Hampshire Safeguarding Children Partnership

SERIOUS CASE REVIEW
CHILD A

INDEPENDENT REVIEWER

Karen Tudor

November 2018 updated March 2020

INTRODUCTION

1. This Serious Case Review (SCR) concerns a three-year old girl who died from drowning in the Autumn of 2017; the child is known as Child A. Her parents are a professional, couple who had separated shortly before her death. Child A's mother was charged in connection with her death and subsequently found guilty of murder. Child A's parents are referred to as Ms AM and Mr AF.

2. The SCR was commissioned by the Hampshire Safeguarding Children Board (HSCB) in Autumn 2018; the reason for the delay was because Child A's mother spent time in hospital immediately after the child's death, this delayed the criminal investigation into the cause of Child A's death.

3. An Independent Reviewer was appointed, and chronologies were requested from the agencies who knew the family; the Reviewer held two meetings, one with the chronology authors and one with the practitioners. As there had been relatively little professional involvement prior to Child A's death, only three practitioners attended the meeting. The process was overseen by the SCR sub-group.

4. The Review covers the period from Ms AM's pregnancy with Child A, June 2014, to Child A's death in October 2017.

SUMMARY OF AGENCY INVOLVEMENT

Wiltshire Health and Care - diabetes service	Ms A had been diagnosed with Type 1 diabetes as a child and was insulin dependent. She was well known to the diabetes service with which she engaged well. Her condition was described as "well managed." She had experienced some hypoglycaemic episodes, one of which occurred when she was driving, and this led to the temporary loss of her driving license. The fear of further attacks was reported to have caused her anxiety.
Salisbury NHS Foundation Trust Maternity Services 2014	Child A was born by emergency Caesarian Section after a traumatic labour. Ms AM recovered well and there was nothing unusual or notable about the pregnancy or post-natal period.
Health Visiting (4 home visits and 2 clinic appointments)	Health Visiting provided a Universal Service to Child A. The usual assessments were carried out and Child A's one- and two-year development checks showed she was developing normally. Health Visiting's most recent contact with Child A was a year before she died. The service had no concerns about her care.

GP	Child A and her family were registered at the same GP practice who had known the family for many years. They attended occasionally with minor conditions; Child A's immunisations were up to date. When Child A was four months old, a letter to the GP from Ms AM's diabetes consultant referred to the possibility of Ms AM being depressed. Following a consultation with the GP Ms AM self-referred for counselling. Apart from this, practitioners had no concerns about Child A or her parents.
Private Counselling Service	When Child A was 4 months old (2014) the diabetes consultant, during a routine appointment, questioned whether Ms AM's low mood might be post-natal depression. A letter was sent to Ms AM's GP who discussed the matter with her and she self-referred for 10 sessions from a private counsellor. The counsellor worked with Ms AM on some marital issues. Child A was present during most of the sessions and the counsellor described Ms AM as a "good and loving mother." There were no safeguarding concerns identified during the counselling process.
Children's Social Care - Adoption Team	In October 2016, when Child A was aged 2 years, her parents expressed an interest in adoption, the records indicate they wanted another child but Ms AM was reluctant to go through another pregnancy. An assessing social worker visited them at home and their application was not taken forward, primarily because of the couple's limited appreciation of the challenges of adoption. The assessing social worker observed the couple with Child A and described her as "much loved."
Nursery	Child A attended a private nursery, two days a week, for 6 months before her death. The nursery had suggested referring Child A for some speech and language help but had no concerns about her health, wellbeing or care.

FINDINGS AND ANALYSIS

5. It is inevitable that the degree of scrutiny involved in a Serious Case Review will highlight practice which could have been better and in this case the Health Visiting service have indicated that the routine assessments of post-natal depression and possibility of domestic abuse could have been more robust. There were no indications that either of these factors were a feature of family life and the

assessments were superficial. It appears that neither Ms AM or Mr AF were asked about domestic abuse.

6. The key practice issue was Ms AM's management of her diabetes which meant she had regular appointments with medical practitioners, she engaged well with the services offered and communication between the hospital and community was appropriate. The possibility that Ms AM might be suffering with post-natal depression was picked up, communicated to the GP and promptly addressed with Ms AM.

7. The diabetes service had the most contact with Ms AM and, after Child A's birth, it appears that she was present during most of Ms AM's appointments; this is not made explicit in the records and the service has indicted that in the future they will make a more detailed note.

8. In general, all the work carried out with Child A and her family was proportionate, focused and to an expected standard.

9. The adoption service in particular, although they only carried out one interview, provided sensitive insight into this family's life.

10. Child A was observed to be well cared for, her one- and two-year developmental checks showed she was healthy and developing normally. The nursery were planning to provide some additional speech and language input but there were no concerns about her care.

11. Child A's death came as a great shock to all the practitioners who knew her.

LEARNING AND CONCLUSION

12. During this Review there was some general discussion among the health professionals about the impact of long-term medical conditions and the value of considering the impact on parenting, to promote the well-established "think family" message.

13. However there was no indication of any warning signs or indicators of risk which might have prompted further assessment or intervention.

14. Despite the tragic death of Child A, this Review concludes that, at this stage, there is no learning to be taken forward by the Hampshire Safeguarding Children Partnership.

Family Involvement in the Review

Following conclusion of the criminal investigation both Father of Child A and Mother were invited to meet with the Independent Reviewer.

Father accepted the invitation and met with the independent Reviewer. Mother declined the opportunity to contribute to the review. Following the meeting with father no additional learning was identified in this case.

Karen Tudor
Independent Reviewer
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