CONFIDENTIAL

EAST SUSSEX LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW OVERVIEW REPORT

CHILD K

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1 Introduction

1.1 Death of 'Child K' & response of the Local Safeguarding Children Board (LSCB)

1.1.1 Child K was the first child born to Mother, who was aged twenty two years at the time of K's death, and Father who was aged twenty six years. K was born in September 2012.

1.1.2 Ambulance paramedics attended the home address in response to a 999 call from the Father in November 2012. The Father claimed to have suffered a fit whilst holding Child K, ending up on top of K, suffocating the child and causing other injuries. Father was in sole care of the child at the time.

1.1.3 Medical examinations, at first at a local hospital, and later at a London hospital, showed that Child K had bruising to her face, chest, abdomen and lower limbs; fractures to both left and right collar bones of different ages; a fractured rib, traumatic damage to the liver, and evidence of severe hypoxic brain injury. K died 5 days after admission as a result of these injuries. Medical expert opinion subsequently concluded that this pattern of injury was consistent with inflicted injury of the shaking/impact type.

1.1.4 In accordance with procedures, a Serious Case Review (SCR) Panel was held and reviewed the information known about the incident and received reports from all agencies known to be involved with Child K and family. The case was considered using the framework in Chapter 8 of Working Together to Safeguard Children, HM Government 2010, specifically Paragraph 8.9. (Note that Working Together 2010 was the legislation in place at the time of this Review).

1.1.5 On 21st March 2013 the Chair of the East Sussex Local Safeguarding Children Board (LSCB), made the decision to carry out a Serious Case Review (SCR). On 4th April 2013 the Chief Executive in each agency involved with Child K and family was written to and asked to contribute Individual Management Reviews (IMRs) to the Serious Case Review process.

1.1.6 Ofsted was notified of this decision and the Care Quality Commission (CQC) was informed in writing by the Designated Nurse on 26th April 2013.

1.1.7 Following a criminal investigation, Father was charged with the murder of Child K. Immediately after the death and during the period leading up to the criminal trial, Father maintained that the fatal injuries to K were as a result of a fit he had suffered whilst holding K. However, once the trial had commenced, Father pleaded guilty to the less serious offence of manslaughter, a plea which was accepted by the prosecution. On 9th July 2014 he was sentenced to eight years imprisonment.

1.1.8 Alongside identifying learning lessons for future practice, the review can identify if there is evidence that the outcome was "predictable" or "preventable".Given the constraints of skills, knowledge and authority attributed to relevant professionals at the time, it is the view of the Author and of the SCR Panel that the tragic death of Child K was neither predictable nor preventable.

1.2 Purpose of the serious case review

1.2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 (SI2006/90) requires LSCBs to undertake reviews of serious cases in accordance with procedures set out in Chapter 8 of the Working Together guide.

1.2.2 An SCR should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and,
- as a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.2.3 An SCR is not an inquiry into how a child died or any culpability for their death. These are matters for the Coroner and criminal court respectively.

1.3 Serious Case Review Panel

1.3.1 Micky Richards, Deputy Director Operations - South, Crime Reduction Initiatives (CRI), agreed to chair the SCR Panel; CRI being a member agency of the LSCB which had had no involvement with Child K and family.

1.3.2 Paul Kerswell, an independent consultant with experience of over 20 SCRs and with no previous involvement in the case or its management was appointed as Overview Author to:

- collate and critically appraise all IMRs and other documents
- develop, for consideration by the SCR panel, an analysis, conclusions and recommendations for action by East Sussex LSCB, its member agencies and, if relevant, other local or national agencies

1.3.3 The SCR Panel for this review was comprised of:

Deputy Director Operations - South, Crime Reduction Initiatives (Chair)
Designated Doctor Safeguarding Children, East Sussex
Designated Nurse Safeguarding Children, East Sussex
Head of Looked After Children Services, ESCC
Child Protection and Safeguarding Manager, Protecting Vulnerable People Branch, Sussex Police
LSCB Manager

1.3.4 A first meeting of the SCR Panel was held on 16th April 2013.

2 Review Process

2.1 Relevant Agencies

2.1.1 The following agencies were identified as having or likely to have information and opinions of relevance to the serious case review:

- Sussex Partnership NHS Foundation Trust (SPFT) (providing mental health services to Father from 2009 to date)
- Sussex Police (only involved following the incident on 5th November 2012. Input to this review agreed by panel in the form of a non-standardised report)
- GP Practices (providing community based medical services)
- East Sussex Healthcare NHS Trust (ESHT) -Acute (providing hospital and midwifery services)
- East Sussex Healthcare NHS Trust (ESHT) –Community (providing health visiting services)

2.2 Timetable for SCR

2.2.1 A first meeting of the SCR Panel was held on 16th April 2013. Terms of reference (Appendix I) were negotiated and agreed. IMRs were formally requested from the relevant agencies on 3rd May 2013, with 6th June 2013 agreed for receipt of chronologies from agencies.

2.2.2 It was noted that there was a police investigation into the circumstances surrounding Child K's death and that this might impact on IMR Author's ability to interview staff members and access reports. A list of relevant staff members was compiled and Sussex Police subsequently agreed to IMR Authors interviewing those who were potential witnesses, providing contemporaneous notes of those interviews were kept and made available if required for future disclosure.

2.2.3 An IMR briefing session for IMR Authors was held on 16th May 2013. Individual Management Reviews and first draft of the Health Overview were due by 28th June 2013 and any required revisions by 24th July 2013. First drafts of this Overview Report and a Health Overview were anticipated by 23rd August 2013 and the panel planned to consider and agree second drafts on 3rd September 2013 and sign off final versions and agreed action plans on 27th September 2013.

2.2.4 During the process of quality assuring the IMRs, the SCR Panel decided to invite all IMR Authors to attend the panel meeting where the IMRs were discussed in order to both aid the panel in hearing and understanding first-hand the findings of the IMR Authors and to promote the dissemination of learning through the IMR Authors.

2.2.5 At its second meeting on 5th July 2013, the SCR panel acknowledged that the final report could not be published until any criminal investigation and prosecution were complete. The panel agreed that the meeting on 27th September 2013 would agree final draft status of this interim report. The Health Overview Report was also to be agreed, both pending any changes that may need to be made subsequent to any further information being available following the completion of the criminal investigation and any possible prosecution.

2.2.6 It was agreed, however, that an Interim Action Plan should be finalised at that date and submitted to the East Sussex LSCB for approval on 24th October 2013.

2.2.7 The third meeting of the SCR Panel on 31st July 2013 agreed to consider papers from the pre-birth assessment regarding Mother's second child at the next SCR Panel meeting on 3rd September 2013, in order that this review might benefit from information that has been learnt in hindsight.

2.2.8 The SCR Panel of 31st July 2013 also identified that there had initially been no medical input or oversight of the ESHT Acute IMR. This was identified as learning for the panel process and was addressed in the finalised report.

2.2.9 The Detective Superintendent, Head of Surrey & Sussex Major Crime Team, attended for part of the SCR Panel on 31st July 2013 to share information and updates.

2.2.10 The 'Incomplete Draft 1' Overview was submitted on 23rd August 2013 for debate by the panel on 3rd September 2013.

2.2.11 An Interim SCR Overview Report and Interim Action Plan were agreed by the SCR Panel on 27th September 2013.

2.2.12 On 28th April 2014 the SCR Panel met and were informed that Father was due to appear before the Crown Court in July. Plans were made to conclude the review once the outcome of the criminal prosecution was known.

2.2.13 Following a criminal investigation, Father was charged with the murder of Child K. Immediately after the death and during the period leading up to the criminal trial, Father maintained that the fatal injuries to K were as a result of a fit he had suffered whilst holding K. However, once the trial had commenced, Father pleaded guilty to the less serious offence of manslaughter, a plea which was accepted by the prosecution. On 9th July 2014 he was sentenced to eight years imprisonment.

2.2.14 The SCR Panel met on the 9th October 2014 to meet with the police Senior Investigating Officer (SIO) and to consider the final report.

2.3 Family Involvement

2.3.1 The following steps were taken to engage with the bereaved family.

2.3.2 The SCR panel chair wrote letters separately to Mother and Father, which were hand-delivered by the Designated Nurse Safeguarding Children, East Sussex, on 15th July 2013 to inform them that the SCR was being undertaken, to introduce the Overview Author and to encourage their contributions at a later date.

2.3.3 The SCR Panel agreed that this contact could not be made until the police investigation and, possibly any criminal prosecution arising from it, had been concluded. The Overview Author will write to make contact with the family when appropriate.

2.3.4 In October 2014 letters were sent to both parents, inviting their views and offering to share the findings of the review with them. Neither parent responded to these letters.

2.4 Critique of process

2.4.1 The merged chronology was clearly presented and the standard of most IMRs good. The IMRs for this review are, with the exception of the police, all from health agencies. The Author's view is in agreement with the comprehensive comments by the Health Overview Author. Brief comments about each specified IMR are:

- *Police:* The IMR was completed by a suitably independent and experienced practitioner giving a clear, thorough account of the agency's very limited involvement; no recommendations for improved service delivery are offered.
- *GP Practices:* The IMR was completed by a suitably independent and experienced practitioner. A clear and thorough report which also gave a useful overview of historical medical information for Mother and Father. The Author identified appropriate learning and subsequent recommendations.
- *ESHT Community (Health Visiting):* The IMR was completed by a suitably independent and experienced practitioner. The report was concise and clearly laid out. The Author identified appropriate learning with a resulting recommendation.
- *ESHT Acute (Hospital):* The IMR Author had not had previous involvement in the case or in its management. However, the report lacked continuity and critical analysis which may have been due to having been co-authored by the Named Nurse and the Named Midwife with some responsibilities for the management and delivery of the existing service. The report did identify learning and a subsequent recommendation and the Author recognised the difficulty in objectivity due to role conflict. The Overview Author notes the Health Overview Author's efforts to provide further insight into the experience of the Midwives working this case.
- *SPFT:* The IMR was completed by a suitably independent and experienced practitioner. The service had minimal involvement with Mother and Father within the review period, but provided a useful overview of previous involvement with Father. The Author explores the issue of protracted waiting lists and makes a recommendation to address this.
- *The Health Overview Report:* This was completed by a suitably independent and experienced practitioner. It provides a clear, comprehensive and balanced account, with a recommendation made by the Designated Nurse on behalf of the Clinical Commissioning Groups (CCGs) as commissioners.

3 Agency Contact with family prior to review period

3.1 Introduction

3.1.1 A multi-agency chronology of involvement was prepared to inform the review and provides a summary of contacts by all agencies from 1st January 2012 to the death of Child K (aged six weeks) on 9th November 2012.

3.1.2 There were records held for both parents by the GP which give some information about them prior to the review period and Father had some involvement with the Sussex Partnership NHS Foundation Trust in 2009.

Mother

3.1.3 The background information on Mother gives some indication of low level mental health concerns. These may be related to her being the victim (aged nine years) of a sexual assault by two boys. In 2009, aged twenty years, she was seen by her GP for Obsessive Compulsive Disorder and a moderate depressive episode which were treated with an anti-depressant and a referral for counselling which she did not attend. In 2010 she was seen again by her GP for anxiety with depression.

Father

3.1.4 The background information on Father gives a picture of a disturbed and troubled childhood. He was effectively raised by his maternal grandparents. He had an emotionally troubled childhood and was referred for psychological assistance from the age of eight years.

3.1.5 It is now known that Father's parents separated when he was nine months old after which he lived for a short time with his mother then with his father until, at aged two years, he went to live with his grandparents. At age twelve years he is said to have had intense periods of anger and jealousy, a long history of nocturnal enuresis (bed wetting) and behaviour problems at school. Self-harm is first mentioned in 1999, (aged thirteen years).

3.1.6 In 2006 he was seen by a psychiatrist following further concerns of self-harm. There were two further suicide attempts in 2006. In 2008 he was diagnosed with Guillain Barre Syndrome[1] . After a two week admission, Father was fully mobile on discharge from hospital.

3.1.7 During this period Father was also self-reporting seizures and epilepsy. In 2009 he took an overdose and was seen by a psychiatrist who recorded depression caused by multiple seizures[2] .

3.1.8 In 2010 he was diagnosed as having Juvenile Myoclonic Epilepsy and was prescribed medication. Apparently he has not regularly collected his prescribed medication for epilepsy.

4 Period of review: 1st January 2012 to 9th November 2012

4.1 Introduction

4.1.1 This section provides in more detail the events and professional judgements in the period from 1st January 2012 to Child K's death in November 2012. The review would normally detail these in generally chronological order but in this instance the review Author has chosen to deal with Father's health issues separately in order to aid continuity and understanding.

[1] Guillain Barre Syndrome: a condition of progressive paralysis which can last several months but usually resolves completely

[2] For the purposes of this report, the terms **fit** and **seizure**, mean the same thing and can be used interchangeably

4.2 Father's health

4.2.1 On 31st January 2012 Father was seen at an orthopaedic outpatient clinic seeking treatment for recurrent dislocation of his left shoulder. The orthopaedic surgeon wrote to the GP that Father's "fitting has become less recurrent and is now more absences and black out seizures rather than the chronic type". Father had surgery on 3rd May 2012 following which he discharged himself on the same day, against medical advice. He also failed to attend an appointment at the GP surgery on 9th May 2012 to have the wound dressed. The follow up in outpatients on 29th May 2012 revealed that he had removed his sling after three days instead of keeping it on for the four weeks he had been advised. He was seen again in orthopaedic outpatients for a follow up on 26th June 2012.

4.2.2 On 13th February 2012 Father was seen by the GP for a review of his epilepsy, when he reported having ten fits per month.

4.2.3 On 16th March 2012 Father was referred by the GP to a Consultant Oral and Maxillofacial Surgeon for a dental extraction under local anaesthetic as an outpatient.

4.2.4 On 3rd May 2012 the Sussex Partnership NHS Trust wrote to Father informing him that he had been placed on the waiting list for the Sussex Neuropsychiatry Outpatient Service. There is no record of an appointment being offered. On 18th June 2012, presenting to the GP with infected insect bites, Father reported that his fits now occur three times a month and that he has a large supply of medication at home which he is taking.

4.2.5 On 22nd August 2012 Father was discharged from the care of an East Sussex hospital where he had had repairs to the tendon of the right thumb, relating to an injury while using a soldering iron in 2010. He was seen three times in September 2012 in the plastic surgery clinic.

4.3 Mother's health

4.3.1 On 2nd February 2012 Mother was seen by her GP who noted she was six weeks pregnant and that she self-referred to the Midwife.

4.3.2 On 6th March 2012 Mother saw the GP reporting some morning sickness. On 11th March 2012 she was seen by a Community Midwife (CM1) at the hospital for a routine booking at twelve weeks pregnant. Copies of the booking were sent to the GP, the Health Visitor and placed in Mother's hand held notes.

4.3.3 On 14th March 2012 Mother attended the Obstetric Ultrasound Department at the hospital for a routine 13+1 weeks scan. The pregnancy was described as viable with all well.

4.3.4 On 17th April 2012, at eighteen weeks pregnant, Mother attended a routine antenatal check with CM1 during the course of which she disclosed mood swings and anger problems. She consented to the completion of an Additional Support Form (ASF)[3] to the

[3] **Additional Support Form(ASF):** Referral mechanism for ASM

Additional Support Midwife (ASM)[4] . That referral was completed on 19th of April 2012 and copied to the GP, Health Visitor, ASF file, Paediatric Liaison Nurse and Additional Support Midwife.

4.3.5 On 27th April 2012 the health visiting records confirm the receipt of the ASF from the Midwife. On 2nd May 2012 Mother attended the Ultrasound Department for the 20+1 weeks scan. The pregnancy was again described as viable with no identified concerns.

4.3.6 On 16th May 2012 Mother, twenty-two weeks pregnant, attended the antenatal clinic for a routine check with CM1, who noted that she had not heard from the ASM and would follow up.

4.3.7 On 13th June 2012 Mother again attended a routine check with CM1, who informed her that due to staff shortages they were unable to provide the additional support. Mother was offered the Perinatal Mental Health Service[5] but declined this.

4.3.8 On 27th June 2012 Mother presented at the GP surgery with a suspected urinary tract infection.

4.3.9 On 4th July 2012 Mother, now twenty-eight weeks pregnant, attended the next routine antenatal clinic with CM1 to whom she disclosed having a difficult time with her partner who had been in and out of hospital with epilepsy.

4.3.10 At the next antenatal clinic on 31st July 2012, Mother (at thirty-two weeks pregnant) was reported to be physically well and in 'good spirits', having recently stopped work.

4.3.11 On 20th August 2012 Mother (thirty-five weeks pregnant) attended the antenatal clinic at the children's centre with CM2 and discussed the birth plan.

4.3.12 The next routine antenatal check was with CM3 at the GP surgery on 3rd September 2012. Mother was described as physically well.

4.3.13 On 4th September 2012 a home visit was undertaken by the Health Visitor (HV1) in response to the Additional Support Form. Mother (thirty-eight weeks pregnant) was seen. Father was not present. Mother revealed that she suffers from low mood two days out of seven but did not feel that she needed any support at that time. She also told HV1 that Father suffered with epilepsy, having two epileptic 'experiences' a week.

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[4] **Additional Support Midwifery Service (ASM):** The service provides additional help to those women whose need is greatest to try and improve their outcomes and that of their babies. The service covers most of East Sussex and works in addition to and in partnership with core maternity services. It is tailored towards individual specific needs of pregnant women and is more family and future orientated than core maternity services are able to be.

[5] **East Sussex Perinatal Mental Health Service**: The service provides a coordinated specialist approach for women who develop severe mental health problems related to pregnancy, mothers with post natal mental illness and those with pre-existing psychiatric conditions who become pregnant. The SPMHS works with women throughout their pregnancy until one year post childbirth and also takes referrals of young mothers under the age of 18. The service offers direct clinical work in the form of telephone advice, information and signposting, outreach assessment and follow up from the practitioners, access to specialist consultant psychiatry time for those appropriate for the service and indirect work such as teaching, training, consultation and advice to other healthcare professionals, in particular to primary care and acute medical trusts.

4.3.14 On 12th September Mother presented at the GP surgery complaining of low abdominal pain persisting over three days. The GP noted the need for her to be seen at the maternity unit and that a referral letter was completed.

4.3.15 On 17th September 2012 mother (thirty-nine weeks pregnant) attended a routine antenatal check with CM2 at the children's centre. She was reported to be feeling very anxious but physically well.

4.3.16 At the next routine antenatal check on 24th September 2012, Mother was described as tired and uncomfortable and a provisional date of 29th September was given for induction of labour.

4.3.17 At 13:15 hours on 26th September Mother attended the delivery suite in suspected early labour; she was sent home to await developments and then admitted eight hours later.

4.3.18 Child K was delivered by forceps delivery at 18:55 hours on 27th September 2012, weighing 3575 grams. No concerns were documented. Mother and K were discharged home to the care of the GP and Community Midwife on 29th September 2012.

4.3.19 On 30th September 2012 CM2 undertook a home visit.

4.3.20 On 3rd October 2012 CM2 undertook a second home visit.Child K weighed 3480 grams and was now being bottle fed. No concerns were documented.

4.3.21 On 6th October 2012 Mother took Child K to the GP surgery concerned about infantile colic. Mother also said she was tired, was moving house and was worried that the baby may have inherited Father's epilepsy as K twitches when asleep. K was examined and found to be well; Mother was reassured and encouraged to bring the baby back if unwell.

4.3.22 On 7th October 2012 CM2 undertook her third and last home visit. Child K weighed 3580 grams; CM2 noted that the family were moving house that day. She discharged K but made sure Mother was aware she could make contact up to twenty-eight days post birth.

4.3.23 On or around this time, Mother transferred both herself and K from the GP practice to the Walk-in Centre.

4.3.24 On 17th October 2012 HV2 made a routine new birth visit. Mother was described as low and anxious. An enhanced health visiting service was offered and HV2 discussed safe procedure regarding baby and epilepsy. The East Sussex Health Trust (ESHT) – Community Author notes that HV2 had a further discussion with both parents about the safety implications of parenting with epilepsy. Mother was offered and agreed to accept an enhanced health visiting service.

4.3.25 On 19th October 2012 Mother saw the GP at the Walk-in Centre on the recommendation of HV2. She reported that she used to drink heavily before she was pregnant. She described feeling panicky and anxious since giving birth three weeks ago. The GP prescribed anti-depressants and made a referral to Health in Mind. (A Tier 2/3 service providing lower level psychiatric support)

4.3.26 On 23rd October 2012, following the visit to the GP by Mother, HV2 telephoned Mother who reported feeling more settled.

4.3.27 On 27th October 2012 Mother took Child K to the GP surgery with concerns for K being first constipated and then very loose. The GP examined K and reassured Mother.

4.3.28 On 5th November 2012 Father called an ambulance for Child K. He said that following a fit he had come round to find himself lying on top of the baby. K was resuscitated on the way to the hospital. Investigations, including CT scans[6] and full body X-Rays, identified concerns about historic and current injuries. The parents attributed the older injuries "to a previous fit". The parents had neither sought medical attention at the time, nor drawn this incident to the notice of any professional. This view was initially accepted by the Consultant Paediatrician who felt that the historic injuries could be consistent with Father's account of a previous fit or could be the result of non-accidental injury. At that stage it was agreed by a Strategy Meeting that the cause of the injuries was unclear. However there was enough concern to warrant initiating a Section 47 Enquiry[7] if events had not taken over.

4.3.29 Child K was transferred to a London hospital, where the medical view was that the injuries were very concerning. K died as a result of these injuries on 9th November 2012.

5 Analysis

5.1 Introduction

5.1.1 Section 5 will address each item of the given terms of reference. Sections 6 and 7, respectively, will then offer findings and conclusions, and recommended organisational changes.

5.2 Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

5.2.1 The GP IMR Author notes that Father's medical notes were notably copious for a man of his age and that he seemed to have repeatedly requested help, then not attended appointments made to try and address his concern.

5.2.2 This review, conducted with the benefit of hindsight, has had access to information collected and collated as part of the pre-birth assessment for the parents' second baby.

5.2.3 It is the view of the SCR Panel that no one practitioner working with Father during the time period covered by the review could have realistically pulled together all of the information about Father's medical and social history.

[6] **A CT scan** is a method of taking an image of the brain. CT stands for *computed tomography*, a procedure that produces a clear, two-dimensional image of the brain that shows abnormalities such as brain tumours, blood clots, strokes, or damage due to head injury.

[7] **Section 47 of the 1989 Children Act** places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm.

5.2.4 The GP IMR Author notes however, that as the pregnancy progressed and Child K was born, both GP practices were aware of the relevance of Father's uncontrolled epilepsy and of his past history of repeated self-harm and emotional instability to the welfare of Child K.

5.2.5 It is of some concern therefore to note that the Principal of GP Practice 1 claims to be unaware of a reporting mechanism from Midwifery to GPs for women who book directly with Midwives. The Health Overview Report comments that the GP was aware of the pregnancy from early stages and therefore could have shared Mother's mild OCD and Father's history of uncontrolled epilepsy with the Named Midwife.

5.2.6 The GP IMR Author reflects that both GP practices raised concerns about the difficulties for communication and team work against a backdrop of geographical working, increased workloads and unfilled vacancies. That Author also raises the issue of the use of the Children Index[8] by primary care; a tool which could assist in identifying which other professionals are working with a family, pointing out that each GP practice has a Named Health Visitor lead.

5.2.7 The Health Overview Author also comments on the failure of GP Practice 2 to share information about Mother's anxiety and low level depression with the Health Visitor (HV2) who could have offered additional support.

5.2.8 The recommendations made by the GP IMR Author address the issues of timely and relevant communication between health professionals.

5.2.9 The Midwifery services working with Mother clearly understood and identified the impact of her reported mood swings in April 2012. CM1 appropriately referred Mother for Additional Support Midwifery and subsequently checked and followed up when no further contact had been made with Mother to discover that the service had been withdrawn due to staffing shortages.

5.2.10 The Health Overview notes that in interview CM1 was able to confirm that other services were discussed and offered to Mother, who declined them at the time. It is not clear if or how this service deficit was recorded or escalated to managers of the service.

5.2.11 It is clear that by July 2012 the Midwifery Services were aware of Father's epilepsy from Mother's own reports. It is not clear that the impact of this on his ability to care for a new-born baby was considered or discussed with Mother by the Midwives. Arguably this should have been raised by CM1 as an issue for safeguarding supervision.

5.2.12 The ESHT Acute IMR Author notes that CM1 did advise Mother that her plans to start college in September 2012, at the time the baby was due, were unrealistic and comments that CM1 thinks this may be the reason Mother changed Midwives at thirty-six weeks. There is no recorded communication between the Midwives, though

[8] **The Children Index** is a directory of all children in East Sussex, and contains only basic information on each child and young person, including their contact details and the services supporting them. It enables all agencies working with children to share basic information on what services are being provided for each child or young person, and to let other practitioners know that they are working with a child or young person and his or her family.

presumably the hand held notes (held by Mother) were available whichever clinic Mother attended.

5.2.13 The ESHT Acute IMR Author notes that "the Midwife did not explore further as she had advised Mother to defer her course and assumed she would be caring for the baby". Mother subsequently choosing to change her Midwife by attending a different ante-natal clinic and the lack of communication between those Midwives meant that issue was never followed up with Mother, nor was it passed to the Health Visitor.

5.2.14 The Health Overview Author notes that the Health Visiting Service first became aware of Mother's pregnancy in April 2012 on receipt of an Additional Support Form (ASF) from CM1. The first Health Visitor contact with Mother was an antenatal visit three weeks prior to the birth. The ESHT Community IMR Author notes that given the significant time period between the ASF being received and the antenatal contact taking place, direct communication between the services may have resulted in Mother receiving earlier or alternative support.

5.2.15 The ESHT Community IMR Author also identified that HV1 correctly completed the assessment during the antenatal visit but failed to analyse the impact of:

- **F**ather's epilepsy on his parenting capacity
- Mother's poor relationship with her family
- Mother's intention to return to college
- The issues raised by CM1 through the ASF

It does not appear that HV1 enquired who was to care for the baby.

5.2.16 The Health Overview Author notes that this may have been a missed opportunity of assessing the potential risk presented to Child K by Father's epilepsy.

5.2.17 The post birth visit was undertaken by a different Health Visitor, HV2, seemingly because the family had moved, within the same locality, shortly after the birth of Child K. There is no recorded direct communication from Midwife to Health Visitor or from HV1 to HV2.

5.2.18 HV2, a newly qualified Health Visitor, however, did appropriately offer an enhanced health visiting service in recognition of Mother's vulnerabilities; communicated this to the GP and spent some time discussing the implications of Father's epilepsy in caring for a new-born baby with both Mother and Father, on the understanding that Mother was to be the primary carer.

5.3 Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

5.3.1 Both GP practices had designated Child Protection leads and a policy. Neither had access to the Children Index which the GP IMR Author notes as a potential missed opportunity to explore why Mother transferred GP practices within the same building so soon after giving birth.

5.3.2 The ESHT IMR Authors and the Sussex Partnership NHS Foundation Trust (SPFT) Author document their compliance with the Sussex Child Protection and Safeguarding Procedures.

5.4 What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way and, if this was not the case, what was preventing this?

5.4.1 Key points for assessment must include Mother's antenatal and postnatal appointments with Midwives and Health Visitors. CM1 clearly assessed Mother's needs due to her pregnancy and was aware of the impacts of her reported mood swings and depression. Mother was appropriately offered additional support and, when it later became clear that this was not available, alternatives were discussed with her.

5.4.2 The Additional Support Form (ASF) completed by the Midwife in April 2012 was not updated at any point although Midwives continued to have regular contact with Mother at antenatal clinics. Debate by the SCR Panel has revealed that there is no expectation that this form is regularly updated and further, due to the IT design of the form, putting an update on it risks losing earlier information as its field depth is limited. The ESHT Acute IMR Author indicates that the safeguarding support and advice which would have been expected to be provided by the Safeguarding Specialist Midwife may have addressed these issues. The post was vacant from September 2012 and there appears to have been no contingency to cover this absence.

5.4.3 In July 2012 it was evident that Mother informed CM1 of Father's epilepsy and the difficulties this presented her with during the pregnancy. There does not appear to have been any assessment of the risks that this might present to a new born baby and, although CM1 clearly discussed with Mother the wisdom of her attending college from September when the baby was due, there is no evidence of any exploration about who would care for the baby. The Health Overview Author makes a recommendation to ensure that there is a process to assess the impact of parental epilepsy on parents' ability to care for babies.

5.4.4 The change to CM2 at thirty-six weeks pregnant, by Mother attending a different ante-natal clinic, may have been an opportunity to explore the reasons for the change which was missed.

5.4.5 The first Family Assessment undertaken by the Health Visiting Service was at three weeks prior to birth in September 2012. The Health Visiting Service had received the Additional Support Form from Midwifery in April 2012, six months previously. The Health Overview Author notes that direct communication between the services may have resulted in earlier or alternative services being provided to Mother.

5.4.6 Direct communication may also have informed and updated the assessment made by HV1 which, as noted in point 5.2.10, lacked analysis and assessment of the risks to the baby.

5.4.7 The new birth visit undertaken by HV2 did assess the impact of both Mother's vulnerabilities and Father's epilepsy on their ability to care for Child K.

5.4.8 The last recorded review of Father's epilepsy was in February 2012 and although early in the pregnancy, was at a point when the GP practice was aware of Mother's pregnancy. The impact does not appear to have been considered.

5.4.9 There must be some mention made of the information held by Father's GP practice about his health issues, particularly the ongoing reported epilepsy but also Father's somewhat inconsistent behaviour in seeking and adhering to medical advice and opinion. With hindsight, could some analysis of the cumulative information held about Father's behaviour, with regards to his health, have led to a better understanding by the GP of his ability or willingness to take and heed advice?

5.5 Were concerns about this child shared between the relevant agencies in a timely manner with appropriate communication and analysis? Should communications be reviewed between agencies in order to identify if there were issues of concern that were not shared?

5.5.1 As noted above there are distinct weaknesses in communication between health agencies throughout the period of this review:

- between GP practice and Midwifery when Mother made her antenatal booking
- between Midwifery and Health Visiting with regard to the ASF
- between Midwifery and Health Visiting when handing over the care of Child K post birth
- between Midwife and Midwife when Mother changed antenatal clinics she was attending
- between Health Visitor and Health Visitor when the family moved within the town

5.5.2 These issues are appropriately addressed by the IMR Authors and the Health Overview Author.

5.5.3 The ESHT Community IMR Author comments on the rollout of the 'Goodstart Programme' piloted in a neighbouring town in 2011. The Goodstart Programme provides an opportunity for Early Help Workers, including Health Visitors, Additional Support Midwives, Family Outreach Workers and Keyworkers to come together every fortnight to agree Early Help provision for families with identified needs. This includes women requiring additional support during the antenatal period.

5.5.4 The Goodstart Service is now fully implemented across East Sussex and includes a universal offer of an antenatal contact to all mothers by a Health Visitor.

5.6 Did actions accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?

5.6.1 See 5.2 and 5.4. When assessments were made, appropriate actions were taken. However, all the Health Agencies involved in this review commented on increasing work pressures, staff shortages and unfilled vacancies as significant factors. This is further explored in 5.10.

5.7 Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability to the child and family, and were they explored and recorded? If this was not the case, why did this not happen?

5.7.1 The agencies involved variously explored the cultural issues arising from what was known about Father's and Mother's backgrounds and known history. Social isolation was considered and not deemed to be a factor. It is possible that a more in depth understanding of Father's background and responses to his health issues (see 5.4.9) may have changed professional perceptions of the family's capacity to heed professional advice.

5.8 Were senior managers or other organisations and professionals involved at points in the case where they should have been? If this did not take place, what were the reasons for this?

5.8.1 Section 5.10 explores the issues of organisational and service management against the backdrop of increasing workloads and staff shortages.

5.8.2 The case management issue worthy of note is that of the status of HV2 as a newly qualified Health Visitor. Having been qualified for only two months, HV2 had an allocated preceptor with whom she had met formally twice. The ESHT Community IMR Author notes that the preceptor went off sick and that HV2 mentioned that this was a problem for her, although she had access to Team Leaders and colleagues who were very supportive.

5.8.3 This lack of formal support does not seem to have impacted on the quality of HV2's work with the family. (See 5.2.14)

5.8.4 In the absence of the Safeguarding Specialist Midwife at that time it is not clear what the process was for Midwives to raise issues about safeguarding in supervision, or indeed whether they receive effective and challenging supervision of their work. (See 5.2.8).

5.9 Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards? If this was not the case, what was preventing this from happening?

5.9.1 This case highlights issues about what may be termed best practice in communications between GPs, Midwives and Health Visitors.

5.9.2 There are also failures to recognise the possible impact of Father's epilepsy, as well as his responses to advice, on his capacity to successfully parent a new-born baby.

5.10 Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

5.10.1 Through the work of the IMR Authors and subsequent debate at the SCR Panel meetings it is apparent that all of the Health Agencies involved in this review identify current

difficulties in the management of increasing workloads and staff shortages. This was not communicated effectively to either internal or external partners.

5.10.2 The SPFT Neuropsychiatry Service refers to the delays in offering Father a service following the referral from the neurologist at Kings College Hospital in May 2012. Although the service wrote to Father informing him there was a sixteen week waiting list, he had still not been offered an appointment by July 2013. The IMR Author notes that the delay was due to increasing workloads and comments that, as a non-commissioned service, it is not possible to obtain funding to increase staffing levels. The service apparently has a prioritisation system, but did not let patients, nor presumably referrers, know that the waiting time had increased. Following a request from the SCR Panel, Father was offered an appointment on 12th August 2013 which he failed to attend.

5.10.3 That Author also acknowledges that there was no management accountability at the time for the increasing demand on the service and, as a result, recommends that managers review waiting times against national standards and where difficulties are identified have action plans in place. The SPFT IMR Author also notes that the service is currently being reviewed with the Commissioners.

5.10.4 The GP IMR Author identified difficulties for both GP practices resulting from Health Visitor and Midwife geographical team working, increasing workloads and unfilled vacancies.

5.10.5 In April 2012 CM1 appropriately referred Mother for additional support, only discovering by following up in June 2012 that the Additional Support Midwife (ASM) service had been withdrawn from 1st June 2012. The ESHT Acute IMR Author notes that the impact of this on Mother was that she did not receive additional support in the form of home visits or phone calls that would monitor her mood and anger management issues. These contacts would also have given the opportunity to assess her depression and anxiety score when indicated. Father did not attend antenatal appointments with Mother so speculatively the ASM might have had contact with him during her visits, thereby enabling a fuller understanding of the family dynamics.

5.10.6 Of greater concern may be the apparent lack of a coherent management strategy to deal with this issue. The ESHT Acute IMR Author goes on to explore the caseload of the Community Midwife at the time: At 140 this was more than forty percent in excess of Royal College of Midwives Guidance (2009). CM1 discussed these issues with her team leader and the Midwifery Clinical Services Manager but received only limited advice due to the severe staff shortages.

5.10.7 The ESHT Acute IMR Author also discusses recruitment and staffing difficulties within the ESHT Maternity Department. These resulted in a limited cover for the vacant Safeguarding Specialist Midwife post and increased and unevenly distributed caseloads. High levels of maternity leave resulted in an increased use of agency staff and the Additional Support Midwives being withdrawn from specialist services to support core midwifery provision. The impact of this was that Midwives with safeguarding cases did not have the time to follow them up robustly. Provision was agreed between the Maternity Commissioners, ESHT Maternity Managers and Children's Centre Managers to support vulnerable women through the Public Health Specialist with the Family

Outreach Service and early Health Visitor antenatal visits. However, it is not clear that any of this was fully communicated to practitioners or partners.

5.10.8 Within a similar timescale the health visiting service was also being severely affected by staff shortages. The ESHT Community Author notes that the Health Visiting Service was on the Trust Risk Register due to staffing vacancies. Again it is not clear that this was communicated to either practitioners or partners.

5.10.9 The SCR Panel has viewed a copy of the current risk assessments and action plans from ESHT with respect to anticipated Health Visitor shortages. The Health Overview Author notes that the Health Commissioners have been working closely with ESHT with regards to the Midwifery service. The Commissioners will continue to monitor the recommendations and action plan produced by ESHT.

5.11 Was there sufficient management accountability for decision making? If accountability was lacking, what would have assisted this in taking place?

5.11.1 (See 5.8 and 5.10)

6 Findings & conclusions

6.1 Introduction

6.1.1 This section encapsulates the learning from this case in relation to the way in which participating agencies worked to safeguard and promote Child K's welfare.

6.1.2 It offers a brief summary of good and sub-optimal response (systemic and individual) as well as the Author's evaluation of whether the tragic outcome might have been predicted or prevented.

6.2 Good practice

6.2.1 While the practice of professionals was largely adequate, there was nothing which stood out as being exceptionally 'good' (i.e. exceeding what would be expected in comparable cases)

6.3 Conclusions

6.3.1 The Author wishes to acknowledge the work of the Health Overview Author, the IMR Authors and the SCR Panel in their input to this review. The issues arising from this review, undertaken with the benefit of hindsight, fall under several broad themes.

6.3.2 Communication between practitioners was identified as a recurring theme across the IMRs. There is a commonly held view that communications between GPs, Midwives and Health Visitors, both within and between those professional groupings have been affected by staff shortages, recruitment difficulties, changes in service delivery and use of locum practitioners. The Health Overview Author notes that during times of change and pressure, good communication is essential to the maintenance of effective services, thereby ensuring children are kept safe.

6.3.3 There is also evidence that some of the tools designed to facilitate that communication are:

- Not used: for example the Children Index not being accessed by either GP practice. (The Children Index requires regular use in order to maintain access)
- Not fit for purpose: for example the ASF which does not have a review date and does not enable new information to be added without risking the loss of previous information.
- Not universally known and understood: for example Mother's first GP stating he was unaware of the form available for providing information when women book their pregnancy through the Midwives.

6.3.4 In addition, changes to services and working arrangements as a result of staff pressures were not communicated to frontline practitioners and it was also not clear to the practitioners what alternative measures had been put in place.

Epilepsy/Non-Epileptic Seizures

6.3.5 At the criminal trial it was concluded that Father suffered from Functional Non Epileptic Attack Disorder (FNEAD), i.e. his seizures were non-epileptic in origin. During the period covered by this review he had been referred for a neuro-psychiatric assessment which he ultimately failed to attend.

6.3.6 This review would add that the presence of poorly controlled epilepsy and/or non-epileptic seizures; an important factor for either parent of a new-born baby, was known to a number of practitioners involved with the family. This should have prompted further enquiries regarding Father's health and the potential impact on his parenting capacity, especially in the light of Mother's stated original intention to delegate the primary care of Child K to Father while she returned to her studies.

Management support/accountability

6.3.7 The Health Overview Author notes that frontline professionals across health agencies are currently working with high caseloads, erosion of early support services and the increasing expectation of being able to provide early help services. There is evidence of high caseloads and high levels of sickness with anecdotal accounts of staff dissatisfaction. The impact of this has been low morale with some professionals perceiving a lack of management support and understanding. This highlights the need for effective and challenging supervision, both clinical and safeguarding. This need is at its most acute at times when services are under pressure.

Services Under pressure

6.3.8 Within the current economic climate it is inevitable that public services come under enormous pressure. Not only are they faced with financial efficiency demands and pressures, they also have to address an escalation in the level of need and vulnerability amongst the populations they serve. It is essential therefore that services working within the same "community" are transparent with each other, sharing the impact of resource issues in partnership with each other. If services are reduced or reconfigured, the impact must be fully assessed, minimised as far as possible and acknowledged and shared.

6.3.9 Although this review clearly identifies pressures on services, Mother received all of the recommended contacts.

6.4 Predictability & preventability

6.4.1 Alongside identifying learning lessons for future practice, the review can identify if there is evidence that the outcome was "predictable" or "preventable". Given the constraints of skills, knowledge and authority attributed to relevant professionals at the time, it is the view of the Author and of the SCR Panel that the tragic death of Child K was neither predictable nor preventable.

7 Recommendations

RECOMMENDATIONS FOR THE ESSCB
Review Process
1. In any future serious case reviews, the SCR Panel should consider carefully the issue of conflict of interest for proposed IMR Authors and ensure that IMRs include the necessary clinical input and oversight.
Health Overview
2. All families where one or both parents suffer from epilepsy, or non-epileptic seizures, should be alerted to the British Epilepsy Association guidelines on safety of infants in their care. In cases where the epilepsy or fits are uncontrolled and the parent has sole care of the child, a risk assessment should be undertaken by health professionals.
Overview
3. The LSCB should ensure that all partner agencies when they withdraw, reconfigure or reduce services which might impact on safeguarding to report: • The communication strategy in regard to withdrawal/reconfiguration/ reduction • The risk assessment and risk management action plan • The plan to monitor the impact
4. The LSCB should ensure that East Sussex Healthcare NHS Trust audits the quality of supervision to Midwives and Health Visitors and provides evidenced assurance to the LSCB.
5. The LSCB should ensure that the recommendations from the individual IMRs presented to the Panel are completed.

8 Glossary

CM1	First Community Midwife
CM2	Second Community Midwife
ESHT	East Sussex Healthcare NHS Trust
HV1	First Health Visitor
HV2	Second Health Visitor
IMR	Individual Management Review
SCR	Serious Case Review
SPFT	Sussex Partnership NHS Foundation Trust

9 Appendix I - Terms of Reference

TOR for IMRs - Child K – dob 27.9.12

1. Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare? Should the practitioners not have worked in this way, comment should be made about the reasons for this.

2. When, and in what way, was the child's wishes and feelings ascertained and taken into account when making decisions about the provision of children's services? Was this information recorded? If this work was not undertaken, the reason for this not taking place should be noted.

3. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

4. Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?

5. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way and, if this was not the case, what was preventing this?

6. Were concerns about this child shared between the relevant agencies in a timely manner, with appropriate communication and analysis? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?

7. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? If appropriate actions did not take place, what was obstructing this?

8. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

9. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability to the child and family, and were they explored and recorded?

10. Were senior managers or other organisations and professionals involved at points in the case where they should have been? If this did not take place, what were the reasons for this?

11. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards? If this was not the case, what was preventing this from happening?

12. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

13. Was there sufficient management accountability for decision making? If accountability was lacking, what would have assisted this in taking place?

Period covered by this review – 1.3.12 to 9.11.12

10 Appendix 2

Recommendations from the Agency IMRs

East Sussex Healthcare NHS Trust (ESHT): Acute and Community

1. All families where one or both parents suffer from epilepsy should be alerted to the British Epilepsy Association guidelines on safety of infants in their care. In cases where the epilepsy or fits are uncontrolled and the parent has sole care of the child, a risk assessment should be undertaken.

2. For Specialist Midwife- Additional Support (ASM) team to produce a resource file of local services available to support families, including referral processes and paperwork to aid the Midwife to signpost to other agencies.

3. The Additional Support Midwives role or a robust substitute service is maintained during times of midwifery staffing shortage.

4. The ASFs to be reviewed to ensure that all updates are easy to identify and there is adequate space to do this.

5. Review the caseloads and aim to achieve the national recommendation of ninety-eight per whole time equivalent community midwife within six months.

6. Midwives need to formally escalate concerns regarding caseloads and safeguarding concerns to their line manager and if they feel that their concerns are not being acted upon that the Trust's whistle blowing policy is followed.

7. In addition to the Additional Support Form (ASF), to ensure that information is shared between the midwife and health visitor, particularly when risks have been identified and further support is required.

8. Review process for managerial communication to practitioners particularly when services are being withdrawn or reduced. Consider wider groups that should be included in sharing information.

9. The process for transfer of records between Health Visitors to be reviewed.

10. The Named Doctor for Safeguarding should be consulted prior to the strategy meeting in all cases of likely NAI.

Sussex Partnership NHS Foundation Trust

1. Review waiting times for services and consider whether waiting times meet national and local guidelines and whether lists are being managed appropriately. Consideration should be given when allocating appointments to ensure the specific needs of the individual are reviewed and that carer/parental or potential parental (unborn child) responsibilities are considered.

2. Should a service experience an increase in demand, then patients on the waiting list should be contacted to ascertain whether their need has changed or whether they require an alternative provision whilst continuing to wait.

Clinical Commissioning Groups (Primary Care)

1. The CCG should review with Midwifery, arrangements for information sharing at antenatal booking.

2. Practices' access to the Children Index to be facilitated and Practice Leads to be helped to develop a policy on the use of the Index.