioners were aware of and the degree of reference to and compliance with potentially relevant shared local policies, procedures and protocols such as:

a) Hampshire Safeguarding Children Board and Children's Trust Thresholds Chart (July 2015)

b) the 4LSCBs' *Maternity and Children's Services Unborn Babies Safeguarding Protocol* (the current version was due for review in July 2015)

c) the Hampshire Children's Trust *Information Sharing and Confidentiality Policy* (May 2010)

d) the *HSCB protocol for multi-agency child in need planning* (2014)

e) the 4LSCBs' *Joint Working Protocol: Safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress (2014)*

5.3.25 As noted above, these set out expectations of practice and its organisation and management for all children, young people and families and can ensure consistent and coherent practice in every case.

5.4 Individual agency reports, learning, recommendations, developing and quality assuring practice and its organisation and management; multi-agency audits and quality assurance

5.4.1 The review panel has noted positively the many learning points and recommendations for the development of practice and its organisation and management identified by the authors of the individual agency reports. The review report author has been impressed by the commitment to develop practice from the point where learning and recommendations have been identified including in relation to additional matters noted during meetings within the review process.
5.4.2 The Hampshire Safeguarding Children Board's programme of multi-agency audits is to be encouraged as this can provide a robust process to track themes and to assure the application of learning and the implementation of recommendations from this and other reviews.

6) Recommendations

In addition to the many recommendations in the individual agency reports, the Hampshire Safeguarding Children Board and its partner agencies are invited to consider the following recommendations linked to the themes and areas for development in section 5, above:

It is recommended that the Hampshire Safeguarding Children Board and its partner agencies:

1) review what are considered to be key policies, procedures and protocols for multi-professional practice and update these as necessary to meet scheduled review dates and also ensure that they reflect the latest versions of statutory guidance and advice *and* the current operational arrangements for the management of local services and practice;

2) ensure that links are established between relevant policies and procedures and the practice based upon them, for example the *Maternity and Children's Services Unborn*

Babies Safeguarding Protocol and the *HSCB protocol for multi-agency child in need planning* - updating assessments, plans and actions accordingly especially at the birth of a child;

3) consider the strategy for promoting practitioners' awareness, use of and compliance with policies, procedures and protocols - especially in relation to practice at all levels regarding:

- information management and sharing between individuals, organisations, teams and services;
- promoting the participation of parents and carers (particularly including fathers and partners) and children and young people, and especially in relation to assessments of a child's needs and parents' capacity and in relation to participation in meetings and in the development of agreed, shared plans - and work within them;
- the identification of and clarity of the role of a lead professional;

4) consider developing, running and evaluating the impact of a local public campaign regarding the prevention of injuries to babies especially severe head injury - perhaps as part of a wider campaign relating to the promotion of advice and information about positive and safe parenting.

7) Conclusion

7.1 This report has highlighted aspects of practice and its organisation and management (identified through a review of information, agency reports and meetings and a consideration and analysis of key themes) during the period of involvement with Child U's parents and family in the preceding months prior to her birth and in the short period between her birth and death.

7.2 All those involved directly with Child U and her family and who contributed to this review, expressed great shock and immense sadness at the news of the death of Child U, aged just 49 days old. It is hoped that the lessons identified and the recommendations in both the individual agency reports and in this overview report – along with learning from audits of practice contributing to positive outcomes for the majority of children, young people and families with whom agencies work day in and day out – may play a contributory part in the continuing positive development of individuals', specific agencies' and inter-agency practice and its organisation and management both generally and in situations where the risk of harm for a child or young person is identified or identifiable.

Appendices

A) Further details of the review process, the review group and the lead reviewer

a) Panel composition *(roles)*

- Area Director, Hampshire Children's Services

- Designated Doctor, Hampshire CCGs
- Designated Nurses, Hampshire CCGs
- District Manager, Children's Services
- Independent review panel chair and report author
- Named GP, Hampshire CCGs
- Serious Case Reviewers, Serious Case Review Team, Hampshire Constabulary

b) The Serious Case Review process included:

- Writing of agency reports and their review and scrutiny
- The collation of a comprehensive chronology of involvement with Child U and family
- Meetings of the review panel
- Meetings with practitioners
- A Practitioners' workshop
- Consideration of the report by the LSCB SCR sub-committee
- Presentation of the report to a LSCB meeting

c) Practitioner meetings and interviews

Thirteen individual meetings and interviews were held with key practitioners and managers from the main services and agencies that had contact with Child U's mother, father and Child U herself covered by this review including from the local authority children's services, primary health care, perinatal mental health services, the health visiting service, midwifery services both hospital and community based. A group meeting was also held with these practitioners and managers and members of the review panel.

The panel would like to thank all who contributed to the review process especially the practitioners and managers. The panel is also grateful to the authors of agency reports: for their thoroughness, their analysis of practice and systems to support and manage practice and for the obvious commitment to further develop effective services and to enhance the way that individuals and agencies work together, not least through the learning identified and, where appropriate, the recommendations made with plans to implement and monitor them.