Serious Case Review Overview Report

In respect of: Child L

Produced by Professor Pat Cantrill

May 2013

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SECTION ONE – INTRODUCTION AND BACKGROUND

1.0 Introduction

This Serious Case Review looks at the circumstances surrounding the sudden unexpected death on 8th October 2012 of Child L aged 5 weeks 6 days. Child L was pronounced dead shortly after arrival at Hull Royal Infirmary. The initial post mortem found the cause of death to be a severe skull fracture with no known explanation. Child L's death was considered by the Police to be suspicious. Adult N (Child L's mother) was arrested on suspicion of causing the death of Child L. On 11th November 2013, at the commencement of her trial for murder, Adult N admitted to, and the court accepted, a lesser charge of infanticide due to post natal depression. Adult N received a Community Order with a supervision requirement for three years.

1.1 Reasons for Conducting the Review

Chapter 8 Regulation 5 of 'Working Together to Safeguard Children' 2010[1] and Regulation 5 of 'The Local Safeguarding Children Boards Regulations 2006' requires that a Local Safeguarding Children Board considers undertaking a Serious Case Review in cases where there has been a death or serious impairment to the health and development of a child and abuse or neglect is known or suspected. The circumstances surrounding the death of Child L were considered consistent with these criteria and a Serious Case Review was commissioned.

The purpose of this Serious Case Review is to establish the role of services and their effectiveness in the care of Child L, whether information was fully shared by the professionals involved and that procedures were appropriately followed, so that any deficiencies in services can be identified and lessons learned to minimise the risk for another child. This should also reassure the public and prevent the need or demand for further external inquiries.

1.2 Scope and process of the review and terms of reference

A Serious Case Review was recommended by the Hull Serious Case Review Sub-Committee; which is a sub group of the Hull Safeguarding Children Board (HSCB) on 23rd November 2012. A Serious Case Review (SCR) was commissioned by the Independent Chair of the Hull Safeguarding Children Board on 23rd November 2012, in line with the requirements and expectations of Working Together 2010[2].

A specific Serious Case Review Panel met on 22nd January 2013 to consider the circumstances surrounding the sudden unexpected death of Child L. Child L was known to universal services only.

[1] Working together to safeguard children - a guide to interagency working to safeguard and promote the welfare of children, DCSF 2010

[2] The process was initiated and completed in accordance with the statutory guidance (Working together to safeguard children, 2010) which was in place at the time of the commencement of the SCR rather than that identified in the new guidance Working together to safeguard children, 2013.

In line with 8.26 Chapter 8 of 'Working Together to Safeguard Children' 2010 the Chair of the LSCB sought advice from police and partner agencies about progressing the SCR during criminal investigations and determined that this should not delay the review.

Parallel investigations:

Criminal/Civil

Humberside Police kept the HSCB informed of the ongoing criminal investigation and provided regular updates through the HSCB SCR sub-committee.

Conduct/Professional Practice

It was agreed that should any conduct/professional practice issues arise, in respect of an individual member of staff during this review, they would immediately be dealt with in accordance with agency procedures and the outcome relayed to the HSCB.

Any other professional practice issue that may arise must be dealt with immediately and the HSCB informed of any immediate training issue or change needed to processes/procedures.

1.3 Subjects

The subjects of the review were identified by the Serious Case Review Panel on 23rd November 2012 as Child L and Family M.

1.4 Time Period

The time period under review is from 15th February 2012 which is the date that Adult N 'booked in' with midwifery services, to 8th October 2012, the date that Child L died. The time period applies to each of the family members within Family M as specified within the terms of reference detailed by the HSCB.

1.5 Terms of Reference

It was agreed that the review should cover the above time period. Under Chapter 8 of Working Together 2010 the purpose of this review is to:

1. establish what lessons are to 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;
2. 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;
3. improve intra- and inter-agency working and better safeguard and promote the welfare of children.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

Each agency is asked to:

1. Examine whether or not Child L's death could have been anticipated or prevented.

2. Construct a comprehensive chronology of involvement with the named family members.

3. Examine the agency's involvement with the individual members of the family particularly in respect of any:

   3.1. concern for Child L's welfare which arose from services provided to the family ante and post-natally;

   3.2. identified causes of stress in family life which might have affected the care provided to Child L;

   3.3. referral or request for service (including self-referral).

   By analysing in detail any concerns that arose in respect of Child L, her mother or father, or other people living in the family home at the time, and, in particular;

   3.3.1. how the concern was dealt with;

   3.3.2. the quality of assessment and decision making and how that was recorded;

   3.3.3. the quality and relevance of any service provided;

   3.3.4. the quality of the agency's child protection procedures and whether or not they were followed;

   3.3.5. how Child L's needs and welfare were considered;

   3.3.6. how information was shared between agencies.

4. Examine specifically what was known about mother (Adult N) and if there was any evidence to suggest that she might pose a risk to Child L.

5. Examine considerations around ethnicity, religion, diversity or cultural issues that may require special attention.

6. Consider the impact of the social, cultural and economic environment in which the family were living and in which the professionals operated.

7. Consider the context in which local professionals work and the extent to which their actions are influenced by the organisations and systems in which they are working.

8. Take account of any relevant lessons learned from research and from biennial overview reports of serious case reviews and describe how these lessons have been applied to the analysis of this case.

9. Examine whether or not there were opportunities for agency intervention that were missed.

10. Identify any recommendations for action:

10.1. within the agency;
10.2. in respect of local child protection guidelines and procedures;
10.3. of national significance.

1.6 Process

The specific Serious Case Review Panel requested that the following agencies/bodies secured their records and identified and commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review. Individual Management reviews were requested from the following agencies:

- Humberside Police
- Health:
  - City Healthcare Partnership
  - Hull and East Yorkshire Hospitals NHS Trust
  - NHS Hull Clinical Commissioning Group - Primary Care (GP)

  The Designated Nurse (NHS Hull CCG) also prepared a health overview report.
- Yorkshire Ambulance Service
- Hull City Council (incorporating Adult, Children and Family, Services, and Neighbourhoods and Housing Directorates)

Hull City Council Adult, Children and Family Services Directorate had no contact with Adult N and Child L, or any relevant involvement with any other member of Family M during the period under review and therefore did not produce an IMR. Senior representatives from the Council's Safeguarding and Learning and Localities service areas remained as members of the panel to provide any required information, to contribute to the review process and to ensure that the learning from the review could be captured for both agencies. An IMR was produced by the Hull City Council Neighbourhoods and Housing Directorate.

Additionally, all HSCB partners were asked whether any family members were known to them and the nature of their involvement, to consider whether IMRs were required from any other agency. Hull Youth Justice Service, Humberside Probation Trust, Children and Family Court Advisory Support Service (CAFCASS), Adult Mental Health, Adult Substance Misuse and Domestic Abuse Partnership confirmed that no family members were known to their service.

The author of the overview report, Professor Pat Cantrill, is a Registered Nurse and health visitor and was a senior civil servant at the Department of Health. Pat has led a number of high profile serious incident and domestic homicide reviews. Professor Cantrill attended panel meetings from 22nd January 2013 as the overview author to observe but was not a formal member of the panel.

Her appointment is in accordance with the guidance at 8.20 in 'Working Together to Safeguard Children' 2010 which states that: 'the overview author should be independent of the local agencies, professionals involved and the LSCB. And that the person should not be the chair of the LSCB or the SCR subcommittee / panel'.

1.7 Membership of the Serious Case Review Panel:

Independent Chair	
IMR Authors	
Named Nurse for Safeguarding Children	City Health Care Partnership (CHCP)
Named Nurse for Safeguarding Children	Hull and East Yorkshire Hospitals NHS Trust (HEYHT)
Head of Safeguarding	Yorkshire Ambulance Service NHS Trust (YAS)
Named GP	NHS Hull Clinical Commissioning Group
Designated Nurse - Health overview report	NHS Hull Clinical Commissioning Group
Practice Manager	Hull City Council - Neighbourhoods & Housing
Detective Inspector, Lead for Child Protection and FLC, Policy Unit	Humberside Police
Other Panel/SCR Sub-Committee members	
Lay member	Hull Safeguarding Children Board
Manager	Safeguarding Adults Partnership Board
City Learning & Skills Manager	Hull City Council Adult, Children & Family Services
Designated Nurse	NHS Hull Clinical Commissioning Group
City Children Safeguarding Manager	Hull City Council Adult, Children & Family Services
Chief Superintendent	Humberside Police
Project Manager, The Difference Engine	North Bank Forum for Voluntary Organisations
Designated Doctor	NHS Hull Clinical Commissioning Group
Assistant Head of Service	Hull City Council - Adult, Children & Family Services - Safeguarding Children directorate
Safeguarding Children Officer for schools	Hull City Council - Adult, Children & Family Services - Learning & Skills directorate
Hull Safeguarding Children Board advisors	
Manager	
Professional Practice Officer	
Child Death Review Co-ordinator (administration)	

The objective of the Individual Management Reviews (IMRs) that form the basis for the SCR, is to give as accurate an account as possible of the effectiveness of services provided to help and support Child L and her family, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective response to a similar situation in the future.

The authors of the Individual Management Reviews are independent in accordance with the guidance at 8.33 in Chapter 8 of 'Working Together to Safeguard Children' 2010. This states that:

"Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved".

The IMR authors and the overview author have provided a valid analysis and cross referenced information to complete gaps. Where possible, triangulation of sources of evidence has been used

to increase confidence in the findings. All of the agencies involved in this review have provided frank accounts of their involvement in order to establish if there are any lessons to be learned.

The report's conclusions represent the collective view of the Serious Case Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

In addition, a comprehensive integrated family chronology of agency involvement and significant events from the period 15th February 2012 to 8th October 2012 has been compiled and analysed by the Serious Case Review panel.

The Overview Report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned. An action plan has been developed and is being implemented. The implementation and impact will continue to be monitored by the HSCB SCR sub-committee.

1.8 Involvement of the family

'Working together to safeguard children 2010' recommends that Serious Case Review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'. In reporting the views of individuals who received services, the Review Panel is not endorsing those views as accurate or as a fair assessment of the services they were given. They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the service providers.

The report author and the HSCB Manager met with Adult N - (Mother), Adult P - (Father) and Adult R - (Maternal Grandmother) and the HSCB Manager with Adult P's mother and father (Paternal Grandmother and Grandfather). They were interviewed to discuss their views about the involvement and effectiveness of agencies and to enable them to contribute to the review. The content of the report has been discussed with them and their contribution approved.

1.9 Family composition and background

Subject: Child L

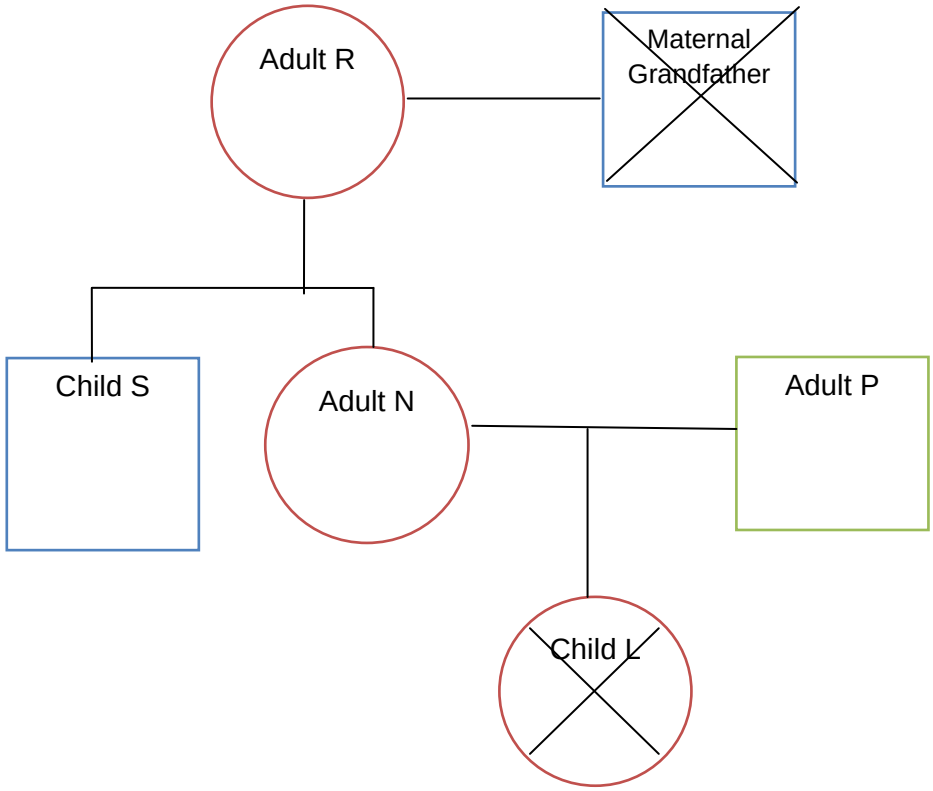
Family Members:

Adult N - (Mother)
Adult P - (Father)
Adult R - (Maternal Grandmother)
Child S - (Uncle - Mother's sibling)

Adult N's older sibling, Adult T, is identified by some agencies as being a member of the household.

The review has established however that Adult T, whilst registered at the address, did not live as a member of the household during the significant time period and has therefore not been included as part of the review.

1.10 Family Genogram



1.11 A Child's Journey

In her second interim report called '*The Child's Journey*', Professor Munro identifies the importance of analysis of the child's journey from needing to receive effective help for problems arising from family and social circumstances. In the case of Child L that journey was extremely brief as she was only six weeks old when she died.

Child L was born on the 28th August 2012 to Adult N aged 20 and her partner Adult P aged 25 years. Adult N lives with Adult P, Adult R (her mother) and Child S (her sibling). Adult N experienced an uneventful pregnancy. Adult N and Child L remained in hospital until discharged on 29th August 2012. There were no recorded clinical or other concerns. Child L had a full physical examination before discharge from hospital by a Paediatrician. It is recorded that there were no abnormalities and no risk factors warranting further investigation. Child L was seen by community midwives and by a health visitor and was progressing well.

On 8th October 2012, Yorkshire Ambulance Service (YAS) received a 999 emergency call from Adult P, about Child L. She was said to have stopped breathing.

Support was offered to Adult P by the Emergency Operations Centre (EOC) to initiate Basic Life Support until the ambulance arrived. When the Ambulance crew, a Paramedic and Ambulance Practitioner arrived Child L was in cardio-respiratory arrest and she was taken immediately to the Hull Royal Infirmary Emergency Department. Child L was pronounced dead ten minutes after arrival at hospital. Child L had a severe skull fracture and the Police and Children's Social Care were informed.

No family members accompanied Child L on the transfer to the hospital. It became apparent that Adult N had been brought to the same hospital in a different ambulance following what was stated to be a fall.

The Police arrested Adult N on suspicion of causing the death of Child L. On the 11th November 2013 Adult N admitted to the infanticide of Child L caused by hitting her head against a hard surface, causing fractures. She was given a three year Community Order with a Supervision Requirement.

SECTION TWO - ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS

The focus for this section of the report will be an analysis of the response of services involved with Child L and Adult N, why decisions were made and actions taken or not taken.

Service Involvement with Family M

Review and analysis of records for Family M ,who lived with Adult N and Child L, has established that there are no significant factors regarding services with Adult R or Child S that had any direct or indirect impact on the death of Child L and therefore reference to them is limited in the report.

The format of the analysis sections varies to reflect the requirements of each agency. In order to manage an account of agencies' involvement with Child L and Adult N the author has described separately the involvement of each agency.

Health Services

This part of the report contains analysis from the Health IMRs and the Health Overview report. At the end general cross service comments are addressed.

At the time the incident occurred, the structure of the NHS consisted of the Yorkshire and Humber Strategic Health Authority (SHA) and Hull Teaching Primary Care Trust, who had responsibilities for performance management and commissioning of the healthcare in the area. Since 1st April 2013 the NHS within the area has been transferred to the structures as detailed within the Health and Social Care Act (2012). The commissioning architecture now consists of NHS England with Regional and Local Area Teams and Clinical Commissioning Groups (CCGs). For the purpose of this report this now encompasses NHS England, North Yorkshire and Humber Area Team and NHS Hull Clinical Commissioning Group. At the time of the review, the health care that Adult N and Child L received was provided by City Health Care Partnership, and acute care and some community paediatric services by Hull and East Yorkshire Hospitals NHS Trust. In September 2013 there was a transfer of community paediatric services from Hull and East Yorkshire Hospitals NHS Trust to City Health Care Partnership

2.1 General Practice

General Practice is the main point of contact for all primary healthcare services. It is expected that General Practitioners will have a holistic overview of their patients and their needs. However, General Practice has changed significantly in the last decade. The traditional practice where one or two practitioners know all their patients, and their extended families, is disappearing. Moves towards larger practices with part-time and/or salaried clinicians, a range of service providers (e.g. GP Out of Hours Services, Walk-in Centres, and GP-led Health Centres) has tended to fragment this knowledge base and continuity of care. It is therefore critical that communication and record-keeping is robust and meticulous.

This IMR considers the involvement of the GP Practices and their staff in relation to Child L and Adult N. Adult N and Child L were registered with one general practice. Adult P was registered with

a different practice during the period of this review. A detailed examination of his records has taken place. There were no significant issues identified from Adult P's records.

Service Involvement with Child L and Adult N

There were four episodes of contact during this period which included**:**

- In February 2012 Adult N received care from the Out of Hours GP Services. At the time she was 13-14 weeks pregnant and was admitted to the local maternity hospital. This episode did not raise any child protection issues surrounding Adult N's unborn child.

- In September 2012, when Child L was four weeks old, Adult N saw the GP accompanied by Adult R. Adult N was complaining of feeling low and tearful, not able to cope. The entry in the record states that she was "*happy with baby, lives with mum and gets good support, poor appetite, no other triggers, happy with boyfriend, goes out with baby whenever he is free, denied any crisis, also feeling exhausted ...*". The GP noted that Adult N has "good rapport but tearful, normal speech, Insightful." Adult N was given a prescription for an antidepressant. The GP also recommended a blood test which identified that Adult N had anaemia and medication was given. This was the only occasion when information about Adult P was referred to in any consultations with Adult N or Child L. There is nothing in the GP records related to concerns that would or should have triggered the initiation of child protection procedures.

- On 2nd October 2012, Child L was seen by the nurse at the GP surgery for oral thrush which was said to have been identified by the health visitor the previous day (this was in fact by the nursery nurse who saw Child L at the clinic). Adult N informed the nurse that she had been advised to "get treatment." It was also documented that Child L was feeding well and gaining weight, but was having difficulties defecating. Examination of Child L by the nurse identified that, except for oral thrush which the nurse treated with the appropriate medication, there were no other problems.

- The GP was notified of Child L's death on 8th October 2012 by the HEYHT Safeguarding Children Team. The practice was also notified that Adult N presented to A&E twice on 8th October 2012, once at 08.52 hours and then again at 19.10 hours. The information provided about Adult N was limited.

Analysis of Involvement

Child L and Adult N

Firstly, the conclusion based on the information held in the electronic GP record system (SystmOne), is that Child L's death could not have been anticipated or prevented, but there were factors present that pointed to there being potential safeguarding issues associated with Child L but no child protection issues.

Section 2 of the GMC's 'Protecting children and young people: The responsibilities of all doctors'[3] identifies the importance of Doctors considering whether a patient poses a risk to children.

[3] Protecting children and young people: The responsibilities of all doctors. General Medical Council. September 2012.

When Adult N attended the GP practice in September 2012 she identified she felt stressed, struggling to cope with her new baby (Child L) and at the time was diagnosed with depression.
The GP did explore the relationship between mother and baby as well as what kind of support the mother was getting from relatives. The GP identified that Adult N's mood was low, that she felt she could not cope and prescribed appropriate medication. Adult N reported good support from her own mother and was asked about the input from Adult P. Whilst overall, there were no factors indicating that the child was at increased risk of violence or other forms of child abuse or neglect there were safeguarding issues associated with low mood, having a new baby and post natal depression. It would have been good practice for the GP to have discussed Adult N with the community midwife or health visitor to enable them to contribute to the assessment of Adult N and to provide her with additional support.

There also appears to have been a lack of curiosity about the role of Adult P. Adult P's role within the family unit is only recorded on one entry in the GP notes when the mother presented to the GP in the September 2012. Reference to his role within the family is limited to, "happy with bf (boyfriend)", "goes out with baby whenever he is free". There is no reference to his level of involvement within the family unit or the extent to which he was able to contribute to the care of Child L.

The next contact with Adult N and Child L was on the 2nd October 2012, six days before the death of Child L. The consultation did not give rise to any concerns regarding the welfare of Child L. The care provided by the practice nurse is in line with that expected and is documented clearly. The practice nurse identifies that Adult N did not appear to be distressed or tearful and if that had been the case, she would have documented it and would have taken appropriate action/s.

Multiagency Information Sharing

The review of documentation and recorded information sharing identifies mixed performance. GP records had references to various members of the family having had contact with health professionals at Child Health Unit at Hull and East Riding CHS information systems but there is no specific detail about this contact. GPs and nurses at the Family M practice have access to entries made by health visitors and child health provided that they are recorded on the computer system being used in that surgery, but don't have access to the information recorded on the CHCP electronic system.

The capacity of professionals to be able to view each other's records would significantly improve child safety and is in the process of being reviewed as part of the implementation of SystmOne. Individual practitioners or agencies may have a low suspicion of concerns about a child's safety that would not reach the threshold for activating child protection procedures but trans-agency record sharing may escalate concerns and elicit appropriate action.
This may require the patient to actively consent to the sharing of information. There are issues identified by this case in enabling different branches of the organisation and agencies to view each other's records such as Child Health team, GP surgery and A&E.

City Health Care Partnership (CHCP) is committed to introducing the electronic record SystmOne (S1) for Adult Services, and Children and Young Peoples Services, to complement approximately 80% of GP Practices in Hull which currently use S1 as their patient record. The S1 electronic

record essentially provides a single electronic patient record to which professionals working with the patient can contribute.
A new sharing model is being introduced in early 2014 within the Yorkshire and Humber area which will enhance the sharing ability of the S1 electronic patient record.

Religion, Diversity or Cultural Issues

The GP records do not contain any information about the family's religion, diversity or cultural issues. The records, however, do specify ethnicity in registration details but do not mention them anywhere else in the record during the time interval investigated. Ethnicity is specified in the GP record. According to the GP records Child L had the ethnic origin "British or mixed British-ethnic category 2001 census" and Adult N has the ethnic origin "White and Black Caribbean-ethnic category 2001 census". This is the first and only reference to Adult N being "White and Black Caribbean" and is believed to have been a recording error. All have English recorded as the main spoken language recorded although Child L would not have been old enough to be in command of any language. The ethnic status or main language of adult P is not recorded in the documents.

Training and Supervision

The GP practices which Family M are registered with have in place a Safeguarding Children Policy dated 22nd May 2012.

All doctors and nurses are up-to-date in their Safeguarding Children and Child Protection Training and three core members of the administrative staff also completed the training. Further practice-wide training sessions are being held and will ensure that all staff are trained in the subject and also to meet CQC best practise baselines.

Both practices have supervision arrangements in place and a GP identified to take the lead in matters of safeguarding children. GPs will also discuss cases of concerns amongst each other. As no concerns regarding child L's safety had been raised, this case had not been discussed amongst the healthcare professionals of the practice at the time.

2.2 Hull and East Yorkshire Hospitals NHS Trust (HEYHT)

Hull and East Yorkshire Hospitals NHS Trust (HEYHT) was established in October 1999 through the merger of the Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. The Trust operates from two main sites: Castle Hill Hospital and Hull Royal Infirmary (including the local Emergency Department and Women and Children's Hospital/maternity hospital), as well as other locations within the geographical area served by the Trust. The Trust provides medical and surgical services, both acute and planned, for approximately 600,000 people who live in the Hull and East Riding of Yorkshire area, in addition to a range of more specialist services to a much wider population, and employs over 8,000 staff.

Service involvement with Child L, Adult N, and Family M

HEYHT's knowledge of the children and family health history during the time period of the review is summarised below by family member:

- Child L was known to the Trust as an unborn child from the initial antenatal contact with the midwife, and as an individual from birth, until death.

- Adult N received services from HEYHT prior to the commencement of this review, and which are unrelated to this review. During the period of this review Adult N received maternity services input and two contacts with urgent care services.

- Adult P has not received a service from HEYHT during the period of this review however he has accompanied other family members during their contacts with the organisation.

HEYHT's contact with Adult N and Child L is divided into three episodes of care: antenatal care, postnatal care and the 8th October 2012, the date of Child L's death.

Service Involvement with Adult N Antenatal Care

Adult N attended the first appointment with the midwife in February 2012 accessing maternity services via the Direct Access to Midwifery Service self-referral system prior to her 12th week of pregnancy, as recommended by the Royal College of Obstetricians and Gynaecologists (2008)[4].

A comprehensive midwifery led assessment took place and was recorded in Adult N's hand held maternity records, and electronically recorded to enable the Community Midwifery Service access to the assessment. Adult N disclosed a family history on both maternal and paternal sides of various medical conditions. Adult N was asked the "routine enquiry for domestic abuse" question and answered "no, never". It is clear from the maternity records, that Adult N lived at the same address as Adult R. It is documented that Adult N's partner is Adult P; however, it is not made clear if Adult P lived at the same address as Adult N.

[4] Royal College of Obstetricians and Gynaecologists (2008) *Standards for Maternity Care: Report of a Working Party.*

Midwife X referred Adult N to a Consultant Paediatrician and Consultant Obstetrician (Dr U) in accordance with HEYHT Guidance (2010). Both of these outpatient appointments took place. Adult N was assessed as not requiring further intervention. A referral to the "smoke free team" was generated at the initial call to the Direct Access to Midwifery Service.

Adult N was returned to "midwifery led care" at 21 weeks gestation. In line with expected practice Adult N was asked questions in relation to her mental health and it is documented that following this assessment of mental health, no further action was taken; this decision complies with NICE Guidance. Following a viable pregnancy and expected due date being confirmed, a summary of the antenatal booking was sent to Adult N's GP and the Health Visiting Service, in accordance with HEYHT guidance (2011). Both Consultant Obstetrician U and midwife Z discussed smoking cessation with Adult N during the pregnancy.

Service Involvement with Adult N Postnatal Care

On 28th August 2012 Adult N attended hospital and Child L was born. Child L was assessed by the midwife and no anomalies or abnormalities were detected. Adult N and Child L remained in hospital until discharged on the following day. There were no recorded clinical or other concerns. Child L had a full physical examination by a Paediatrician prior to discharge. This is standard practice and meets with the postnatal requirements documented within the National Screening Committee Guidelines. It is recorded that there were no abnormalities and no risk factors which would warrant further investigation. The midwives caring for Adult N and Child L in the postnatal period did not express concerns about their progress. Midwife U has documented that a routine informative discussion occurred with Adult N, prior to her care being transferred to the community midwives.

Each postnatal visit to Adult N and Child L at home comments on Child L's progress. Child L's birth weight was 2790 grams and on the 6th postnatal day Child L was weighed and had lost 4%[5] of birth weight, which is classed as within normal limits.

On 10th September 2012 Child L was seen in the postnatal clinic at the Children's Centre by midwife Z with Adult N, Adult P, and Adult R. Child L's progress was again assessed and she weighed 2900 (6 pounds and 6 ½ ounces). The weight gain made by Child L was within normal limits. A holistic examination of Adult N was undertaken at the postnatal appointment which concluded that there was no cause for concern regarding her general health and wellbeing. Adult N and Child L were discharged by the midwifery service with contact numbers and information regarding how Adult N could access the midwifery service for up to 28 days in the postnatal period, if she had any concerns or required advice, and information that Adult N could access other health professionals such as the health visitor or GP for appropriate advice and support as required.

The postnatal care received by Adult N and Child L was "routine". No concerns in relation to child protection or child welfare had been identified during this period.

Analysis of Service Involvement

[5] 4% weight loss in between birth and post natal day 6 is considered to be a normal weight loss. If an infant were to lose more than 10% of their birth weight, action would be taken.

Midwives are the lead professional for healthy pregnant women. They have the expertise to refer to and coordinate between specialist services when required (Department of Health 2007 and 2010)[6]. This is clearly demonstrated with the appropriate referrals for consultant opinion and subsequent agreement that Adult N could continue under Midwifery Led Care. Adult N's referral to another service following a concern about her health was the only issue documented in the antenatal period. She was referred promptly and appropriately to the correct service for medical investigation. Information regarding this referral was shared appropriately with the Primary Care Service, and documented in the HEYHT Maternity records.

Adult N received routine antenatal care in accordance with the National Institute of Health and Clinical Excellence (NICE) Guidance (2008)[7], which states "in an uncomplicated pregnancy, there should be 10 appointments for nulliparous[8] women". This translates into practice as 9 appointments in the antenatal period and 1 appointment if the woman goes past her due date. Adult N had nine appointments in the antenatal period however Child L was born the day before the due date. Therefore Adult N received the correct amount of antenatal appointments. Smoking cessation was discussed with Adult N in accordance with National Institute for Health and Clinical Excellence (NICE) guidance (2008) and The Department of Health (DoH) Child Health Promotion Programme (2008), for the benefit of the unborn child.

It is evident from the midwifery records that a discussion was held with Adult N and information leaflets given regarding: postnatal care and home visiting; jaundice in babies; preventing cot death; postnatal exercises for new mothers; family planning and sexual health; baby feeding information; smoking cessation and passive smoking; and new-born blood spot tests. Adult N was given information regarding how to access the midwifery service if she had any concerns or if advice was required and contact numbers were given in writing and transferred to the care of the community midwife from hospital following childbirth.

There are two relevant issues related to Adult N's contact with services during the post natal period:

- The Department of Health (2005)[9] recommend health professionals routinely enquire about domestic abuse. HEYHT and CHCP (Health Visiting Service) use the same codes for Routine Enquiry responses, following a recommendation from a previous SCR, to enhance communication between partner agencies. This does not appear to have been effective in this case because of changes to IT systems which resulted in the interpretation of codes not being consistent across partner organisations.

- The pre-printed records for the first assessment or "booking in" appointment with a midwife, do not facilitate easy documentation of who else lives in the family home. This point of

[6] Department of Health (2010) *Midwifery 2020: Delivering expectations.* Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.*
[7] National Institute for Health and Clinical Excellence (2008) *Antenatal Care: Routine care for the healthy pregnant woman.*
[8] Nulliparous is the medical term for a woman who has never given birth to a viable, or live, infant.
[9] Department of Health (2005*) Responding to domestic abuse. A handbook for health professionals.*

learning is being added in reference to the research on adult males: [10]Ofsted (2011) and Brandon et al (2010)[11].

Service Involvement with Child L and Adult N on 8th October 2012

A pre-alert call was received from the Ambulance to inform the local hospital (Hull Royal Infirmary) Emergency Department that Child L was being transferred to them requiring resuscitation and that cardio-pulmonary resuscitation had been commenced in the community. Area E1 of the Emergency Department was prepared for the emergency and specialist staff were in attendance when Child L arrived. No family members accompanied Child L on transfer to the hospital. It is unusual for a parent not to accompany a child under these circumstances. It became apparent the Adult N had been brought to the same hospital in a different ambulance following a fall. Parents are normally asked if they would like to be present during the resuscitation. In this case, because the parents did not arrive with Child L, they were unable to observe the resuscitation and be verbally prepared by staff for the death of their child which is the usual practice prior to the cessation of resuscitation. As the parents did not accompany Child L to hospital in the ambulance, on arrival in area E1 Dr Z took a history of events from the paramedics and examined Child L. Later, when Adult P attended area E1, Dr Z took a detailed history of events prior to the discovery of the child's collapse, to inform assessment of Child L. Child L arrived at A&E at 08.22. Paediatric resuscitation continued until Child L was pronounced dead at 08.40.

Dr Z informed Adult P of the death of Child L, accompanied by nurse Z, as Adult N was in area E2 of the Emergency Department at this point in time, awaiting assessment. Adult P informed Adult N of the death of Child L. Adult N, Adult P and Adult R were all able to hold Child L, whilst nurse Z maintained a discreet presence. Consultant Paediatrician Dr W was also present during this time. Working Together to Safeguarding Children (2010) and The Foundation for the Study of Infants Deaths (2005)[12] recommends that parents and other family members are allowed the time to hold the baby. The staff in area E1 enabled this to take place.

Dr W examined Child L within 1 hour of confirmation of death, and a full history was taken from both Adult P and Adult N to inform this assessment. Dr Z was concerned about Child L's skull fracture and the Police and Children's Social Care team were notified of the unexpected child death, the definition of which is taken from Working Together (2010: page 212: para 7.21). The Sudden Unexpected Death in Infancy (SUDI) box was completed[13].

A Rapid Response Meeting was convened promptly, including the relevant staff identified at that time, and chaired by the Designated Paediatrician for Deaths in Childhood, in accordance with Working Together to Safeguard Children (2010).

Adult N

[10] Ofsted (2011) *Ages of Concern: learning lessons from serious case reviews* London: Ofsted

[11] Brandon, M. Sidebotham, P. Bailey, S. Belderson, P. (2011) *A study of recommendations arising from serious case reviews 2009-2010* University of East Anglia: Department for Education, DFE-RR157

[12] Foundation for the Study of Infant Deaths (2005) Sudden and Unexpected Deaths in Infancy: Guidelines for Accident and Emergency Workers

[13] This is a briefcase containing a contacts list and checklist of all the necessary tests, samples and forms required for the pathologist looking into the cause of death, which has been agreed with the local Coroner.

Adult N was brought to hospital area E2 by ambulance. After the death of Child L, Adult N returned to area E2 with Adult P and Adult R. Dr Z attended area E2 to assess and plan the care for Adult N's injuries. This is good practice as this provided continuity of care for Family M, and offered Family M additional opportunity to ask questions of Dr Z. There was a difference in the history of events given between Adult N and Adult P. Adult N reported her collapse and hitting her head on the floor. Adult R reported that Adult N had "hit her head on a door jamb". There are no recorded safeguarding adult concerns around the injury to Adult N. Following examination Dr Z diagnosed that Adult N had a "minor head injury and facial injury". Adult N was discharged with advice regarding the management of the head injury. She was arrested by the police and taken into custody.

Adult N returned to HEYHT area E2 that evening accompanied by the police, who had been concerned about her behaviour whilst in custody. Following triage, Adult N and the accompanying police personnel were escorted to wait in a separate room. Adult N was seen by Dr Y promptly due to the clinical concern regarding her head injury. She was discharged following investigations and a period of observation, without follow up care being required.

Analysis of Services Provided on 8th October 2012

Management accountability for decision making was taken by the Consultants on the date of Child L's death, which is appropriate and adheres to the HEYHT Policy for situations where abuse or neglect is suspected, and the guidance within Working Together (2010).

The child death checklist was completed by nurse Z. This checklist is a HEYHT form which prompts the nursing staff to action, date, and sign when procedures/offers of support/contacts were actioned.

The HEYHT Safeguarding Children Team were notified of Child L by area E1 staff whilst she was being resuscitated. A member of the Safeguarding Children Team contacted a senior police officer and the children's social care team manager to alert them of the likely referral. This effective communication enabled suitably qualified police and social care personnel to attend HEYHT in a timely manner. The Designated Paediatrician for Deaths in Childhood convened a rapid response meeting which occurred the same day. The reporting of unexpected child deaths to the Police and Children's Social Care followed the Guidance in "Working Together to Safeguard Children" (2010).

Training and Supervision

There were no outstanding issues identified for HEYHT in respect of staffing, and no escalation policies activated in respect of staffing numbers in the work areas which Adult N and Child L accessed. Therefore the issue of staffing has not been highlighted as an area of concern.

Current HSCB Guidelines and Procedures are available on the HEYHT Safeguarding Children intranet site.

The review of information within HEYHT illustrates that where the threshold of need for intervention was met, appropriate referrals were made in a timely manner to the appropriate agencies, following the HEYHT Safeguarding Policy and HSCB (2011) 'Thresholds of need guidance'.

HEYHT has a target set by the Primary Care Trust, of 80% staff trained at Intercollegiate (2010) Level 2 Safeguarding Children Training. HEYHT's performance against this target on 1st September 2012 was 82%. 5 of the 6 midwifery staff caring for Adult N and Child L are up to date with their Intercollegiate Level 2 Safeguarding Children training. None of the 6 midwifery staff were up to date with their Intercollegiate Level 3 Safeguarding Children Training at the time. However they could have sought advice from the Safeguarding Children Team if there had been any concerns of a safeguarding nature.

Supervision arrangements for staff are described in the HEYHT Child Protection Supervision Guidance (2012). Staff that are not identified caseload holders have access to ad-hoc safeguarding supervision with a member of the Safeguarding Children Team who are based on the Acute Hospital site, on weekdays. Out of hours support can be sought from line managers and safeguarding children advice can be sought from the Consultant Paediatrician on call. No safeguarding supervision had been sought in respect of Family M as no risk factors or concerns had been identified prior to the death of Child L.

Conclusion

Adult N had in total nine antenatal appointments. She was seen by midwife Z for six of these appointments. During this period Adult N had ten contacts in the hospital and three postnatal contacts in the community. Midwife Z attended Adult N at two of these appointments. The midwifery service delivered to Adult N, Adult P, and Child L is an example of good continuity of care. The care delivered to Adult N during the period of this review was appropriate and timely, and met the HEYHT standards and guidelines. There were no safeguarding concerns identified and none were missed. When Child L died, an appropriate and timely referral was made to the Police and Children's Social Care team.

2.3 City Health Care Partnership Community Interest Company (CHCP)

City Health Care Partnership CIC (CHCP) provides community health services to the City of Kingston upon Hull and surrounding areas. City Health Care Partnership CIC (CHCP), previously NHS Hull provider services, officially formed on 1st June 2010 as an independent health services provider separate to the commissioning organisation, NHS Hull. Amongst other services, CHCP provides community paediatric nursing, health visitors, school nurses, dentistry, public health and GP practices in a community setting.

During the time period of the review, the north locality Health Visiting team consisted of 9.6 Whole Time Equivalent (WTE) staff and had one vacancy. The Health Visiting team covered both the Northern and Wyke boundary areas. Health Visiting teams use a corporate approach to the pro rata allocation of families to a named health visitor. It is regularly reviewed by the team with the clinical manager to ensure equity in terms of number of children, families and levels of need within each practitioner's caseload. Health visitor caseloads are typically 400 per WTE[14] which is consistent with other health visitor services nationally.

Service involvement with Child L, Adult N and Family M

Contact with Adult N

The health visiting service's contact with Adult N commenced when she was 34 weeks pregnant and included:

- February 2012 - The first communication regarding Adult N was from Community Midwifery Services following Adult N's attendance at the local maternity hospital. The Health Visiting Service was notified that Adult N had booked for care during her pregnancy and had been assessed by a midwife. The Antenatal Booking Summary provided the Health Visiting Service with information about Adult N's family status, which was "single two parent", her ethnic group, her occupation, family history and personal health history, including Adult N's gynaecological and surgical history. No problems were identified; either related to Adult N's pregnancy or welfare issues. There is no record of the Routine Enquiry question about domestic violence being asked (the midwife did ask and Adult N said "no"). This would have provided information for the health visiting service about whether Adult N considered herself a victim of Domestic Violence either currently or in the past. It would have enabled a risk assessment to be made. As identified in section 2.2 there is no specific place on the midwifery booking form to record this. The only public health issue identified which could have impacted on the health and well being of Child L was that Adult N was a smoker. It was clear that the midwife had addressed this during her assessment but it was not clear if the advice given had been followed by Adult N.

  In the absence of other information relating to risk, this issue would not have led to Adult N being assessed as needing a service above the universal provision being offered.
  It is not clear if Adult P was present at the 'booking in appointment' but there is some limited information about his ethnicity and employment on the antenatal booking summary.

[14] Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. (Department of Health Policy Research Programme, ref. 016 0058)

- In March 2012, as there was no other liaison from midwifery services an assessment was made that Adult N should be allocated to the Universal/Corporate antenatal Health Visiting caseload. Based on the information held by Health Visiting services at this time this decision followed CHCP organisational practice. Following this assessment, Adult N was sent and attended an appointment at the antenatal clinic at her local health centre in July 2012. It is recorded that Adult N attended with Adult P and Adult R. The record details information about Adult P and refers to Adult R and Child S. Adult R's first name is written in the record but the full name and date of birth of Adult R and Child S, as significant others in the same household, were not recorded within the generic health record. The Whooley[15] questions have also been addressed. The framework covers areas of potential health concern and safeguarding risk including smoking, alcohol/substance misuse, support from fathers and safe sleeping. Specific discussion or information gathered is documented in more detail. Adult N declined a referral for smoking cessation. The records confirm that Sudden Infant Death, co-sleeping and shaken baby ("handle with care") were discussed. It is also recorded that Adult N's emotional health was assessed. The records identify that Adult N had no history or current signs of depression. The records also indicate that the Routine Enquiry question about domestic violence was not asked, the box was not ticked. This is confirmed by a written entry in the record stating that Routine Enquiry was not asked but without an explanation why it was not.

- In August 2012 Adult N was seen again for a screening following a referral from the GP.

Contact with Adult N and Child L

- On the 31st August 2012 Child L's birth pack was received by the Health Visiting Team from Child Health Services. On receipt of this Adult N and Child L's care was reassigned to Health Visitor #2's caseload. The birth pack was then made available for Health Visitor #2 to review and to arrange the birth visit. Due to annual leave the health visitor did not return to work until 3rd September 2012. It was noted during the review that the letter to Adult N was not generated by the administration team until Monday 10th September 2012. The letter was to arrange an appointment for 13th September 2012 which was outside of the recommended birth visit by 2 days (Healthy Child Programme 2010). The short delay was due to the impact of annual leave.

- On 13th September 2012 the primary birth visit was completed as planned by Health Visitor #2. Child L was 16 days old. The review of the records indicated that the assessment, which includes revisiting all the issues relating to health and potential safeguarding risk, was completed. This includes repeating the Routine Enquiry question for domestic violence.

  There is no record of a response to this enquiry. Health Visitor #2 has no recollection of asking the question therefore it has not been possible to establish if the Routine Enquiry question was asked. Health Visitor #2 did state that she would as routine revisit the Routine

[15] The NICE Antenatal and Postnatal Mental Health Guideline (2007) recommend use of the Whooley questions in the antenatal and postnatal periods. During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things? Is this something you feel you need or want help with?

Enquiry questions if Adult N was alone at the follow up visit. The CHCP guidance for health visitors is that the Routine Enquiry questions should be considered at each contact.

The assessment undertaken during the visit identified no unmet health needs or safeguarding concerns. This review has highlighted, however, that there was an opportunity for establishing if there was any domestic violence in the family home.

The service level of need was assessed at Universal and Health Visitor #2 therefore booked the follow up visit for the 8th October 2012 with Adult N, when Child L would be almost 6 weeks old (5 weeks 6 days). A follow up visit between 6-8 weeks follows the universal core visiting programme (National Healthy Child Programme, 2010).

- On 1st October 2012 Child L attended the Child Health Clinic and was seen by the nursery nurse which is standard practice. Child L's weight was recorded as 3560 grms which was an appropriate increase. The documentation suggests that Adult N had concerns about Child L's bowel movement and that Child L had oral thrush. The family were advised to see the GP. The nursery nurse assessed that the relationship between family members was appropriate and no health or safeguarding concerns were identified.

- On 8th October 2012 Child L died. This was the same date that an appointment had been arranged with Adult N by Health Visitor #2 to complete the follow up visit. On 8th October 2012 following Child L's death, the established operational Rapid Response process was instigated by the Hull and East Yorkshire Hospitals NHS Trust staff. This resulted in information being shared with Health Visitor #2 via the CHCP Safeguarding Children Team in a timely manner which prevented Health Visitor #2 visiting the property of Family M for a planned, routine review and prevented causing unnecessary distress to Family M and Health Visitor #2.

Analysis of Involvement

There was no information available to Health Visiting services during any contact with Adult N, Adult P, Adult R and Child L which raised any unmet or unaddressed health needs or safeguarding concerns. The care provided to Child L and Family M was generally compliant with CHCP standards in relation to service delivery, with the exception of the use of Routine Enquiry and of establishing significant others in the family. Adult N, Adult P and Adult R engaged with arranged appointments at the antenatal clinic and, following the birth of Child L, Adult N engaged with services at the birth visit.

When Adult N, Adult P, and Adult R had concerns about Child L they actively sought support and guidance from Health Visiting services at a child health clinic. During the 2 post natal contacts, observation of the interactions with Child L, Adult N and Adult P appeared to demonstrate that Child L was being cared for appropriately by her parents and significant other.

There were no emotional health issues identified in relation to Adult N. The protective factors in place were that Child L had both parents involved in her care and she was recorded as living in a two parent family.
However, it is unclear from the records if her parents were living together following her birth. Adult N, Adult P and Child L appeared to be well supported by family members. They proactively

engaged with services, seeking support and guidance when necessary and appeared receptive to the advice given. There were no missed opportunities for intervention identified.

Antenatal care

New antenatal referrals to Health Visiting services are triaged on their receipt by the duty health visitor and are allocated according to clinical requirements. Triaging the antenatal booking form takes into consideration the information available to the service i.e. previously identified health needs or areas of concern. This means that those women assessed as having no additional needs are offered an antenatal clinic contact and those women identified as having additional needs are allocated to a named Health Visitor and a home visit is offered. A full health needs assessment is completed at this contact.

Reviewing the care of Adult N during this period there are no significant areas of practice that would have influenced the outcome for Child L and no identifiable missed opportunities.

Antenatal contact with Adult N took place when she was 34 weeks pregnant which is outside of the Healthy Child programme of best practice guidance of a contact at 20 to 28 weeks gestation. This was as a result of a capacity issue at this particular time which was identified by staff and service managers and extra clinics were arranged to address the delay.

This review has highlighted the lack of clarity regarding the meaning of the term “single, two parent”, which appears to have been open to interpretation by health professionals. This reflects the importance of establishing significant others within family units.

Taking into consideration information shared by midwifery services and Adult N’s response to issues discussed during the contact, the assessment of Adult N raised no un-addressed health needs or safeguarding concerns. There are, however, two issues that have been raised which might be more significant in other cases.

Information About Significant Others

The guidance on recording significant others in the family household was not followed as the information obtained was incomplete. Adult R and Child S were not identified, and detail of Adult P was not complete. Health Visitor #1 recorded that Adult N lived with Adult R and Child S but did not record their details as significant others. She did record the name, relationship and date of birth of Adult P. Significant others in families includes other family members. Recommendations made from a previous Serious Case Review (SCR. Family F 2011) stresses the importance of recording significant others in the child’s records. Health Visitor #1 had attended the training implemented following the last SCR in Hull. It appears she had taken this into consideration in her assessment in terms of Adult P but had not extended it to include Adult R and Child S.
Review of the antenatal booking form has highlighted uncertainty regarding the use of the terminology regarding the family, in particular use of the term “single, two parent” and its definition. This illustrates the need for clarity and consistency across health partners with regards to language and communications.

This review has highlighted the need to ensure that there is a process to systematically record significant others in the health care record. This requires addressing both in terms of the individual

practitioners concerned, to establish the quality of the practice of each, as well as across the service to ascertain the scale of this issue.

Organisations will undertake an audit of records to establish if this is an isolated occurrence or if it is prevalent within the service. The findings of the audit will be addressed.

Routine Enquiry About Domestic Violence

The antenatal booking form has no specific place to record if the Routine Enquiry questions about domestic violence have been asked by a midwife and what the response to that enquiry was. Health Visitor #1 did not ask the routine question at the antenatal meeting she had with Adult N. Health Visitor #1 identified that she would not ask the questions when others were present due to the potential to escalate risk if the perpetrator of any domestic violence was present. She explained that she would leave the tick box empty to highlight to health visitors at future contact that Routine Enquiry had not been asked. The documentation was incomplete as the proforma within the generic health record used to evidence that Routine Enquiry had been considered or questions have been asked, was not completed. This proforma does include an option of a tick box to indicate that the questions were not asked because others were present. Health Visitor #1 did record more detail in her assessment of Adult N and her emotional health which, as identified earlier, did not identify any concerns and also that Adult P was a smoker and that they didn't live together at that time. There was no alcohol or substance misuse reported. She recorded that she had not asked the Routine Enquiry question but did not record why she made that decision. On questioning she feels she didn't ask it because others were present, but because the record is incomplete this is not conclusive. Not asking the Routine Enquiry question when others are present is within CHCP practice guidance due to the potential to increase risk to the mother and unborn/child if a perpetrator is present. The response, or the reason why the question was not asked, should be recorded, however, to inform future assessment and intervention.

At the primary birth visit, the health visitor is expected to revisit all the issues relating to health and potential safeguarding risk. This includes repeating the Routine Enquiry question for domestic violence. There is no record in the primary birth visit of a response to this enquiry. The documentation is incomplete in terms of Routine Enquiry. Health Visitor #2 has no recollection of asking the question therefore it has not been possible to establish if the Routine Enquiry question was asked. It was not significant in this case as there is no indication of domestic abuse but it may be significant in other situations.

Healthy Child Programme

Health visiting services are delivered in line with the national Healthy Child Programme 2010. This follows a model of a universal core programme of service delivery to all antenatal mothers and fathers progressing to a programme of care and service that meets different levels of need and risk (progressive universalism). The Assessment takes place at each contact with the service user. It takes into consideration identified current need and future risks which inform the level of service provided.

The three service levels of need are; *Universal* which, as stated, is a core programme of care; *Universal Plus,* where a short time-limited increase in service is provided in response to an assessment of additional need, for example support with breast feeding; and *Universal Partnership Plus* programme of care which is provided where an assessment of health need has identified a child or their carer as having an additional health need, physical need and/or where there are safeguarding concerns around an unborn child or a young person. (Health Visitor Implementation Plan, DoH 2011)

It is recorded that Adult N's antenatal assessment took place when she was 34 weeks pregnant which is outside the recommended best practice guidance of contact between 20-28 weeks gestation (Healthy Child Programme 2010). The reason for this was explored and during the summer months of 2012, including July, it was identified by the service that the regular clinics did not have the capacity to offer appointments within timescale to the number of antenatal mothers requiring an appointment. In response to this, extra clinics had to be arranged to ensure antenatal contact was offered to all antenatal mothers registered with the Health Visitor Services.

The birth visit took place at 16 days which was outside the guidance of taking place 'by 14 days', and therefore identified as not being best practice. This was attributed to the health visitor being on annual leave at the time. Assessment at the birth visit did not identify any concern or risk in relation to the care of Child L. The service level of provision offered was therefore Universal which, based on the review of the information, was appropriate and in line with national guidance (The Healthy Child Programme, DH, 2010). The performance of CHCP in relation to meeting the targets set in the Healthy Child programme is assessed against an indicator set by NHS Hull CCG. Whilst the visits made to Adult N, both antenatal and for the birth visit, were outside the standard by 6 and 2 days respectively, this is not significant in this case.

Training and Supervision

The focus of the review of training is in three areas; Handle with Care, Routine Enquiry and the recording of significant others.

In relation to this review, the injury Child L sustained raises issues about the health visitors' knowledge of working with parents to enable them to develop the appropriate skills of handling vulnerable babies.

Handle with Care training and information shared with antenatal/postnatal mothers was explored as part of this review. The last Handle with Care training session for staff from training records was February 2008. A new 'Vulnerability of Babies' training package was piloted in January 2012 which evaluated well. Health Visitor #1 has not had the Handle with Care training as she was not in post when the training occurred. Health Visitor #2 and the nursery nurse have had the training as they were in post when the training was available.

Training on Routine Enquiry is provided by the organisation but is not systematic. The training records of the staff concerned with this family indicate that, whilst training has been accessed in the past, it pre-dated the current record keeping process. The training therefore is likely to have been provided a minimum of four years ago. Training on Routine Enquiry needs to be systematic and monitored by the management team as with other safeguarding training.

Training on the recording of significant others in families has been incorporated into the Record Keeping Training since 2010 following a previous local SCR recommendation. All staff working within Children and Young People's Services were provided with access to training and three training sessions are provided annually to address new staff. It is noted however that Health Visitor #2 did not attend this training. This training also includes identifying and supporting male victims of domestic violence.

All staff have access to supervision provided by the Safeguarding Children Team. The health visitors who are caseload holders receive regular safeguarding supervision at a minimum every three months. Health Visitor #1 and Health Visitor #2 were compliant with this requirement. Health visitors are also able to access the safeguarding team whenever they have concerns. The performance of CHCP relating to clinical and managerial supervision is assessed against an indicator set by NHS Hull. There were no safeguarding concerns identified in this case which would have indicated a need for discussion in supervision with a supervisor.

2.4 Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service (YAS) NHS Trust was established on 1st July 2006 when the county's three former services merged. Currently, YAS employs 4,358 staff, who, together with over 3,000 volunteers, provides a 24-hour emergency service to more than five million people; approximately 1.2 million of those are under 18 years of age. YAS currently attends on average 3 unexpected child deaths a week, and consistently makes over 250 referrals to Children's Social Care for vulnerable children a month. The Safeguarding Team within YAS consists of 2 Named Professionals for Adults, 1 Named Professional for Children and the Head of Safeguarding.

Service Involvement with Child L and Adult N

Incident 1

There is no record of YAS contact with Family M outside the timescales of the review.

The first contact was on 8th October 2012 when YAS received a 999 emergency call regarding a 6 week old child who was stated by the caller, Adult P, to have stopped breathing. The YAS member of staff from the Emergency Operations Centre (EOC) confirmed details with the caller and provided directions to initiate Basic Life Support (BLS) until the ambulance arrived.

A Double Crew Ambulance (DCA) was sent to the incident and Paramedic1 (Para1) and Advanced Practitioner1 established that Child L was in cardio-respiratory arrest. The attending YAS staff made the decision to remove Child L to the Emergency Department (ED) at Hull Royal Infirmary (HRI). The adults in the home were asked who would travel with the child but as there was no response Para1 made the decision to convey Child L to hospital as quickly as possible for treatment and left without any adults to accompany her.

The DCA left the incident with a turnaround time of 2 minutes. AP1 made a pre-alert call to request that HRI ED staff were made aware of an impending paediatric cardiac arrest.
Six minutes later the DCA arrived at the ED. BLS was continued throughout the journey. On arrival the patient was taken to the paediatric resuscitation area and handed over to the awaiting staff. There was no handover signature obtained from ED staff by Para 1.

YAS EOC informed the local Clinical Supervisor of the incident, who went to the ED to offer immediate support for the staff. Para 1 and AP1 completed a referral to Children's Social Care via the YAS Clinical Hub in line with policy and procedure following the event. The Clinical Supervisor remained at the ED with the staff and returned to the ambulance station with the crew to complete a Post Incident Care report. This process also informs the YAS Safeguarding Team of an unexpected child death and was only recently launched following lessons learnt from another child serious case review.

Incident 2

YAS received another 999 emergency call to attend the address of the previous incident 3 minutes after the DCA had left the address on 8th October 2012. The adult female caller indicated that her daughter's baby had just been taken by an ambulance to hospital and that she needed help for Adult N.

On arrival, Para 2 was shown to the patient, Adult N, who was still on the bed. The supporting DCA arrived at the incident two minutes later. Para 3 and AP 2 entered the house. Para 2, Para 3 and AP 2 were informed that Child L had just been conveyed to Hospital #1. A set of primary clinical observations were recorded for Adult N and some bruising, swelling and abrasions to her left eyebrow and left shoulder noted.

Adult N was conveyed to HRI. Adult R travelled with Adult N to hospital as they thought this necessary due to the situation. Adult N was described as being in a highly distressed state throughout the journey, but only required basic care with no further clinical interventions. On arrival at HRI Para 3 provided a clinical handover to staff, and a signature was obtained on the Patient Report Forms (PRF) as per procedure. Para 3 escorted Adult N to the resuscitation area where Child L was being treated.

Analysis of service involvement

The appropriate service was provided by YAS during both incidents. The 999 calls were handled and graded appropriately.

The attending YAS practitioners during incident 1 were faced with a critically ill child. Staff recognised the significance of the cardiac arrest Child L had suffered and transferred her to hospital. Practitioners acted appropriately in transferring Child L to the nearest children's Emergency Department (ED) as recommended in Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines (2006) for children under 18 years of age. The crew recognised the child was critically ill and made the right decision to request a full resuscitation team to attend at the ED. This decisive action followed YAS Policy. Their initial clinical assessment and management of Child L highlighted two areas of concern regarding treatment of Child L and PRF completion standards.

The IMR author identifies that the incident with Child L focussed on resuscitative efforts and at the time gaining further information about the incident would have been very difficult. It is noted that no adults travelled in the ambulance whilst Child L was being resuscitated. Had this been the case, then there may have been opportunity to obtain more information about the incident and issues regarding family functioning during the journey and on immediate arrival at hospital.

YAS provided emergency assessment, treatment and transport to an ED for Child L and Adult N. The emphasis on dealing with 999 emergency calls is dictated by the requirement for a rapid telephone assessment, response and dispatch of appropriate resources. National response targets require ambulance services to reach 75% of Red Calls within 8 minutes. This target was achieved during incident 1.

During Incident 1 YAS practitioners appear to have made the correct assessments and decisions during the initial management of the incident. A total of 2 minutes was spent at the address assessing the patient. Unexpected child death procedures in YAS were followed and the decision

to convey Child L to hospital for further assessment and treatment was the correct action to take. A Clinical Supervisor was informed of the incident by the EOC and immediately attended the ED to support the staff.

This support enabled assistance with completion of a referral to Children's Social Care and completion of Post Incident Care documents and for provision of support to the attending staff.

The Safeguarding Team were also notified of the incident and discussed the case with the Clinical Supervisor the same morning. This should be highlighted as the expected level of support for emergency service staff that are faced with such demanding incidents.

It must be acknowledged that the post incident care (PIC) process in YAS is a new and innovative process amongst UK ambulance services and appears to have worked well during and immediately following incident 1.

A review of YAS staff support in 2012 was completed as a result of another child serious case review in Yorkshire. It was identified that YAS had numerous policies and procedures in place relating to the health and well-being of staff, but no method of capturing and collating the data across the Trust. The PIC process was introduced in August 2012. The system is intranet based and whenever staff receive care and support following a traumatic or distressing event, this is captured following completion of the document. If the event relates to child protection or an unexpected child death, then the system also generates an immediate e-mail to all members of the YAS Safeguarding Team. This serves numerous purposes of notification, but just as importantly, delivers early help and support to frontline practitioners dealing with distressing incidents. A PIC interview was also completed for the EOC call handler who dealt with the 999 call for incident 1. Members of staff disclosed that incident 1 was their first paediatric cardiac arrest and that they had found the event extremely distressing.

Children's Social Care was appropriately and promptly informed the same day, which is expected practice in this situation. The YAS staff recognised the potential indicators of abuse/neglect and acted appropriately in line with YAS 'Safeguarding Children and Young People Policy and Procedure' (March 2011) when there are concerns raised about a child(ren) at an incident or attendance at a child death.

The Safeguarding Team requested that the Patient Report Forms (PRF) for the incident were secured and forwarded for immediate attention for subsequent CDOP processes. Whilst not contributing to the death of Child L the review of the PRF identified that the quality of completion was below standard and that some elements of the resuscitation were also below standard for incident 1. The YAS Head of Safeguarding consulted the locality Clinical Manager and Clinical Development Manager and it was agreed that a Clinical Case Review (CCR) would be convened to address the identified areas.

The Clinical Case Review was completed on 9th November 2012 and Para 1 and AP 1 received actions as a result of the review. These actions are:

- Complete two reflective accounts based on medical document completion and paediatric resuscitation.
- Attend a Paediatric Advanced Life Support Course.

- Attend the Hull and East Riding Child Death Rapid Response Training

Para 1 and AP 1 accepted that some of their judgements may have been rushed and affected by the distressing nature of the event. This issue was discussed during the CCR and further help and support was offered by the panel.

The YAS EOC constantly audit 1% of 999 emergency calls for compliance against national standards. Both calls were audited at 100% compliance in respect of asking the correct questions, providing the correct advice and customer care elements.

The attending staff (Para1) during incident 1 did not follow YAS guidance for PRF completion in relation to these issues during the event. Para 3, however, did complete these areas on the PRF during incident 2. There were different demands placed on Para 1 and Para 3 in the separate incidents. Incident 2 appears to have been a more controlled environment, whilst still physically and mentally challenging for the attending staff. It is normal working practice for ambulance personnel to work as autonomous professionals when responding to emergency and urgent cases, following calls for help. The evidence relating to staff in this case clearly demonstrates that first line supervisors and staff in managerial positions were informed about both incidents at relevant points during and after the event.

YAS provides safeguarding children and child protection training for frontline practitioners which is compliant with the Royal College of Paediatrics and Child Health (RCPCH) 2010 inter-collegiate guidelines. A review of safeguarding training status of the members of staff involved in the two incidents demonstrates that 4 of the 5 staff who attended the incidents were compliant at the time. The review of training reports indicate that Para 2 had dropped from compliance at the time of incident 2. A subsequent check of all staff from YAS Workforce Information reports, demonstrates that all 5 staff are currently compliant with training requirements for level 2.

Conclusions

The incidents identified during this review are typical of demands in pre-hospital emergency care. The nature of care in this field dictates that all elements are conducted with swift responses in mind. A quick triage through the EOC, rapid deployment of resources and a quick assessment and transport of patients were required. All of these elements were compliant within this sequence of events on the 8th October 2012. YAS EOC staff and frontline practitioners usually have no knowledge of the child and family functioning or background. This does present particular problems for ambulance services when entering homes and houses particularly regarding information sharing and accessing background knowledge that other professionals and agencies have. This issue is compounded by the time spent with service users as in incident 1, when the YAS staff spent only 2 minutes at the home address.

2.5 Health Organisations - General Issues

Child death review processes

Following the death of Child L, child death review processes were instigated and organisations secured their records in line with the national guidance ('Working Together' Chapter 7, March 2010). The case was reported through the NHS critical incident reporting system to the Yorkshire and Humber Strategic Health Authority. The NHS Mental Health Service provider for Hull and East Yorkshire was asked to screen their records which revealed no contact with Adult N or Adult P.

On 7th January 2013 and 14th January 2013 meetings were co-ordinated by the Designated Nurse and Doctor for Safeguarding Children with the HEYHT, CHCP and Primary Care (GP) IMR authors in order to discuss initial findings collectively and identify any immediate actions to be taken. It is positively acknowledged that, where possible, provider organisations have already taken action in regard to some findings. In addition, individual authors have been given support and guidance regarding the process by the designated leads.

Guidelines and Procedures

All three organisations involved in the provision of health services to Family M have safeguarding children guidelines and procedures relevant to their organisations which are regularly reviewed and are accessible to staff. Procedures are in line with HSCB Guidelines and Procedures. The HSCB has a Guidelines and Procedures Sub-Committee on which the Designated Nurse sits in addition to the Named Nurses for the key health provider organisations. Therefore, there is an effective route to disseminate any changes and updates to the HSCB guidelines and procedures within health organisations. There are no issues identified in this review in relation to an absence or inadequacy of safeguarding children policies and procedures.

Training and Supervision

In July 2009 the Care Quality Commission published a report[16] following a review of safeguarding arrangements in the NHS. It identified areas for improvement including safeguarding children training levels. Therefore, all Trusts were required to review their services to ensure the necessary improvements were being made and publish a declaration of compliance prior to registration with the CQC in April 2010. NHS North of England Area Team have continued to monitor compliance on a quarterly basis. Currently the Hull CCG and all local Trusts are compliant. GP practices are also now required to be registered with the CQC and to have training arrangements in place.

Both HEYHT and CHCP have current safeguarding children training strategies.

Training uptake is monitored by HEYHT and CHCP internally and via the NHS Hull CCG Safeguarding Assurance Board. GP and practice staff training uptake is also monitored by the NHS Hull Safeguarding Assurance Board.
Training issues are monitored by the HSCB safeguarding training sub-committee. Level 1 and 2 safeguarding children training (Intercollegiate Document 2010)[17] is delivered as single agency training within the 'family' of health providers.

It is recommended in the Intercollegiate Document 2010 and in Working Together to Safeguard Children 2010 that midwives receive inter-agency training. IMRs identified that the majority of staff

[16] Care Quality Commission (July 2009) *Review of Arrangements to Safeguard Children in the NHS* CQC
[17] Intercollegiate Document (2010**)** *Safeguarding Children and Young people: roles and competences for health care staff.* Royal College of Paediatrics and Child Health

who had contact with Adult N and Child L had received the required level of training. However, although trained to Intercollegiate Level 2 none of the 6 midwives involved in the care of Adult N and Child L have received inter-agency safeguarding children training. This is not considered to have had an impact on the outcome for Child L in this case. The HSCB is aware of the historical difficulties of some agencies in accessing multi-agency safeguarding children training and this is being addressed through the Training sub-committee. A revised HSCB training strategy has now been ratified (January 2013). Its implementation should be prioritised.

A process of case supervision is in place on an ad hoc basis in GP surgeries to enable GPs to discuss cases of concern. It is also a local requirement that each GP practice has an identified child protection lead. This requirement is in place in the GP practices offering services to Family M. Additionally, there is a Named GP and a Designated Doctor for Safeguarding Children as well as other safeguarding children professionals to whom GPs have access for advice and support. It was not necessary to seek safeguarding advice or supervision from those professionals in the case of Family M.

Both CHCP and HEYHT have adequate supervision processes in place although it is less clear what arrangements are in place for community midwives. Nursery nurses receive supervision from the health visitor who is the caseload holder for the child and family.

Practice

Most of the practice evidenced within the three IMRs was of the expected and required standard. Additionally, there is some evidence of good practice. In general, decision making was appropriate and recording of decisions was clear although there are some areas that need further consideration:

- There was no consideration by the GP of communicating with the health visitor in relation to Adult N presenting with low mood in the postnatal period.
- Documentation was not rigorous in recording Routine Enquiry or the significant members of a household.
- The role of Adult P as a significant partner was not well understood or documented.

2.6 Hull City Council

Hull City Council Adult, Children & Family Services Directorate

Safeguarding Children Service Area

Children's Social Care services had no involvement with Child L or any other members of the Family M during the time period under review. For this reason no IMR was produced by Children's Social Care.

Learning & Skills Service Area

During the period under review no concerns or reports were raised in relation to any member of Family M. For this reason no IMR was produced by Learning Services.

Hull City Council Neighbourhoods and Housing Directorate IMR

Neighbourhoods and Housing is an integrated housing service which involves the Housing and Wellbeing Team, the Housing Investment Team, the Housing Strategy and Renewal teams and the Area Teams working together to deliver a full range of housing and regeneration activity and services within the city and across housing tenure.

Service Involvement

Adult N submitted an application for council accommodation for her and Child L in June 2012. She was pregnant and stated in her application that she had been asked to leave her family home. Adult N was sent information advising her that she should contact the Options Team for further advice. However she did not make any subsequent contact with any department in Neighbourhoods and Housing in connection with her application and she did not place any bids for properties that were advertised.

During the review period, contact with the household in connection with tenancy management was in the course of carrying out repairs to the property. Routine repairs resulted in several members of staff attending the property during the period between Child L's birth and death. Child L was seen on at least one occasion. None of the staff who attended the property identified any issues or concerns.

Analysis of Involvement

The service provided to Adult N in connection with her application for accommodation was standard and in accordance with internal procedures. There were no safeguarding issues or concerns identified. The tenancy management service provided in connection with the tenancy held by Adult R was standard and in accordance with internal procedures. There were no safeguarding issues or concerns identified.

Adult N's only contact with Neighbourhoods and Housing was the application for accommodation which she submitted in June 2012. It appears that the application form was completed by Adult N and she declared just herself and Child L as wanting rehousing.

Adult N stated in her application that she had been asked to leave her current accommodation and she stated that there was “too much animosity in the house. Not enough room for me when baby arrives, myself and teenage brother always arguing. My mum is disabled and sick of the atmosphere”.

She also stated that she needed to be rehoused close to her family to provide support stating that “my mum is disabled and needs me to help dress and wash her, go to shops etc”. Adult N was sent a letter advising her that she should contact the Options Team at the Centre for further advice. Adult N did not make any subsequent contact with Neighbourhoods and Housing in connection with her application and she did not place any bids for properties that were advertised.

This limited information suggests that there may have been pressure in the household prior to the birth of Child L. However there was no further contact from Adult N, or any other member of the household, in connection with the application and there were no incidents or information that staff in Neighbourhoods and Housing were aware of that raised any concerns in respect of Child L either prior to or after her birth.

Safeguarding procedures are in place throughout Neighbourhoods and Housing. Safeguarding Children procedures were formally reviewed and updated during 2012. These were endorsed by the HSCB in May 2012 then disseminated to all members of staff within Neighbourhoods and Housing. A 3 year training schedule delivered via HSCB is in place to ensure that staff have appropriate up to date awareness training. Repairs and Maintenance Contracts have reference to a Corporate Social Responsibility including safeguarding.

Conclusion

During the review period the only contact with the household by Neighbourhoods and Housing was in connection with repairs to the property and the application form submitted by Adult N for rehousing. In all instances standard procedures were followed, there were no concerns identified and consequently no actions taken.

Based on a thorough investigation of the limited involvement the service had with the household it is the overall conclusion of this IMR that there were no opportunities for intervention that were missed and that Child L’s death could not have been anticipated or prevented by Housing staff.

2.7 Humberside Police

Humberside Police Force covers the unitary local authorities of North East Lincolnshire, North Lincolnshire, East Riding of Yorkshire and Kingston-upon-Hull. Humberside Police employs 1,829 police officers and 1,956 police staff.

In 2005 Humberside Police formed Major Investigation Teams (MIT's) with the key aim of enhancing performance and following national best practice within major investigations. There is one MIT for the Force, with bases within each of the three Force Divisions. The MIT is managed by a Detective Superintendent who reports to the Head of CID.

The Public Protection Team in Hull is a dedicated team which has the responsibility for,

1. Protecting children
2. Tackling domestic abuse
3. Protecting vulnerable adults
4. Tackling honour-based violence
5. Managing sex and violent offenders (and other potentially dangerous people)
6. Dealing with missing people
7. Assessing rape investigations for inclusion within public protection arrangements
8. Tackling prostitution

The Team are overseen by a Detective Chief Inspector and have an establishment of 2 Detective Inspectors, 7 Detective Sergeants, 44 Detective Constables, 7 Investigating Officers (at scale 5) and 12.5 support staff which includes a Juvenile Liaison Officer. The total establishment is 76.5 staff.

Service involvement

Humberside Police did not have contact with either Adult N or P during the timescales of this review, until the admission of Child L to Hull Royal Infirmary on the 8th October 2012. The criminal investigation initiated in response to Child L's death resulted in Humberside Police having contact with all family members involved in this review on 8th October 2012 and beyond.

The initial report of Child L's attendance at Accident and Emergency was made to Humberside Police by nurse #1 directly to police officer #1, a Dedicated Decision Maker who works within a co-located team with Children's Social Care. A joint decision was made by police officer #1 and social services manager #1 about the required response and an agreement was made for the case to be investigated jointly between Humberside Police and Children's Social Care in accordance with Section 47 Children Act 1989.

Police officer #1 immediately brought the situation regarding the death of Child L to the attention of police officer #5, a Detective Inspector in the Public Protection Unit who attended the hospital with staff to obtain further information and assessment of the case. Following an initial assessment of information and evidence available to police officer #5, the case was referred to police officer #7, a Senior Investigating Officer within the Major Incident Team, who took overall responsibility for the criminal investigation.

Adult N and Adult P were arrested at HRI on suspicion of the murder of Child L. The decision to arrest Adult N and Adult P was based on early enquiries and information received from hospital staff that the injuries sustained to Child L were potentially non-accidental, and that Child L had been in the care of both Adults prior to her admission to hospital. As the death of Child L was being treated as suspicious, arrangements were made for a Home Office post mortem to be undertaken at a hospital out of area .

It is National and Humberside Force Policy for police to deploy Family Liaison Officers to families when an investigation is being undertaken into an unexplained death. Family Liaison Officers were deployed to Adult R and to the paternal grandparents of Child L.

Following their arrest, Adult N and Adult P were interviewed by officers from within the Major Investigation Team. Adult P was subsequently released unconditionally from police custody. Adult N was released on police bail.

Analysis of service involvement

This case demonstrates good working relationships between Humberside Police and partner agencies, in particular with Children's Social Care. Both agencies have a lengthy history of working together on investigating child abuse allegations jointly. The co-location of Humberside Police with Children's Social Care allowed for immediate information sharing taking place between the agencies, which directly informed the decision making.

There was good communication between HRI, Humberside Police and Children's Social Care and decisions made between agencies were in accordance with HSCB Guidelines and Procedures. Detailed records were maintained by Humberside Police in respect of key information sharing during the earlier stages of the criminal investigation. There were no organisational difficulties experienced either within Humberside Police or with external partners. This allowed for initial attendance at the hospital to be undertaken by Specialist staff and Supervisors from within the Public Protection Unit, who identified and undertook immediate lines of enquiry and information gathering in order to secure the existence of forensic and medical evidence to support the criminal investigation.

From the point of referral, the criminal investigation was directed and managed by a Supervisor from within the Public Protection Unit, with overall responsibility for the case being undertaken by a Senior Investigating Officer from the Major Incident Team

The investigation into the death of Child L was undertaken in accordance with Force, National and HSCB Guidelines and Procedures.

All staff involved in the case were working in the fields of Public Protection and Major Incident Teams, therefore conversant with the investigation of Serious and Complex Crimes.

Appropriate Supervision for the case was in place. Initial attendance at the hospital was undertaken by a police officer #5 who is a Detective Inspector from the Public Protection Unit.

This officer has worked in the field of public protection for a number of years, has been trained at a National level on the Investigation of Sudden Deaths in Childhood and has previous experience of investigating childhood deaths. Police officer #5 also represents Humberside Police on a number of groups within HSCB , including the Child Death Overview Panel (CDOP).

The criminal investigation was managed and overseen by police officer #7 who is a Detective Chief Inspector within the Major Incident Team and a Senior Investigating Officer. This officer is highly trained in the investigation of childhood deaths, having attended a National Senior Investigating Officer course and undertaken the National training from the NPIA on the Investigation of Sudden Deaths in Childhood. Police officer #7 delivers training with two Local Safeguarding Children Boards on Rapid Response Procedures to child deaths and has done so for the last five years. This officer has also previously worked within the field of Public Protection and investigated previous deaths of children.

The conduct of the criminal investigation was sensitive to the racial, cultural, linguistic and religious identity of Family M. There is no record of any issues identified regarding communication, or the social or economic environment in which Family M resided.

Humberside Police has in place policies and procedures in respect of safeguarding and promoting the welfare of children. The Force has a practice direction entitled – *'Unexplained Child Deaths – Police Action,'* which was last updated in June 2012. This document supports national police guidance contained within a number of documents including – '*The Murder Investigation Manual,' NPIA (*National Police Improvement Agency) – *'Guidance on Investigating Child Abuse and Safeguarding Children 2009*,' '*Chapter 7 Working Together to Safeguard Children 2010'* and Local Safeguarding Children Boards Guidelines and Procedures. Access to Force policies, National guidance and HSCB Guidelines and Procedures is available to all staff via the Force Intranet, which is accessible 24 hours per day.

Humberside Police are in the process of ensuring all Detective Supervisors and Senior Investigating Officers, within Public Protection Units and Major Incident Teams receive training on the National Police Improvement Agency course on 'Investigating Sudden Childhood Death.' This is a specialist accredited course aimed at Supervisors investigating unexplained childhood deaths, particularly in relation to babies and young children.

Conclusion

As Humberside Police had no contact with Family M prior to Child L's death there is no evidence from this review which identifies that the death of Child L could have been prevented or anticipated. There were no missed opportunities for intervention by Humberside Police or information known around any potential risks posed to Child L.

What is apparent from the review is that the police applied policies, National guidance and HSCB Guidelines and Procedures and that there was effective multiagency working in response to Child L's death.

SECTION THREE - LEARNING LESSONS. IMPROVING SERVICES.

The specific Working Together[18] terms of reference (a) to (c) (8.5) required in every SCR are reflected throughout the lessons to be learned. Specific terms of reference are identified at the end of the section:

- establish what lessons are to 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
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

This section of the report identifies conclusions that have arisen from this detailed review of the services provided to Child L, Adult N and Family M. Some of the issues identified do not relate directly to Child L's death but provide an assessment of her and her family's journey and contact with services.

Overall Conclusion

Adult N and Child L were known to universal services only and therefore there was no history of involvement of Children's Social Care services. The social, cultural, and economic environment in which the family were living had no impact on this case or on the way in which professionals operated. Adult N's post natal depression and the GP's knowledge of the history of Adult N, Child L and family health problems should have resulted in Adult N being referred to the midwife or health visitor who could have provided additional support which may have assisted in safeguarding Child L. However if this action had been taken it is unlikely to have either anticipated or prevented the death of Child L.

3.1 LEARNING LESSONS

1. What is obvious from reviewing the IMRs from the different agencies that provided services for Child L and Adult N is that there are areas of notable practice.

   This included:

   - Adult N had a total of nine antenatal appointments and saw the same midwife for six of these. Adult N received two postnatal contacts and saw the same midwife on both occasions. The author considers this indicates a high level of provision of continuity of care. 8 out of 11 of the community midwifery contacts with Adult N were carried out by the same midwife which provides a high standard of continuity of care within community midwifery.

   - Where an applicant states on their housing application that they have been asked to leave their current accommodation, for example as a result of relationship breakdown, the applicant is sent information advising that they should contact the Housing Options Team for further advice and support.

     Although in this instance Adult N did not seek further advice or support, this practice demonstrates a joined up approach which helps to raise awareness of the service provided by the Housing Options Team in providing advice and support for people in housing need.

[18] Working Together to safeguard children 2010 DCSF

- The pre-alert call made by the Ambulance staff to the HEYHT which facilitated the arrival of key members of staff in the resuscitation room prior to the arrival of Child L.
- The referral to the police being made directly to the Detective Inspector of the Public Protection Unit rather than a 999 call. This is an example of good inter-agency activity.
- There is evidence of good information sharing and inter-agency working with partner agencies and Humberside Police following the admission of Child L to hospital, as well as good communication and working within the police service between Public Protection Unit and Major Incident Team.
- The report highlights the demands placed on professionals in cases of the unexpected death of babies and children. Having identified from a previous SCR the potential emotional impact of pre hospital care from both the YAS EOC and front line staff perspective, YAS have developed their Clinical Supervision Policy and Procedure to ensure that in such cases, general clinical supervision is provided at local level to all operational and front-line staff via locality Clinical Supervisors (CS) and Clinical Managers (CM).
- The co-location of Humberside Police with Children's Social Care allowed for immediate information sharing taking place between the agencies, which directly informed the decision making between both agencies, the joint investigation and commencement of a criminal investigation
- The referral to Children's Social Care being made directly to the team manager. This is an example of good inter-agency activity.
- The same senior Dr examined both Child L and Adult N, which is an example of consideration for the needs of Family M.
- The care of Child L and attention to the parent's cultural and religious views in respect of Child L. There is evidence of sensitive practice in relation to arranging a blessing for Child L by the hospital chaplain and ensuring the privacy and dignity of Adult N whilst in the A&E department under police escort.
- Enabling Family M time with Child L in a quiet environment following her death.

2. There has been a considerable amount of work undertaken in Hull with agencies and individual practitioners to increase their knowledge and understanding of child protection and also thresholds of need. What this Review identifies is that there remain issues with some practitioners recognising their role in safeguarding children. Safeguarding children and young people has been defined as:

   All agencies working with children young people and their families taking all reasonable measures to ensure that the risk of harm to children are minimised and where there are concerns about children and young people's welfare all agencies taking appropriate action to address those concerns working to agreed local policies and procedures in full partnership with other local agencies [19]

   Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are experiencing, or are likely to suffer, significant harm. Effective child protection is essential as part of wider work to safeguard and promote the

[19] The 2nd Joint Chief Inspectors' report on arrangements to safeguard children 2005

welfare of children. All agencies and individuals are expected to proactively safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced. Early intervention is crucial to ensuring the best outcomes for children and young people where their safety is an issue. Universal services, like GPs, have to play a key role in the identification of safeguarding issues, early intervention and appropriate referral to other agencies. The GP did not consider a possibility of safeguarding issues related to Adult N's depression. This should have resulted in the GP making contact with other professionals to establish if there were issues related to safeguarding.

3. Multi/trans-agency working is key to ensuring the effective provision of safeguarding services. Reder and Duncan[20] identify the danger of professionals failing to share discrete pieces of information. The knowledge held by an individual agency may not, on its own, appear worrying but, when collated, the overall picture may indicate a more significant level of concern and risk.

   Effective intervention will draw on a range of professional perspectives and will require a coordinated response from all professionals and services involved. Clear co-ordination is also necessary to avoid overwhelming the family or individual and to prevent confusion in the professional network. Intervention strategies need to be congruent with the findings of the assessment. This requires a flexible approach and the ability to match intervention to identified needs. A wide range of formal and informal responses may be needed in any one case to increase the family's ability to offer appropriate care to children. Within the IMRs from CHCP and the GP there is no evidence of communication between the GP and the health visitor or midwife regarding an attendance at the GP surgery by Adult N. It has been a recommendation of a previous local Serious Case Review (Child F 2011) that communication between health visitors and GPs is improved. Information sharing systems are integral to competent safeguarding practice but this not only requires robust systems and protocols, it requires practitioners to simply communicate across organisational and service boundaries. Communication between key health professionals (GP and health visitor) was not evidenced in this review. There remain issues associated with health professionals gaining access to information across agencies and with GP Practices and being sufficiently aware to share it with each other.

4. The previous local SCR completed on Child F in 2011 identified the importance of all agencies working with children and their families to demonstrate how the role of fathers and men in households are considered in service provision and assessments. Ofsted (2010)[21] identified gaps in serious case reviews where "information from or about fathers, whether living at home or elsewhere, and other adults living in the home" might have contributed to a better understanding of the children and their families.

   A previous local serious case review in 2011 recommends "All agencies working with children and their families will demonstrate how the role of fathers and men in households are considered in service provision and assessments. All staff working with children and families should assess the status and role of males and new partners living in the same household".

[20] Reder, P. and Duncan, S. (1999) Lost innocents: a follow-up study of fatal child abuse, London: Routledge
[21] Ofsted (2010) Learning Lessons from serious case reviews 2009-2010, London: Ofsted. www.ofsted.gov.uk/publications/100087

High quality assessments based on a holistic picture of a family are important in order to adequately safeguard children. This case illustrates that, on occasion, assessments made particularly by the GP, midwives, hospital staff and health visitors were not based on full, in-depth information; for example, there was a lack of curiosity about the exact role of Adult P, the extent the health needs of Adult R impacted on her supportive role and the level of attachment between Adult N and Child L. The issue is not just one of recording but also that the appropriate safeguarding culture is in place to ensure that professionals are committed to identifying significant others in a child's life. This is not just a local issue. The Ofsted report (2010) identifies descriptive evidence of the mother's (or female carer's) current parenting capacity was available at respectable levels (high or medium) in 83% of cases. A lower figure of 52% was achieved for information about father's (or male partner's) parenting capacity. However, in 55% of cases in which there was a mother/female carer and 69% of cases in which there was a father/male present, there was little, if any, information about the carer's own developmental and relationship history.

5. Perinatal depression and anxiety affects 15% of women in the antenatal period and 10-20% in the postnatal period[22]. Perinatal depression is a spectrum, with Puerperal psychosis at one end, and mild "baby blues" at the other. But in the middle of these two extremes, many, if not most, new mothers experience profound lows as they struggle to adjust or cope with their changing lifestyle. The true incidence is probably far higher, for postnatal depression is often missed or misdiagnosed. The symptoms of feeling low and despondent, tired and lethargic, inadequate, irritable, tearful and unable to cope, as well as loss of appetite, insomnia and physical symptoms such as headaches and stomach pains are easily explained away by common postpartum experiences such as broken sleep, changes in marital relations and impaired health as a result of the physiological stresses of pregnancy and childbirth. Women are often reluctant or simply too tired to consult doctors, particularly if they expect having a baby to be nothing but a source of joy. Adult N presented to the GP, with Adult R, complaining of feeling "low, tearful and unable to cope". Anti depressants were prescribed by the GP and a blood sample taken which identified borderline anaemia. There is also some description in the record to indicate an unsettled baby.
   Although the symptoms exhibited by Child L are relatively common and mild, the effects on an individual's coping skills in the early postnatal period should not be under-estimated and should be a trigger factor for the offer of additional support.

   It is noted that the GP did ascertain some potentially supportive, protective factors; one key support being Adult R. The GP had a full history of family health problems which could have been used to inform an assessment of the overall support mechanisms within Family M. This information was not considered as part of a holistic picture. There is no evidence that this had an impact in this case. However, there was an opportunity to share this information with the health visitor or midwife to provide a more holistic overview, further assessment and potentially provide additional support.
   Adult N feels that she received limited support from her GP during pregnancy and following Child L's birth and that she was not depressed when she saw the GP and only took one of the prescribed antidepressants. She would have valued more support.

[22] Routine postnatal care for women and their babies. NCCPC 2006

The Government have recently announced that to help identify and support women who may be at risk of postnatal depression every maternity unit in England will have a dedicated mental-health midwife by 2017.

6. The NHS often provides the one setting where adults or children feel able to disclose, and it is, therefore, imperative that the services are aware of the need to provide safe spaces for early identification and prevention of domestic abuse. This Review has highlighted the need to review the use of Routine Enquiry and the recording of significant others. Whilst not an issue in this case, it does identify a gap in service provision which should be addressed. The DoH announced the introduction of Routine Enquiry regarding domestic violence in all health settings within an agreed framework in 2005 (DoH)[23], suggesting all services should now be working towards this goal. Many professional and governmental bodies recommend Routine Enquiry about domestic violence for all women; for example, the British Medical Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Psychiatrists (National Collaborating Centre for Women's and Children's Health, 2008). Screening would be likely to increase the number of women identified as experiencing domestic violence and appropriate support and advice provided or signposted.

   Current Department of Health guidelines state that the successful implementation of policy and guidelines for domestic abuse relies on a comprehensive education and training programme. All staff who have contact with patients should be trained in domestic abuse issues, this includes administrative and reception staff [26.] The Home Office, in its guidance for health professionals, suggests that given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post registration on-the-job training for all health professionals (Taket, 2004) [24]. There is evidence to suggest that the importance and value of Routine Enquiry needs to be reemphasised locally.

[23] Responding to domestic abuse: a handbook for health professionals. Department of Health. December 2005
[24] Should Health Professionals Screen All Women for Domestic Violence? Ann Taket, C. Nadine Wathen, Harriet MacMillan 2004

3.2 TERMS OF REFERENCE

The main source of the evidence in response to the terms of reference is drawn from the IMRs of the health services that had the most relevant contact with Child L, Adult N and Family M during the time period of the review. The section also draws heavily on the conclusions reached in the health overview report. The terms of reference have been combined to reduce repetition of responses. The involvement of the police and ambulance service was after the collapse and/or death of Child L and therefore has less relevance.

1. Examine whether or not Child L's death could have been anticipated or prevented.

9. Examine whether or not there were opportunities for agency intervention that were missed.

There was the potential to promote safeguarding of Child L by providing Adult N with appropriate additional support. The GP had a full history of Adult N, Child L and family health problems which could have been used to inform a holistic assessment of the overall support mechanisms within Family M. This information should have been shared and discussed with other health professionals to inform a more holistic assessment of Adult N and Family M, including the need, if any, for additional support.

3. Examine the agency's involvement with the individual members of the family particularly in respect of any:

3.1. **concern for Child L's welfare which arose from services provided to the family ante and post-natally;**
3.2. **identified causes of stress in family life which might have affected the care provided to Child L;**
3.3. **referral or request for service (including self-referral);**

by analysing in detail any concerns that arose in respect of Child L, her mother or father, or other people living in the family home at the time, and, in particular:

3.3.1 how the concern was dealt with;
3.3.2 the quality of assessment and decision making and how that was recorded;
3.3.3 the quality and relevance of any service provided;
3.3.4 the quality of the agency's child protection procedures and whether or not they were followed;
3.3.5 how Child L's needs and welfare were considered;
3.3.6 how information was shared between agencies.

4. Examine specifically what was known about mother (Adult N) and if there was any evidence to suggest that she might pose a risk to Child L.

Most of the practice evidenced within the IMRs was of the expected and required standard. During the antenatal and postnatal period all the expected health services which are directly responsible for providing care to children and families were involved.

There was no concern about Child L's welfare during the antenatal or post natal period. There is no evidence in any chronology to indicate non-compliance by Adult N and Family M to planned intervention or of "disguised compliance" (Reder and Duncan 1993)[25].

[25] Reder P, Duncan S (1993) Beyond Blame: Child Abuse Tragedies Revisited Routledge: London

The fact that there were no concerns or indicators for future concern about Adult N or Child L is supported by the information that she was assessed to receive the core contacts required within the Healthy Child Programme where increased risk factors are not present and many recognised protective factors were present.

The Healthy Child Programme (Department of Health 2010) is the early intervention public health programme that is at the heart of universal services for children and families. It is part of the Government's Child Health Strategy which has a strong focus on prevention in the first years of life and provides an opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes. The Healthy Child Programme outlines a universal service that is offered to all families, with additional services for those with specific needs and risks.

There were some potential causes of stress in family life which might have affected the care provided to Child L. Some of the issues were known to some professionals involved with the family. Others are difficult to evaluate because of the lack of comment and assessment recorded in records. These include:

- High quality assessments based on a holistic picture of a family are important in order to adequately safeguard children. This case illustrates that on occasion assessments were not based on full, in-depth information, for example, the exact role of Adult P, the extent the health needs of Adult R impacted on her supportive role and the level of attachment between Adult N and Child L.

- The importance of attachment and ensuring that professional contact with the family routinely involves and supports fathers, including non-resident fathers, is noted within the Healthy Child Programme. There was a lack of information and curiosity about Adult P, his relationship with Adult N and involvement with Child L and Family M.

- The assessment of parental–infant attachment is essential as part of the assessment of needs and subsequent intervention for any infant (Howe 2005)[26]. It is of positive note that the emotional health of Adult N was assessed in the antenatal period by both a midwife and health visitor. It is recognised that for some professionals in the postnatal period, parent-child attachment is difficult to assess in a brief snapshot of time. Child L lived for only five weeks so there were relatively few opportunities for assessment. Midwife Z discussed the birth experience with Adult N and Adult P at the first postnatal visit.

- The GP notes in the consultation when Adult N describes feeling tearful and low that she is also "happy with baby". However, within the 9 documented postnatal contacts there is no explicit reference to assessment of the attachment of Adult N and Child L.

- The first three months after the birth of a baby pose the greatest lifetime risk for new mothers in developing mental health difficulties. Management of post natal depression may require more urgent intervention because of its negative effect on the baby, on the woman's physical health

[26] Howe D (2005) *Child Abuse and Neglect, Attachment, Development and Intervention* Palgrave McMillan New York

and her ability to function and care for her family (NICE 2007)[27]. The NSPCC report 'Prevention in mind ', Hogg 2013, identifies that Post partum psychosis affects 2 in 1,000 new mothers which would equate to approximately 10 women in Hull (each year). The report identifies the need for early intervention to reduce the risk of deterioration in the woman's mental health.

On 20th September 2012 Adult N presented to the GP, was assessed as having post natal depression and was prescribed anti depressants. There is also some description in the record to indicate that Child L was an unsettled baby. Although the symptoms exhibited by Child L are relatively common and mild, the effects on an individual's coping skills in the early postnatal period should not be underestimated and should be a trigger factor for the offer of additional support. It is noted that the GP identified some potentially supportive, protective factors. However, consideration was not given to sharing this information with the health visitor and no arrangement was made to follow up Adult N. The Court at Adult N's trial heard that she was experiencing postnatal depression, had gone to see her GP and was given antidepressants. However, due to the stigma she and her family felt about them she had only taken one tablet. As the GP did not ask Adult N to return to assess the impact of the antidepressants or contact the health visitor to request that she contacted Adult N the GP was not aware that Adult N had not taken the prescribed medication.

- Whilst there is no evidence of domestic violence in this case there are issues associated with professionals providing an opportunity for Adult N to disclose if there had been. Routine Enquiry into domestic abuse was asked by the midwife in the ante natal period though not by the health visitor.

- The Housing IMR identifies that Adult N submitted an application for council accommodation on 11th June 2012. At this point Adult N was pregnant and stated in her application that she had been asked to leave her family home.

- The care of Adult N and Child L on the 8th October 2012 after the cardio-respiratory arrest of Child L evidenced within the YAS, Humberside Police and HEYHT IMRs was of the expected and required standard and in many instances provided examples of best practice. There is evidence of multi agency working focused not only on the care of Child L but also on meeting the needs of Adult N, P and family M in difficult circumstances.

5. Examine considerations around ethnicity, religion, diversity or cultural issues that may require special attention.

In their analysis of Serious Case Reviews from 2009-2010, Ofsted found consideration of race, language, religion and culture to be patchy (Ofsted 2010).

The IMRs for each organisation identify that issues related to ethnicity, religion, diversity or cultural issues were considered.

There is only one issue related to the recording of ethnicity in the patient record at GP registration which is confusing as descriptions of the family include White and Black Caribbean which is not

[27] National Institute for Health and Clinical Excellence (2007**)** Antenatal and postnatal mental health. Clinical management and service guidance

included in other records. It has not been possible to establish if this resulted from a recording error which, whilst not significant in this case, in others could influence the care provided.

Organisations involved in this case identify that they give high priority to the equality and diversity agenda and there is evidence to support this. It forms a component of mandatory training programmes for employees of NHS Hull CCG, HEYHT and CHCP.

It is also positive that the HEYHT IMR highlights the sensitivity with which staff attended to the religious needs of Family M after the death of Child L.

Discussions with paternal Grandparents identified however their concerns and distress that they were not allowed to see Child L or to witness the blessing given by the Chaplain that they had requested. The Paternal Grandparents stated that they were told that this was because it was a 'crime scene.' The Paternal Grandparents understood that they would not be allowed to touch/hold Child L. This denied them the opportunity to say 'goodbye' which was clearly very distressing to both of them.

Subsequently Police Officers have met with the Paternal Grandparents to discuss their contact with them during the period that Child L was at HRI. The meeting identified some learning outcomes for Humberside Police which have been incorporated into a number of training programmes including Rapid Response Procedures and Family Liaison Training.

6. Consider the impact of the social, cultural and economic environment in which the family were living and in which the professionals operated.

There is some description of family composition and employment history in records but it is not always accurate or clear and does not appear to form the basis of a comprehensive understanding of the social, cultural and economic environment of the family. There is no documented area within the GP records to note social issues including economic or employment circumstances. Overall, the information contained in all the IMRs in relation to Family M would appear to indicate a greater focus on the assessment of clinical and medical needs with a more limited focus on social circumstances and needs. It is not uncommon within the city for extended family to live with or in close proximity to each other. Thus, it may be easy for health professionals to assume this circumstance denotes a necessary level of support, rather than questioning it further

7. Consider the context in which local professionals work and the extent to which their actions are influenced by the organisations and systems in which they are working.

There is no evidence in the Police, Hull City Council or YAS IMRs of any organisational issues that adversely influenced the care given. There is however evidence that systems in place supported professionals to undertake their roles in difficult circumstances.

In June/July 2011, Ofsted and CQC conducted an unannounced inspection of Hull's safeguarding and looked after children's services. The inspection provides an independent assessment of the performance of children's services and the context in which partnership organisations and practitioners were working.
The overall effectiveness of services in Hull in safeguarding and promoting the welfare of children and young people was assessed as adequate. The Director of Children's Services was found to

provide effective leadership. HSCB was assessed to be well established, fulfilling its statutory duties with the engagement of partners and with good processes in place for consultation with children and young people. Partnerships with the voluntary and community sector were found to be particularly positive and productive. Partner agencies were found to have a clear commitment to securing the safety and well-being of children and to maintaining, within a challenging financial context, sufficient levels of resourcing for front line safeguarding services. (See appendix 1)
The HSCB has a Guidelines and Procedures Sub- Committee on which the Designated Nurse sits in addition to the Named Nurses for the key health provider organisations. Therefore, there is an effective route to disseminate any changes and updates to the HSCB guidelines and procedures within health organisations. There are no issues identified in this review in relation to an absence or inadequacy of safeguarding children policies and procedures. The HSCB has a training policy in place focussing on multi-agency training as recommended in Working Together to Safeguard Children 2010.

All three organisations involved in the provision of health services to Family M have safeguarding children guidelines and procedures relevant to their organisations which are regularly reviewed and are accessible to staff. Procedures are in line with HSCB Guidelines and Procedures.

Information sharing systems are integral to competent safeguarding practice but this not only requires robust systems and protocols. It requires practitioners to simply communicate across organisational and service boundaries. There is evidence of effective communication between professionals but there were issues associated with the GP communicating with the health visitor and midwife.

Consistent findings from studies have shown that tragedies often occur at times of major service re-organisation, staff shortages or lack of resources with practitioners feeling “overwhelmed” (Brandon et al 2010). The NHS and provider health organisations have, over the last three years and continue to undergo, a series of major changes. This does not appear to have had a major impact on organisational capacity in this case although the CHCP IMR does indicate that the two key contacts with Adult N and Child L took place late owing to capacity issues on the first occasion and the impact of annual leave on the second. It is of positive note that CHCP is implementing the NHS Yorkshire and Humber Health Visiting Plan 2011-15 in line with the NHS Operating Framework 2011/12. A four year education commissioning plan is underway which has taken into account numbers of health visitors currently in training, the increase in commissions required to meet the regional four year health visitor target, and the number of potential retirees.

The GP IMR hypothesises that the ten minute consultation period allocated GPs and practice nurses can at times be inadequate and therefore, consultation times overrun. There is no indication that this affected the care given to Family M in this case.

There are some issues related to the provision of training and supervision and auditing outcomes; for example training on Routine Enquiry is provided by CHCP but is not systematic. The training records of the staff concerned with this family indicate that, whilst training has been accessed in the past, it pre-dated the current record keeping process. As such the training is likely to have been provided a minimum of four years ago. Training on Routine Enquiry needs to be systematic and monitored by the management team as with other safeguarding training.

Training on the recording of significant others in families has been incorporated into the Record Keeping Training since 2010 and following an SCR. All staff working within CHCP, Children and

Young People's Services were provided with access to training and three training sessions are provided annually to address new staff. It is noted however that Health Visitor #2 did not attend this training as requested and this has been addressed with her.

An audit of the recording of significant others within the clinical records has not been undertaken by the organisation to date. This requires addressing both in terms of the individual practitioners concerned to establish the quality of the practice of each, as well as across the service to ascertain the scale of this issue. The findings of the audit will be addressed. An audit of significant others will be incorporated into the clinical audit programme to ensure regular review.

8. Take account of any relevant lessons learned from research and from biennial overview reports of serious case reviews and describe how these lessons have been applied to the analysis of this case. Also, any similarities with previous local Serious Case Reviews or national themes, their recommendations and subsequent actions.

In *Learning lessons, taking action* Ofsted identifies that although there have been developments since Every Child Matters[28] there remains a challenge to ensure that effective learning and action results from every serious case review and that all services fully appreciate the role they play in ensuring this happens. This case has been reviewed by IMR authors, overview author and panel by applying the lessons that have been identified in other SCRs by desk top review and by utilising professional knowledge and experience.

There are issues identified in this review regarding:

- The role of universal services in safeguarding children and early intervention.
- The impact of perinatal depression on the effectiveness of parenting.
- The role of fathers and significant others in parenting.
- Early detection and intervention in domestic violence.

There is one recent local SCR that is pertinent to this case. This was the SCR undertaken following the death of Child F (2011). This SCR highlighted the need for those working with children and their families to demonstrate how the role of fathers and men in households is considered in service provision and assessments. This appears to still be an issue and requires further review.

SECTION FOUR - RECOMMENDATIONS

The following recommendations derive from the learning from this review. The recommendations have been agreed by the Hull Safeguarding Children Board Serious Case Review Overview Panel. The recommendations are supported by a detailed action plan which is being implemented by agencies and monitored by the Board's Serious Case Review Sub-Committee.

1. Health practitioners should apply recognised evidence in the recording and information sharing in relation to:

[28] www.everychildmatters.gov.uk/

- The role of significant others within a family and household membership
- The response to Routine Enquiry for Domestic Abuse

Agency with lead responsibility: NHS Hull Clinical Commissioning Group

Impact: There will be effective communication and information sharing between health professionals providing health care and interventions to children and their families to enable appropriate early help to children.

2. Local commissioners and the Local Safeguarding Children Board should work together to ensure that health professionals have access to and receive the appropriate level of safeguarding children training, including wherever practical, inter-agency training.

Agencies with lead responsibility: NHS Hull Clinical Commissioning Group and Hull Safeguarding Children Board

Impact: Health professionals will be able to recognise indicators of safeguarding and child protection issues and take appropriate action.

3. The Named Midwife for safeguarding children will ensure arrangements are in place for midwives to receive child protection supervision

Agency with lead responsibility: Hull & East Yorkshire Hospitals Trust

Impact: Midwives will receive safeguarding supervision that will support them to safeguard children, young people and vulnerable adults.

4. YAS will implement the recommendations resulting from the internal Clinical Case Review within six months.

Agency with lead responsibility: Yorkshire Ambulance Service

Impact: YAS staff involved in responding to the paediatric incident will have increased knowledge of paediatric resuscitation and advanced life support skills, and raised awareness of the process of clinical handover.

Appendix 1 - Ofsted and Care Quality Commission inspection

The Ofsted and Care Quality Commission inspection of Safeguarding services in 2011 identified the benefit from independent leadership and scrutiny brought about by the appointment of an independent chair.

The HSCB has supported change by monitoring the effective implementation of plans to improve services like e-safety and domestic violence. HSCB was also advised by inspectors to:

- Review and strengthen the current HSCB business plan, including arrangements for monitoring core safeguarding activities and the implementation of a multi-agency auditing process.
- Ensure core groups adhere to HSCB Guidelines and Procedures so that individual child protection plans are developed into detailed working tools and that they are meeting sufficiently regularly to monitor actions and outcomes against the child protection plan.
- Introduce annual reporting on the operation and activity of the Local Authority Designated Officer (LADO) to HSCB
- Ensure the evaluation of safeguarding training across children's services monitors the impact of training on service delivery

The inspection recommended that partner agencies should address: threshold issues, timescale compliance, risk assessment, targets and audit, written agreements, strengthening supervision, assessment and analysis and capturing parents' views.

A 'safeguarding improvement plan' was drawn up to reflect the requirements arising from the inspection. Implementation of the plan was overseen by the City Council's Cabinet and the HSCB. Significant progress has been made on these issues (for example, a revised Children's Social Care 'case audit' process, revised safeguarding supervision policies and monitoring arrangements across the 'health provider' family and new guidance for social workers on the use of written agreements

Since the inspection in July 2011, the following work has been undertaken to progress these issues:

- The thresholds guidance has been approved and widely disseminated by HSCB. The dissemination has been supported by a major multi-agency training programme. Both the training and the impact of the guidance on practice and referral outcomes have been evaluated by the HSCB. 'NFA' referral rates have decreased significantly over the period.
- A refreshed HSCB business plan was produced and published in November 2011. Multi-agency 'learning from practice' (auditing) processes have been implemented and HSCB's monitoring framework continues to be strengthened.
- The LADO presented an annual report to the HSCB in January 2012 (and subsequently again in March 2013)
- All HSCB safeguarding training is rigorously evaluated. The HSCB continues to develop more effective mechanisms for evaluating the longer-term impact. One example of this is the work undertaken to evaluate the impact of thresholds training.