Serious Case Review for Child M
6 Step Briefing

The Background

Child M was an 18 week old baby who sustained a catastrophic head injury that led to his death. There had been no prior health concerns and Child M had been growing well and there were no developmental concerns.

Safeguarding Concerns

There was a very intense period around Child M's birth when Mother's mental health was being regularly monitored and supported. After this point, the majority of contact was with Children's Centre staff who had little or no awareness of any concerns and therefore were not in a position to provide support or monitoring of her emotional wellbeing.

The Incident

The circumstances that led to this incident happening are not known. What is known is that on the day of the incident Child M was at home alone with his mother. An ambulance was called by his mother who described Child M as "*unresponsive and he is gulping for air, floppy and struggling to breathe".* An ambulance transported Child M to a local hospital where his condition was severe and once stabilised he was transferred to another specialist hospital, where he subsequently died.

The Review

An SCR Panel of colleagues from Northamptonshire and Milton Keynes undertook this Review and there was good engagement from all agencies involved. The published Cover Report was written by an Independent Clinical Psychologist, Dr Ruth Butterworth. This was deliberate on behalf of both LSCBs to ensure that the author had the appropriate expertise and knowledge to comment particularly on services provided to the Mother in terms of her mental health.

The Findings

* In terms of a clear pathway of support for this family, whilst there was evidence of good practice, there are also many examples of missed opportunities to share information between agencies.

* Lack of professional curiosity and asking more specific / difficult questions to understand the Mother's mental wellbeing and the dynamics of the household.

* The need to understand key perinatal mental health themes.

* Improve record keeping and opportunities to share.

* Safeguarding and thresholds – at least two clear opportunities were missed to make a referral to Children's Social Care with respect to safeguarding concerns in this case.

Northamptonshire Safeguarding Children Board

Recommendations

1. There is a need for a clear pathway of support for parents with perinatal mental health difficulties that recognises the considerable skills of a range of practitioners and integrates these to ensure the family's needs are met in a holistic way.

1a. A workforce competency model should be developed as part of the pathway that specifies the skills, knowledge and practice expected of each professional. This should be complemented by a package of multi-agency training.

2. Local Clinical Commissioning Groups (CCGs) should consider working towards provision of a specialist multi-disciplinary Perinatal and Infant Mental Health Service with dedicated staff who can develop the specialist knowledge and skills required to respond flexibly to the needs of parents, infants and families in this vulnerable period.

3. All agencies should ensure that their staff are aware of the importance and mechanism for escalating the need for a multi-agency safeguarding strategy meeting through the prescribed channels if this does not take place within a timely manner. Wherever possible, safeguarding training should take place in a multi-disciplinary context to facilitate awareness of shared responsibility.

4. Each agency involved in the SCR should complete a quality assurance exercise against the recommendations from their individual IMR, to ensure that changes in practice have been implemented and maintained effectively.

Good Practice and Evidence as a result of this Audit and similar Reviews

The GP practice has developed a regular Practice Multi Disciplinary Team Meeting with Midwives and Health Visitors specifically to share information in relation to vulnerable families. These meetings are already in place in various GP practices across the county.

The Children's Centre now has leaflets regarding Perinatal Mental Health on display in order to make it clear to parents that this is something for which they can seek support from Children's Centre staff.

The Police plan to implement a review with staff in the Force Control Room to ensure that similar cases are treated with sufficient seriousness and appropriate safeguarding referrals made. This is part of mandatory training and the compliance with this training is being monitored and improved.

The Police have improved their procedures and guidance to ensure that the safeguarding of siblings is a priority action for Investigating Officers.

The Maternity Service will now use a summary of this case as part of the Safeguarding Training for Midwives to re-emphasise the need for every practitioner to take individual responsibility for making a safeguarding referral.