East Sussex
Safeguarding
Children
Partnership

Serious Case Review

Child W

REVIEW REPORT

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1 Introduction to the case and summary of the learning from this review

1.1 This serious case review (SCR) is in respect of an eight-week-old baby to be known as Child W. She died while in the care of her parents in September 2018. Her father has been convicted of her murder and her mother convicted of allowing her death.

1.2 Child W spent the first 25 days of her life in hospital having been born at 32 weeks gestation. She returned home to live with her parents and her four-year-old half sibling (Father's child) when she was three weeks old.

1.3 Both parents had been in the care of the local authority when children, Mother in East Sussex, and Father in Kent. Mother was receiving support as a care leaver at the time of Child W's birth.

1.4 Sibling, who is Father's child, had been on a child protection plan in Kent due to concerns about his care. The issues were predominantly regarding the risk posed by his mother, Father's previous partner. The case closed to Kent children's social care (CSC) and Father took on the sole care of Sibling prior to moving to East Sussex.

1.5 The learning identified from the case is in regard to:

- Support for care leavers when they become parents
- Support for parents of babies born prematurely and needing to spend time in hospital
- Pre-birth assessment
- Proactive information seeking and sharing
- The investigations required following an unexpected infant death
- Confidence to challenge families and other professionals
- The need to explore and understand the role and remit of other professionals working with a family

2 Process

2.1 In 2018 the East Sussex Local Safeguarding Children Board (now known as the East Sussex Safeguarding Children Partnership) recognised the potential to learn lessons from this review regarding the way that agencies work together to safeguard children. It was agreed that this SCR would be undertaken using the SILP methodology[1], which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the

[1] Significant Incident Learning Process

learning from the case within their agency and make relevant single agency recommendations.

2.2 All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued when a large number of practitioners, managers and agency safeguarding leads come together for a learning event.[2] The same group then comes together again to study and debate the first draft of the SCR report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review[3].

2.3 It was agreed that the review would consider in detail the period from 1.1.18 – 28.9.18. This covers Mother's pregnancy with Child W until the day the parents were arrested. Detailed case information will not be disclosed in this report[4], only the information that is relevant to the learning established during this review.

2.4 Early family engagement is required as part of the SILP model of review. The lead reviewer tried to meet with both parents in 2019. The parents cancelled the appointments made. Both were contacted again in 2021. Mother agreed to speak to the lead reviewer and her views are included in this report as relevant. Father did not agree to meet, but he is aware that the review has been undertaken.

3 Family structure

3.1 The relevant family members in this review are:

Family member	Referred to as:
Subject child	Child W
Mother of Child W	Mother
Father of Child W and Sibling	Father
Sibling of Child W	Sibling

3.2 Sibling is Father's child from a previous relationship. Child W was Mother's only child. Mother was aged 19 when Child W was born.

3.3 Any other relevant family members will be referred to by their relationship to Child W.

4 The background prior to the scoped period

4.1 Prior to Sibling's birth Kent CSC held an initial child protection conference (ICPC) due to Sibling's mother's previous children not being in her care and on-going concerns about her lifestyle. Legal processes were also started under the Public Law Outline, but not pursued. The assessments that followed considered Father's history of depression and a long-term physical health problem, but he emerged as the primary carer for Sibling and was thought to be able to meet his needs. Kent CSC closed the case and Father took on the sole care of Sibling in 2015, when he was around two years old. Father and child later moved to East Sussex.

[2] The Chair of the ESSCP agreed the SCR and the lead reviewer was appointed. The terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in May and July 2019. The lead reviewer is Nicki Pettitt, an independent social work manager and safeguarding consultant. She is an experienced chair and author of SCRs and a SILP associate reviewer. She is independent of ESSCP and its partner agencies.

[3] Working Together 2015 (the legislation in place at the time the review was agreed as ESSCP had not yet changed to new partnership arrangements) states SCRs should be conducted in a way that; recognises the complex circumstances in which professionals work together; seeks to understand precisely who did what; considers the underlying reasons that led to actions; seeks to understand practice from those involved at the time rather than using hindsight; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings. This review has achieved these objectives.

[4] Statutory Guidance expects full publication of SCR reports, unless there are serious reasons why this would not be appropriate.

4.2 Little was known about Father's care history, but it has been established during the review that he was neglected from a very young age with periods on a child protection plan, and that he was in the care of Kent County Council from the age of 12. He experienced a number of different placements while in care. There are records that he had some mental health issues. He was not in receipt of after-care support at the time he moved to East Sussex as it was some time since he had left care.

4.3 Father was known by a number of professionals to use cannabis as an adult, with him claiming he needed to self-medicate to manage pain due to his health issue.

4.4 There was some limited contact with Sussex Police and with CSC in East Sussex after Father and Sibling moved into the county. This was initially in relation to issues with Sibling's mother's family, and when two anonymous referrals were received, one about father's cannabis use. In 2016 the Single Point of Advice[5] (SPoA) received a referral from a CAFCASS Family Court Adviser about Father's concerning behaviour during an unrelated court hearing he had attended with Sibling's mother.

4.5 When the family came to the attention of CSC in East Sussex, they contacted their equivalent in Kent but due to Father refusing permission for information to be shared, Kent CSC did not inform East Sussex CSC of Sibling's (or Father's own) history. East Sussex systems had information on their systems that Sibling had been on a CP Plan however; as he was removed from the plan shortly after moving to East Sussex, and processes had been followed to ensure temporary registration in East Sussex. They also had access to significant information about Sibling's mother's family. Father was contacted by both CSC and Sibling's health visitor with offers of support. He refused, stating he didn't require this.

4.6 Mother had been in care since the age of five due to concerns about sexual and physical abuse. She had emotional issues and some learning difficulties. She was known to be extremely vulnerable, and there were concerns that she had been exploited. Living independently was a challenge for Mother and she quickly returned to live with her family, despite having a tenancy of her own. She stayed with her mother until she moved in with Father and Sibling. This was following a domestic abuse incident where Mother alleged to the police that she had been physically assaulted by her stepfather.

4.7 Both parents had statements of special educational needs at certain points during their childhoods.

4.8 At the time of her pregnancy, Mother was receiving support from the CSC Throughcare Team.[6] The ThroughCare Team know Mother well and have a good understanding of her family history. Her mental health issues had been managed by her GP and Health in Mind.[7]

5 Key episodes

5.1 The time under review has been divided into four 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family. They are key from a practice perspective rather than to the history of the child. They do not form a complete narrative of the case but summarise the information that informed the review.

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[5] The East Sussex County Council Single Point of Advice (SPoA) receives referral for children's social care and early help.

[6] The through care service in East Sussex is a group of professionals, which includes personal advisors, social workers, a mental health nurse, and the virtual school. They provide support to care leavers.

[7] Health in Mind is an NHS mental health organisation providing courses and other types of therapies that help with stress, anxiety and low mood.

Key episodes
1. Mother's pregnancy
2. Child W's hospital stay
3. Child W's discharge and time at home
4. Response to Child W's death

Key episode 1: (Mother's pregnancy)

5.2 Father and Mother had been in a relationship for around three months when Mother fell pregnant with Child W. She told her Personal Advisor (PA) from the ThroughCare Team that the pregnancy was unplanned but welcome. Father is ten years older than Mother. The PA believes he was not aware of Mother's on-going support from CSC at the time, and they had not met him. Mother told the review she didn't like to talk about having been in care.

5.3 Mother and Father were both caring for Sibling and Mother was living in Father's accommodation. Sibling was attending pre-school sessions at a local primary school and was due to start formal education in reception around the time his sister was due. The school had regular contact with Father and had no concerns. Mother had told her PA that she often struggled with Sibling's behaviour however, and that she struggled with his daily video calls with his mother.

5.4 Father had recently seen his GP due to severe back pain and low mood linked to his health condition. He said he had, until fairly recently, been smoking cannabis to self-medicate. Father was prescribed an anti-depressant. The GP was reluctant to prescribe stronger painkillers as they could impair Father's alertness and potentially have an impact on his care of Sibling. The GP also wrote to a specialist and arranged blood tests[8]. Father did not respond to further appointments and did not receive any more prescriptions.

5.5 Midwifery services referred the unborn child to the SPoA after first meeting Mother. They highlighted; both parents were care leavers; the incident the year before when Mother's stepfather had been violent to her; Mother's previous issues with bulimia and anxiety; Sibling's previous CP Plan in Kent; and Father's physical health issues. Although they did not include it in their referral, they were aware that there was a ten-year age difference between Father and Mother. After consulting with Mother's PA from the ThroughCare team, the SPoA team leader passed the case to the Multi-Agency Safeguarding Hub (MASH)[9] for a pre-birth family assessment.

5.6 The MASH Social Worker consulted with the PA and spoke to Mother who stated that she did not want to engage with social workers or Early Help services in respect of her child. She reported that Father was supportive and that they were both happy about the pregnancy, and that she would continue to work with her midwife and her PA. The case was closed as it was thought that the threshold for a pre-birth social work assessment was not met. The midwife and PA were advised to re-refer in the event of further or escalating concerns.

5.7 Shortly afterwards Mother told her PA that she did not want any further ThroughCare support. Despite this she continued to telephone the PA, who spoke to Mother's midwife to discuss the case. They both believed that Mother would require support when the baby arrived.

[8] They came back as normal.
[9] The MASH is made up of professionals from the police, CSC, early help services and health.

Key episode 2: (Hospital stay)

5.8 Child W was born by emergency caesarean at 32 weeks. She spent 25 days in the neonatal unit (NNU). Mother was understandably upset and worried but visited regularly. Father visited rarely, reportedly due to having to care for Sibling and the travelling time to the hospital.

5.9 The health visitor had intended to visit the family before the birth but was unable to do so due to Child W's early arrival. One of the community midwifes had informed the health visitor that while pregnant Mother was stressed and had said she was unable to manage the difficult behaviours of Sibling, and that Father was not 'disciplining' the child. The health visitor undertook a home visit after the birth and while the baby was still in hospital.

5.10 The health visitor was informed prior to Child W's discharge and was told that Mother was developing a bond with Child W and providing appropriate care but was noted to 'have difficulty in waking for night feeds'. A Discharge Planning Meeting was not arranged as these meetings are only held for cases where there are on-going complex needs, concerns or a Child Protection Plan/Child in Need plan is in place for the baby. None of these were thought to be applicable in this case.

5.11 Three days prior to Child W's discharge, Mother is reported to have told hospital staff that she had 'an argument' with Father. She explained she was asking Father for 'more support' and he had refused, citing his caring responsibilities for Sibling. Mother stated they were not getting on. Mother was asked about domestic abuse and she denied this. This information was not shared with other professionals, including the PA. The PA spoke to the health visitor and shared her concern that Mother told her that there were constant arguments between the parents about Child W and Sibling. Father had undertaken limited visits to see Child W in the neonatal unit, and the PA was concerned that he wasn't supporting his partner. Both parents were invited to 'room in' in the days prior to Child W's discharge but Father did not do so.

Key episode 3: (Discharge and time at home)

5.12 The health visitor visited on six occasions following Child W's discharge. They discussed a possible referral to the Children's Centre key worker service. Father agreed but Mother wanted time to consider the idea before she decided.

5.13 Child W did not put on weight as expected, and the health visitor was concerned that the parents had misinterpreted the instructions for demand feeding that were provided by the GP, as they were only feeding Child W in the night if she woke up. Following seeking supervision on the matter the next day, it was agreed the health visitor needed to urgently give the parents an explicit written feeding plan (after checking they can read) which gave instructions for the night feeds. She did this.

5.14 Mother saw doctors at her new[10] GP surgery a number of times following Child W's discharge from hospital. During her 6-week check she stated that she was struggling at times, that she lacked patience, and said that she sometimes says she 'hates the baby' out of frustration. She had no thoughts of harming Child W. She said her partner was always around and supportive. The GP advised Mother to speak to the health visitor about providing support and if she felt she was struggling she should return to the GP. Child W was also seen for a postnatal check, and the examination was normal.

[10] Mother changed GP surgery shortly after Child W's birth. At the time prior to and at the 6-week check her records were not available to the new GP.

5.15 The health visitor was contacted by the GP the same day and shared the information. The health visitor told the GP that Father and Mother had been in foster care and that Mother had a poor relationship with her own mother. She reported that Mother was also having some difficulties with her relationship with her stepson and found his behaviour difficult to manage. A different GP saw Mother a week later. She was diagnosed with postnatal depression and prescribed anti-depressants, telling the GP that her partner thought she required them. It later emerged that Mother did not take the medication.

5.16 In the week before Child W died Mother contacted ThroughCare a number of times. Firstly, to cancel an appointment stating that Child W had been rushed to hospital with breathing difficulties, subsequently reporting that Child W was 'fine'. There is no evidence from the hospital that this was the case. Two days later she again contacted ThroughCare in a distressed state to report difficulties in her relationship and arguing over parenting. She was only willing to talk to her PA but did not respond to a return call.

5.17 Three days before Child W died there had been a small weight gain and the health visitor had no concerns about how the baby presented and how she was handled by Father, who appeared to be undertaking most of the care. He stated he was doing two feeds each night.

<u>**Key episode 4:**</u> **(**Response to Child W's death)

5.18 Child W was taken to hospital in the middle of the night by the ambulance service, and efforts to resuscitate her were unsuccessful.

5.19 Information Sharing and Planning meetings (under Child Death Review Guidelines) were held following Child W's death and the initial view was that while unexplained, Child W's death was not suspicious. This was because there were no visible injuries and because those involved were aware that Child W had been born prematurely and that she could have undiagnosed health issues relating to this. Sibling was discussed in the meeting in relation to his emotional needs following his sister's death, and the focus of professionals was on supporting the family.

5.20 A paediatric post-mortem was held a week later at the request of the Coroner, and a brain haemorrhage was evident[11]. This information was shared with partners immediately and an urgent strategy meeting took place the same day. It was shared that Child W had most likely suffered 'a life ending injury that was non-accidental in nature.'[12] Safeguarding procedures were immediately considered, including the need for Sibling to be protected. The decision was made to remove him from his father's care the following morning as it was late in the day and he was due to start school the next day. After seeking consent from a senior manager, it was agreed that the risk overnight should be accepted, as this was in Sibling's best interests.

6 Analysis by theme and learning

6.1 From the information gained from the agency reports and from the discussions at the learning events, several key themes have emerged. The following are judged to be most significant and enable us to identify learning for the ESSCP and its partner agencies:

Themes
Parental vulnerabilities

[11] A subsequent Home Office post-mortem took place the following week and confirmed the non-accidental nature of the brain injury.
[12] Subsequent microbiology identified non accidental fractures to the ribs.

Information sharing and communication
Professional challenge and the need to understand roles and responsibilities

6.2 Each theme identifies learning, and each learning point is linked to a recommendation in either this report or within the agency reports. It will be stated if the learning is being addressed elsewhere.

Theme: Parental vulnerabilities

6.3 Both parents had vulnerabilities which could have an impact on their parenting and potentially pose a risk to the children if appropriate support was not offered or accepted. The vulnerabilities include both parent's poor experience of being parented, abuse and neglect during their childhoods, time spent in care, mental health issues, some educational special needs[13], Father's poor physical health and the pain associated with it, Father's cannabis use, Mother's young age, and the fact that the relationship between the parents was new when Mother became pregnant. Add to this the stress that Mother reported in regards to her management of Sibling's behaviour, the lack of meaningful support from wider family, the premature birth of Child W by caesarean[14] and the time spent in the NNU, and Mother's report of relationship difficulties and a domestic abuse incident. There were potentially significant risk factors for Child W and Sibling.

6.4 The 2011 thematic report on learning from SCRs, Ages of Concern[15], focused on babies due to the high proportion of SCRs that are completed on children under one. The report identified recurring messages from the reviews and found that the 'risks resulting from the parents own needs were often underestimated, particularly given the vulnerability of babies'. The report also found that there was a need for improved assessment of and support for parenting capacity, and that there were shortcomings in the timeliness and quality of pre-birth assessments.

6.5 In this case Father was seen as a competent and experienced parent, as he had cared for Sibling since early childhood and there were no known on-going concerns. Mother was believed to be engaging with support from her PA and the midwife then the health visitor. These were believed to be protective factors and led the MASH to decide that the threshold for a pre-birth social work assessment was not met, despite the SPoA team manager, the midwife and the PA believing that an assessment was required due to the known pre-disposing vulnerabilities. The health visitor spoke regularly to staff when Child W was in hospital and was aware that there were some low-level concerns about how Mother was coping. The PA and the health visitor communicated with each other and recognised that Mother would require support after the baby came home, and they acknowledged that they were concerned about how she would manage.

6.6 The ThroughCare team had accepted the MASH workers view that the threshold for a pre-birth CSC assessment had not been met, and as they did not identify any new significant information or event, they did not re-refer to the SPoA. Child W's premature birth, low birth weight, and concerns shared by Mother about the parent's relationship, were not thought to be enough to meet the threshold for a social work assessment so no re-referral was made. Even when Mother stated that she no longer wished to engage with her PA and the ThroughCare team, those involved did not think the case would meet the threshold for

[13] Mother had learning support in school. This was not known to those working with the family at the time.
[14] Having a caesarean birth can impact on a new mother's physical and emotional health.
[15] Ofsted 2011

social work assessment. It is acknowledged that the Continuum of Need document does not fit well with pre-birth concerns. The document and the process can lead to the possibility that the decision is made on whether Sibling would meet the threshold, whereas there may be a need for a different threshold to be applied for an assessment of an unborn baby in the same household. The Continuum of Need document does state that professional discretion can always be applied when making a decision on whether an assessment is required.

6.7 There was good knowledge of Mother's history. In regard to Father and Sibling, less information was available to professionals in East Sussex. It was known that both parents had spent time in care as children, as Father had disclosed this. Health information on Sibling shared from Kent also confirmed it, along with Sibling's time on a Child Protection Plan. While it is important not to discriminate against care leavers, it is also important to ensure that their history is acknowledged and that they are given support to enable them to parent well when they have children of their own. Teenage pregnancy is found more often in children and young people with a care history. They are around three times more likely to become mothers before the age of 18 than their peers who have not experienced state care[16]. Mother would have met the criteria for, and benefited from, teenage pregnancy support from specialist midwives and health visitors, but this care model was not available in the area where she lived at the time. The review has been told that a Continuity of Carer service is now available which means that those aged 20 and under are now cared for by the same team of eight midwives throughout all three stages of pregnancy and birth, which is positive.

6.8 Care leaver's children are also over-represented in child protection cases and in care proceedings. In this case it appears that both parents were fearful of having social work involvement in the lives of their children, due to their own experiences. This could have made then less likely to be honest about the need for support, and less likely to acknowledge difficulties. Father would not give permission for information from Kent CSC to be shared with East Sussex CSC, and Mother stated that she did not want a pre-birth assessment and was reluctant to accept early help support. It is understood that 'care leavers bring the legacy of their own care histories to their relationships with services' and it can be a challenge for those involved to build the relationship and trust required to provide meaningful support. However, it is important to be honest with parents in these situations about the likelihood that their care history will impact on their parenting, and that they are likely to require on-going involvement with support services.

6.9 Those involved believed that Father had been assessed in Kent following concerns for Sibling, and that the outcome was positive as he had Sibling in his care. Without any detailed information being shared by Kent due to the lack of permission from Father, it is not possible to know what the concerns were, what the assessment entailed, and what the result was. As most of the concerns were thought to be about Sibling's mother, it is possible that there was not an in-depth assessment of Father at the time, or even no meaningful assessment at all. It is important not to make assumptions about the quality of a previous assessment or its conclusions. Information from Kent was not pursued following Mother's pregnancy and it was believed that Father was a protective factor. The local school where sibling attended the nursery class had no concerns. They were unaware of the history of him being on a child protection plan in Kent however, and they were not approached for any checks until after Child W's death.

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[16] Haydon, D. (2003) Teenage pregnancy and care leavers; Resource for teenage pregnancy coordinators. Barnardo's.

6.10 Pathways to Harm, Pathways to Protection; a Triennial Review of SCRs 2011–14 was published in 2016[17] (to be referred to as the Triennial Review) and states that the SCRs considered show that there are factors in a parents' background which potentially may present a risk to a child. These include:

- Domestic abuse
- Parental mental health problems
- Drug and alcohol misuse
- Adverse childhood experiences
- A history of criminality, particularly violent crime
- Patterns of multiple, consecutive partners
- Acrimonious separation

The Triennial Review points out that these factors 'appear to interact with each other, creating cumulative levels of risk the more factors are present'.

6.11 Other factors are included in the Triennial Review as significant and include; young motherhood; estrangement from the new mother's own parents; temporary housing or supported accommodation; lack of support from the baby's father and/or a new or unstable relationship with the father.' The average age of first-time mothers whose children were the subject of a SCR was age 19 (the same age as Mother in this case), compared to the national average of age 28 for first time mothers. This and a number of the other factors were present in Child W's case and required consideration.

6.12 Mother told the review that she was very concerned about having social work involvement with her child, due to her fear that the child would be removed. She also stated that her partner had told her that she would be 'set up to fail'. The learning that she identified from her case was that professionals need to give new parents who are vulnerable information about what positive support is available to them and give encouragement and reassurance about the need to accept support. She also feels that professionals too readily accepted that Child W's father would care for the child and wishes they had encouraged her to take on more of the care and challenged him for 'taking over'.

6.13 Child W was particularly vulnerable due to her prematurity and her low birth weight. Mother had had a caesarean section, and the time she spent in the NNU was stressful for her and for Father. They had Sibling to care for and the journey from home to hospital was not straightforward. Research shows that for babies born prematurely 'to have the best possible chance of survival and good long-term health, it is vital that parents are there to support their recovery', and that 'to allow parents to be the centre of their baby's care, hospitals need to provide a range of facilities and support to keep parents with their babies; including support to manage costs and to stay close to the neonatal unit'.[18] The ThroughCare Team paid for taxis for a week then a bus pass for Mother to visit the baby in hospital, but the review was told that it was not an easy journey by public transport and that Mother was clearly stressed much of the time. It has been recognised that consideration could have been given to the best way of supporting both parents to spend time with Child W and meet Sibling's needs at this time, particularly bearing in mind Mother's age and vulnerability.

6.14 There is a known impact on bonding between parent and child and on parental mental health when a new baby requires a lengthy hospital stay following their birth. Parents with a premature baby are 50% more likely to experience psychological distress compared with parents who do not spend time on a special care baby unit. A survey completed by Bliss (an organisation for the parents of babies born sick or prematurely) in 2018 showed that most

[17] P. Sidebotham and M. Brandon et al. (2016)
[18] Families kept apart: barriers to parents' involvement in their baby's hospital care. BLISS 2016

parents felt their mental health got worse after being on the neonatal unit. Both parents in this case attended their GPs with symptoms of depression, Father during Mother's pregnancy and Mother the week before Child W died. Mother told the GP that Father was concerned she was depressed and had told her to seek help. She stated that she believed she was too young to have a baby and that it was the hardest thing she has ever done. She was diagnosed with post-natal depression and prescribed anti-depressants. Father also saw his GP and requested antidepressants after the death of Child W but before Sibling was removed from his care.

Learning:

- The predisposing risks and vulnerabilities need to be considered when deciding if a pre-birth assessment is required. This requires information seeking and sharing, awareness of the parent's histories, and the use of professional discretion alongside the Continuum of Need.
- Children in care are likely to require support when they become parents. This should be a right and a positive part of corporate parenting for all children in care and care leavers. It is acknowledged that this will require a cultural shift from the current deficit led model, and that all children in care should be made aware of this positive support from a young age.
- There should be a consideration of what additional support a family may require following an early birth and when a baby is in a NNU. This should include consideration of the family's financial situation, the wider family support available, and any other challenges for visiting and spending time with the baby.

Theme: Information sharing and communication

6.15 Varying amounts of information about Father and Sibling were known by those involved in East Sussex. Sibling's GP and health visitor had information transferred from Kent, but CSC were told they needed the consent of Father for information about Sibling to be shared when he moved to East Sussex and came to the attention of CSC. Father refused to give his permission. However as the concerns in Kent were of a child protection nature and Sibling had been on a child protection plan while in the care of Father and his ex-partner, it is arguable that this headline information, at the very least, should have been shared with East Sussex CSC. The decision made by Kent CSC was not challenged by East Sussex CSC at the time. A conversation between the two services to explore the issue may have led to the appropriate information being shared.

6.16 Kent CSC have fully cooperated with this SCR and have reflected on the decision to not provide information to East Sussex CSC when it was requested. They have shared that the written request for information received by Kent CSC did not specify whether East Sussex CSC had child protection concerns and needed the information for a strategy meeting. There is no evidence that this was clarified. They believe that if there were no safeguarding concerns Kent CSC may have been justified in not sharing information without parental consent. The rationale for this is not clearly recorded within Kent's children's system however, other than that Father, as the primary carer, did not give his consent. They did not appear to consider if the new area should be aware of the significant safeguarding history if they were to be involved with Father and Sibling. They now recognise the need to share such significant information. East Sussex CSC were considering if they needed to be involved, and the historic information would have assisted in this decision making, although even the full sharing of information was unlikely to have led to any further action being taken at the time.

6.17 When a family moves some information automatically follows them, but not any information held by the local authority if there is no child protection plan in place at the time. As health information tends to be available in the new area, specifically GP records which consistently

follow a person, this is a significant resource for those who are considering if there are any historic safeguarding concerns, although consent should be sought in most cases and it is possible that consent would not be have been given in this case. When the MASH was considering whether a pre-birth assessment was required, there does not appear to have been consideration of checking the case history again with Kent or with the family's GP.

6.18 There was an underlying view that Father must be a reasonable parent because he had the care of Sibling following the involvement of CSC in Kent. Father stated he had a Child Arrangement Order for Sibling, but this was not checked. Despite being the experienced parent, Father was rarely involved in conversations about his expected child. It was Mother who was spoken to by the MASH, not Father. She stated her view that an assessment was not required, but Father's view was not sought. The PA had not met Father and had no idea what he thought about the pregnancy, or whether he thought they required any support, other than what was reported by Mother. Father was rarely seen when Child W was in hospital, and the staff in the baby unit were unable to comment on his competence as a parent or the development of his relationship with Child W.

6.19 Information sharing within community midwifery was challenging as Mother had four different midwives caring for her over the course of her pregnancy. This is not unusual, most women are seen by a number of midwives throughout their pregnancy. There was a reliance on the electronic maternity system for information sharing, and an assumption that subsequent midwives will be able to see if there were any previous concerns and that they will read the electronic records. The Concerns and Vulnerabilities Form completed by the first midwife was available on Mother's record but was not seen by the third and fourth midwives involved. There was a gap in the information sharing system as the second midwife had extended sick leave. The Deputy Named Midwife for Safeguarding Children who received the Concerns and Vulnerabilities Form made efforts to discuss Mother with the Midwives who became involved later, but due to capacity issues she was not successful. There is no evidence that any of the concerns identified in this document were known to the community midwives working with Mother in the later stages of her pregnancy and when she went into early labour, this included the parent's care history, Mother's previous mental health issues, and the involvement of Kent CSC with Sibling. This learning has been addressed in the agency report and action plan for midwifery services.

6.20 There was no discharge planning meeting from the hospital.. These meetings are held in cases where there are on-going complex needs, concerns or a Child Protection Plan/Child in Need plan is in place for the baby. None of these were applicable in this case. Even without CSC involvement with the baby, a meeting that involved the health visitor, the PA and the parents would have been helpful to ensure that coordinated and on-going support was in place. It would have given an opportunity for the PA to share more of the history and to give a fuller picture of Mother's functioning, and for the NNU staff to share their concerns and observations. A plan could then have been put in place to support the family and provide appropriate services. A discharge summary was sent to the GP and the health visitor for Child W, but it was purely medical and included no information in the section entitled 'social issues'.

6.21 Following Child W's discharge, the health visitor recorded that Father increasingly took on much of the childcare. She noted that he handled Child W lovingly and confidently, while Mother appeared to lack confidence on occasion. The health visitor had been made aware by the midwifery service that Mother had previously struggled to manage sibling's behaviour, and that Mother felt that Father undermined her in regard to this. Father had also asked for help in managing Sibling's behaviour. These issues were not discussed with the

parents prior to Child W's birth, as planned, because she was born early. When there were health visitor visits post-birth it appears the focus was on Child W and the many things that need to be done during these initial home visits, including the need to address Child W's slow weight gain. Mother's statements to a number of professionals about the arguments between the couple, her concerns about managing Sibling and lack of support from Father, and her voiced worries about being a parent suggested that Mother required support. While this was acknowledged by the GP, health visitor and PA, there was no plan of how to provide this in a timely way.

6.22 The health visitor liaised with the GP regarding Mother's mental health and ensured that she was assessed promptly. Sibling was due to start school around Child W's delivery date. He would then have been registered under the School Health Service which is managed by Kent Community Healthcare Foundation Trust. Sibling actually started school the day after the decisions was made for him to be removed from his Father's care following the death of Child W. There was no liaison with the School Health Service.

6.23 Following Child W's death, the investigation into why Child W died was impacted on by communication and cross border issues. There was some delay in identifying evidence of probable non-accidental injuries due to initial investigations not including a CT scan and skeletal survey. National guidance recommends that post mortem imaging of the whole body should be carried out in all cases of sudden unexpected death in infancy (SUDI). This will routinely be undertaken at the post mortem examination. However if there are any concerns about the circumstances of the death, and/or there are young in the household, then consideration should be given to undertaking these investigations at point of presentation, or as soon as possible afterwards. The timing of the CT and skeletal survey should be discussed by the paediatrician and Coroner/Coroner's Officer, as coronial agreement is required for post mortem imaging. In this case the post mortem, which was requested by the Coroner with jurisdiction for the area in which the death was confirmed, was not held for around a week. The CT scan undertaken as part of this post-mortem examination identified brain haemorrhages of different ages. The Home Office pathologist then undertook further investigations and saw rib fractures under the microscope which were not apparent to the naked eye. The Coroner had stated that the police should not be in attendance at the post-mortem, but the investigating officer was persistent and was allowed to attend.

Learning:

- Information should be sought from other Local Authority areas if a family have moved and it is believed that they hold historic safeguarding information. If consent is not given, or information is not shared, this should be challenged.
- Partner agencies should be asked to check what historic safeguarding information they hold on family members, and there should be proactive on-going information sharing when any concerns emerge.
- When a baby who has had a longer than usual hospital stay and their sibling/s or parent/s has professionals involved with them (particularly if the parent is a care leaver) consideration should be given to having a discharge planning meeting from the hospital to ensure that information is shared (both health and social) and to consider any additional support that may be required when the baby goes home. A record should be made of the meeting, including the plan going forwards, and this should be shared on discharge with all agencies involved with the family.

- Processes and guidelines should be revised so that Kennedy samples,[19] and a CT scan, alongside a skeletal survey, are carried out for all unexpected infant deaths. The timing of the process also needs to take into consideration if there are surviving siblings who may need protecting.

Theme: Professional challenge and the need to understand roles and responsibilities

6.24 There was a need for challenge, both between professionals and of the family by professionals in this case. Examples where there is the potential for learning are:

- Kent and East Sussex CSC should have asked for more information from each other when the decision was made by Kent CSC not to provide East Sussex CSC with details of Sibling's time on a child protection plan in Kent, including details of the assessments that had been undertaken in respect of Father's parenting.
- Assumptions were made and Father's word was taken regarding the content and conclusions of assessments undertaken in Kent.
- Mother could have been challenged about whether Father knew about her engagement with the ThroughCare team, and the need for him to be aware so that Mother could be supported in her parenting of both children.
- There could have been challenge of the MASH by the midwifery service and the ThroughCare team when they said the threshold for a pre-birth assessment was not met, particularly in light of the recommendation by the SPoA manager that an assessment was required.
- There could have been more extensive questioning and challenge of Mother when she said she was 'fine' when she was spoken to by the MASH, and Father should have been spoken to as the other parent of the unborn child.
- Mother cancelled one of the health visitor's planned visits saying that Child W had a GP appointment. The health visitor consulted with the GP surgery and found this was not the case. There is no evidence that the health visitor challenged Mother about this.
- Mother cancelled an appointment with her PA shortly before Child W's death. She stated that Child W had been rushed to hospital with breathing difficulties. She subsequently reported that Child W was 'fine'. There is no evidence that further information was sought or shared regarding this alleged incident, or that Mother was challenged about this claim.
- Although abuse or neglect were not suspected initially following the death of Child W, this was considered as one of a number of potential causes of death (as a 'differential diagnosis') at the initial strategy meeting. Until the cause of death was established there was no evidence to justify a safeguarding response for sibling. It is therefore essential that the coroner ensures that a post-mortem occurs as quickly as possible when there are siblings to be considered.

6.25 Professional curiosity and challenge are fundamental when working together with other professionals and with families to keep children safe. The need for 'respectful uncertainty' is widely known, but not easy to achieve. Getting the balance right between support and challenge when working with parents can be difficult, it is a complex balance which requires skilled practitioners, reflective practice, effective supervision and professional challenge within and between agencies. The NSPCC published a summary of learning from SCRs about

[19] Named after Baroness Helena Kennedy, who chaired the working group and wrote the multi-agency guidelines for the care and investigation of sudden unexpected deaths in infancy and childhood in 2016. https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html

disguised compliance in 2014. Disguised compliance involves parents giving the appearance of co-operating with agencies to avoid raising suspicions and to allay concerns, which can be an effective way of ensuring that professionals delay or avoid interventions. It is therefore important that professionals triangulate what parents are saying by establishing the facts, gathering evidence about what is actually happening, and communicating well with all involved. While there were examples of good information sharing in this case, there were also areas where this could be improved and where both parent's reports and histories could have been checked with other professionals.

6.26 There is a perceived power imbalance between professionals that impacts on professional challenge. Those involved in this review and other published SCRs are noted to accept that when a MASH worker says that the threshold for involvement is not met, it can be difficult to challenge this, and can discourage future referrals. As stated in the CSC agency report, 'Mother's self-report that everything was fine persuaded MASH to close the referral; this had the twin effect of stopping the immediate assessment but also seems to have impacted on professional confidence to re-refer.' Even when the PA and the health visitor remained concerned and identified other issues, they did not believe they would meet the threshold for re-referral to the SPoA.

6.27 As discussed above, there was not always clarity about the roles of those involved. This was particularly the case in relation to the PA, as Mother's worker who had the specific task of supporting Mother as a care leaver and former 'relevant child'[20] with things like housing, benefits, job seeking and so on. It appears to have been expected that the PA would be able to monitor care of the baby. While the fact that Mother was at least partly engaging with her PA was helpful, the detail of the support that was actually accepted by Mother from the ThroughCare team was not considered by the MASH when they decided that a pre-birth assessment in respect of the unborn child was not required. Mother largely engaged with the PA on her terms, and often avoided face to face contact. It was also the case that the PA had not visited Mother in her new home or met Father or Sibling. The role of the PA is to support the care leaver, not to provide support and monitoring in respect of the baby, although within her mandate the PA spoke to the health visitor and recognised there was a need for Mother to be supported in her parenting.

6.28 The SPoA team manager shared with the review her belief that questions should be asked about the level of a professional's involvement and that assumptions should not be made. The questions should include the level of contact, where they are seeing people, whether they undertake home visits, and what happens if their service is declined. The CSC agency report identified learning in regard to this issue in this case and has recommended that 'ESCC CSC should ensure a proper assessment of any additional needs that Care Leavers may have when becoming parents. This assessment should recognise the different roles that professionals have in relation to the family / unborn.' In light of Mother's limited engagement with her PA and her reluctance to inform her partner of the relationship with the ThroughCare team, it was unrealistic and inappropriate to expect the PA to monitor the care of Child W and support the family with their childcare.

Learning:

- Decisions are made with the information available at the time. These decisions may need to change as more information emerges, and when risks and needs change. Professionals are required to review the need to assess or refer a child during their involvement with the family, and to challenge decisions as required.

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[20] The Children Act 1989 places duties on Local Authorities towards 'looked after' and previously 'looked after' children as they exit the care system.

- It is the responsibility of all professionals to communicate their roles and responsibilities and to ask others what their remit is and to understand the limitations of other's roles.

7 Conclusion and recommendations

7.1 Child W was eight-weeks old when she died while in the care of her parents. She had been born prematurely and was just reaching the date that she was due when she died. Both parents have been convicted in respect of her death. This review has identified learning, as outlined above.

7.2 Good practice has been identified in this case both in the agency reports and during discussions with the professionals involved in the case. They have been outlined above but include:

- The health visitor sought supervision with her concerns and there was a timely response by locality managers.
- Communication between the health visitor and GP, including the GP speaking to the health visitor following concerns identified during the 6-week check.
- The community midwife identified the need to refer the family to CSC.
- The recommendation for a pre-birth assessment by SPOA.
- The support provided by the ThroughCare team to Mother.
- Child W was looked after by a consistent team of nurses in hospital.
- Challenge by the police regarding the post-mortem and persistence in ensuring the right examinations occurred.

7.3 There has been a high degree of cooperation and engagement from all agencies with the SCR process, which has been important in identifying the learning.

7.4 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning, and that changes have been made which will be outlined in the ESSCP's response to this SCR. This includes an unrelated piece of work being undertaken to consider how partner agencies perceive the function of SPoA and the MASH and make use of them. This should be helpful with some of the issues identified in this case.

7.5 The agency reports have made recommendations which have largely been completed by the conclusion of the SCR. Some of the learning identified within this report will have been addressed by the single agency actions plans. For example, in regard to health visitors needing to challenge decisions about discharge planning meetings, and the trust with responsibility for community midwife services is developing a more robust information sharing policy between GPs, health visitors and midwifes.

7.6 Across Sussex a number of children have been the subject of serious case reviews where there is evidence of head trauma. This review has therefore made a recommendation regarding the need for a promotional campaign around safe handling of infants.

7.7 The purpose of providing additional recommendations is to ensure that the ESSCP and its partner agencies are confident that any areas identified as being of particular concern, and not included in the single agency plan, or which require an interagency or ESSCP action, are addressed.

Recommendation 1:

The learning from this review should be disseminated widely, and consideration to be given to how this can happen prior to the conclusion of the criminal investigation. Particularly the expectations regarding:

- Support for care leavers when they become parents
- Support for parents of babies born prematurely and needing to spend time in hospital
- Pre-birth assessment
- Proactive information seeking and sharing
- The investigations required following an unexpected infant death
- Confidence to challenge families and other professionals
- The need to explore and understand the role and remit of other professionals working with a family.

Recommendation 2:

This report must be shared with the Kent Safeguarding Children Board. They should then provide information to the ESSCP on any actions they intend to take in regard to the learning from this review.

Recommendation 3:

The ESSCP to raise with the Department of Health and the Home Office the need to review national guidelines so that a CT scan is carried out immediately (at point of transfer/admission) alongside full skeletal surveys on infants and young children who have died from unexpected or unexplained causes, and where there are siblings who may need to be safeguarded, as this is potentially a national issue.

Recommendation 4:

The ESSCP and its partner agencies, along with the West Sussex and Brighton and Hove SCPs, should explore how they can use multi-agency programmes such as ICON[21] to promote the safe handling of babies.

Question for the ESSCP:

How can the ESSCP and its partner agencies promote cultural change and provide practical support to looked after children and care leavers when they become parents and be positive 'corporate grandparents'?

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[21] https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=2ahUKEwio1oS0zdrjAhWUShUIHUJGC3cQFjADegQIBxAC&url=https%3A%2F%2Fwww.swft.nhs.uk%2Fdownload_file%2F621%2F185&usg=AOvVaw3bVOE3eVZMwZIMMQyp9hF0