

Northamptonshire and Milton Keynes
Safeguarding Children Boards

Cover report

Into the Serious Case Review relating to

Child M

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1. Introduction

1.1 Who was Child M?

1.1.1 At the time of his death Child M was an 18 week old boy who lived with his married parents and three and a half year old sibling in a detached house situated in a village location.

1.1.2 Child M was born in hospital by caesarean section. Apart from a minor infection immediately post-birth, he had no significant health difficulties prior to the events that precipitated this review. He was growing and developing well and there was no reported evidence of abuse or neglect prior to the events at the end of his life.

1.1.3 Child M was a regular presence at his local Children's Centre with his mother and older sibling, and was described as a 'smiley happy baby' by those who came into contact with him there.

1.2 Brief summary of the circumstances to which this review relates

1.2.1 This review was triggered by the death of Child M. In the early afternoon of the 29.03.2014 Child M and his mother were at home alone in the nursery, while his father and older sibling had gone swimming. An ambulance was called by his mother who described Child M as *"unresponsive and he is gulping for air, floppy and struggling to breathe"*.

1.2.2 An ambulance was dispatched and the crew found Child M cold and not breathing, with evidence of cardiac arrest and possible fitting. They provided CPR and then transferred Child M to the local Emergency Department.

1.2.3 An examination by doctors in the Emergency Department revealed that Child M was in very poor health. The cause at this point was unknown but doctors identified that there were significant indicators of a possible non-accidental injury (NAI). Child M was then transferred to a specialist neurosurgical centre with Paediatric Intensive Care Unit (PICU) provision where the likelihood of NAI was eventually confirmed.

1.2.4 Child M's condition was very poor when he arrived at the specialist PICU and continued to deteriorate. On the 30.03.2014 the decision was made to take him off the ventilator and allow him to die more comfortably. He eventually passed away on the afternoon of 31.03.2014.

1.2.5 It is not the role of this Serious Case Review to establish culpability for the death of Child M. However, in Police interview following his death his mother acknowledged having shaken her son on more than one occasion, and she was later convicted of his manslaughter. As such, the review will work on the premise that she inflicted the injuries that led to his death.

1.3 Report format

1.3.1 At the beginning of his report, Section 2 outlines the process of the Serious Case Review as it has been conducted over the past two years, and the mechanisms used to ensure that it provides a robust learning opportunity.

1.3.2 Section 3 provides an overview of Child M's life and the contacts between his family and a range of professionals. Section 4 then covers the timeline of Child M's life in more detail. This is separated into two distinct areas – the period of Child M's life (and significant family history), and the short period between his injuries and his death, when a different set of agencies were in contact with the family.

1.3.3 Section 5 synthesises evidence from the timelines and from the Individual Management Reviews to provide an analysis of the key areas of professional involvement.

1.3.4 Finally, Section 6 draws out some of the themes that emerge from the analysis, including examples of good practice, missed opportunities and lessons learned. The themes are then translated into the conclusions and recommendations in Section 7.

2. The Process of the Serious Case Review

2.0.1 The Northamptonshire Serious Case Review (SCR) Sub Group met on 1st May 2014 and recommended that the threshold had been met to necessitate a Serious Case Review under Section 4 of the Statutory Guidance *Working Together to Safeguard Children* (2013).

2.0.2 This recommendation was endorsed by the Independent Local Safeguarding Children Board (LSCB) Chair following a meeting with representatives from Milton Keynes LSCB on 14th August 2014.

2.0.3 This SCR is being led by the Northamptonshire SCB because the family are a Northamptonshire family. Some of the agencies involved with the family are located in Milton Keynes. It was therefore agreed that this SCR would be completed as collaboration between the Northamptonshire and Milton Keynes Safeguarding Children Boards. The final report is to be published as a joint report by the two LSCBs.

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The role and function of a Local Safeguarding Children Board is set out in law by *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*. Regulation 5 requires the LSCB to undertake a review in accordance with guidance set out in Section 4 of *Working Together to Safeguard Children* (2013 and 2015). The mandatory criteria for carrying out a Serious Case Review (SCR) include where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

2.1.2 Child M sadly died of a suspected non-accidental injury and his mother was charged with murder, and therefore at least one incident of child abuse is assumed to have occurred. Questions have also been raised about Mother's mental health needs, how these were met and the impact that this might have had on the events that resulted in Child M's injuries. As such, a Serious Case Review was considered warranted.

2.1.3 All Serious Care Reviews must result in a published report which summarises the findings of the review. This Cover Report, summarizing the findings of the SCR, will be sent to the Department for Education for publication once it has been ratified by both the Northamptonshire and Milton Keynes Safeguarding Children Boards.

2.1.4 The author is aware of the sensitivity of the information in this report, and the distress that it may cause to family members. There has been an attempt to balance the need for local services to learn lessons from this report, and the need to manage the distress of Child M's family and those who knew him. All personal information is anonymised and pseudonyms are used to refer to the key family members.

2.1.5 This report inevitably only provides an overview of Child M's life and the circumstances leading up to his death. A great deal of more detailed information was collated for the purposes of the review in order to create a rich picture from which to draw learning.

2.1.6 The purpose of a Serious Case Review is to allow for an honest appraisal of practice while recognising the complex circumstances in which professionals are working. It seeks to understand the role of all agencies involved with families, the focus of their work and any strengths or limitations in the ways in which they ultimately acted.

2.1.7 LSCBs are permitted to use any learning model which is consistent with these principles. Having decided to undertake a serious case review to look at how well agencies were working together to support Child M and his family it was decided to implement the systems methodology using a blended approach, taking elements of the process and coverage set out in *Working Together 2010* and combining this with the focus on learning and public accountability encouraged in *Working Together 2013 and 2015*. This has been done to build on current arrangements and experience of obtaining a secure chronology and robust individual analysis through the provision of detailed IMRs from each involved agency, but increasing the involvement of practitioners and encouraging ongoing reflection and learning as part of the process of the Review.

2.1.8 A key principle of the blended methodology is the engagement of frontline staff and managers in conjunction with members of LSCB Serious Case Review Panels or Sub Groups, Designated and Specialist Safeguarding staff, etc. The involvement of frontline staff and managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

2.1.9 The purpose of conducting a Serious Case Review is not to apportion blame or criticism to individual practitioners or the agencies for whom they work. The focus is on an open and transparent reflection on practice, with the aim of generating learning and improving inter-agency working. Practitioners are encouraged to reflect on their thinking at the time, with a recognition that they may see events differently with hindsight. They are also empowered by the SCR process to reflect on the system as a whole and how this may have contributed to their own practice at the time, for better or worse. It is also crucial that good practice is identified and that any gaps in practice are fully understood and can be responded to.

2.2 Scope and Terms of Reference

2.2.1 The full Terms of Reference and Scope for the Review are attached (Appendix 1). The timeframe of the Review is from 1 January 2010 – 1 April 2014. Brief background information that is relevant to the review is also included, beginning in 2001.

2.2.2 The Terms of Reference were discussed and agreed at the first SCR Panel meeting. They were then ratified by the Independent Chair of the NSCB and thereafter became the instructions to the independent chair and authors about the scope required for the Review.

2.3 The author of this Cover Report

2.3.0 *Working Together to Safeguard Children* (2013) mandated that Serious Case Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. On this occasion, to ensure transparency, and to enhance confidence in the process, the LSCB Chair appointed two independent professionals to lead this Serious Case Review. A third author was later appointed to complete this Cover Report, drawing together and re-analysing the evidence collated by the review (including IMRs, Panel Meeting Minutes and the first draft of the Overview Report).

2.3.1 Dr Ruth Butterworth, DClinPsy – Independent Cover Report Author

2.3.3.1 Dr Butterworth was initially invited to attend the second learning event arising from this SCR, in order to contribute the perspective of a specialist in Perinatal and Infant Mental Health. Dr Butterworth is a Clinical Psychologist working within an NHS Perinatal Mental Health Service. She qualified as a Clinical Psychologist in 2004 and has worked for several NHS trusts and at the Universities of Birmingham and Manchester during her career, specialising in the interplay between parental and child mental health and in supporting a 'Think Family' approach to service delivery.

2.3.3.2 At the learning event in February 2016 the decision was made that it would be helpful for the evidence collated by the SCR to be subject to a re-analysis from the perspective of someone with specific expertise in the nature of Perinatal Mental Health difficulties and their impact. Dr Butterworth was therefore asked to take on this role.

2.3.3.3 She has had no involvement of any kind with either the family who are the subject of this review, or the services who were involved in working with the family. She has never been affiliated in any way with any statutory agency in Northamptonshire or Milton Keynes.

2.3.3.4 The Cover Report consisted of a desktop review and analysis of the Overview Report in the context of the IMR reports and minutes from all previous Panel Meetings. It was completed independently of the initial Overview Report.

2.4 Agency IMR Reports

2.4.1 The NSCB continues to make use of Agency Individual Management Reviews (IMRs) within its blended approach, despite the fact that these are no longer required under Government guidance.

2.4.2 IMRs are completed by professionals within the services who have not been directly concerned with the child or family, been the line manager of any of the individual practitioners, or given professional advice on the case.

2.4.3 All of those preparing the individual agency IMR reports for this review were approved by the professionals engaged in the process and the Independent Chair and Author. Each author held a senior role within his or her agency but was completely independent of the care provided.

2.4.4 The SCR Panel asked the following agencies to contribute to this review:

- The Midwifery and Obstetric services
- Health Visiting Services
- Mental Health Services
- Children's Centre (provided by Action for Children)
- Ambulance Service
- The two hospitals where Child M was treated
- Police Service
- Children's Social Care

2.4.5 Appendix 2 gives an overview of the specific local agencies referenced in this report and the acronyms used to refer to them (although these are also identified on the first introduction in the text). For ease of reading they are referred to by their more generic agency titles within the body of the report.

2.4.6 The NSCB provided a template for each agency report author to utilise. This resulted in a high quality of standardised reports, all of which had a very clear focus in relation to the proscribed Terms of Reference (Appendix 1). Each individual IMR author presented their report to the SCR panel where further exploration and clarification could be provided. The original Independent Overview Report author was also able to contact individual IMR authors for clarification or further exploration of specific themes.

2.5 Practitioner Events

2.5.1 As part of the blended approach, all practitioners involved in the case were invited to a Practitioners Learning Event on the 03.06.2015. Forty-seven front line practitioners were invited to the event, from every agency that provided a service to Child M and his family. The SCR Panel Members, IMR Authors and Lead Reviewers were also invited. On the day, 17 practitioners attended, and engaged in a full and robust discussion of the key events. These valuable contributions were recorded and

helped to inform the analysis in both the Overview and Cover Reports. It was suggested that for such an event in future, a lead-time of 6 weeks would normally be required to guarantee the best attendance from health professionals.

2.5.2. A second practitioners' learning event was held on the 17.02.2016 to address issues that had come to light as a result of Mother's sentencing. This meeting also allowed for the involvement of Mental Health Services (who had been unable to attend the first learning event), which was considered to be a valuable addition given the prominence of mental health concerns with this case. The meeting was attended by seven practitioners representing Mental Health Services, Maternity Services, the CCG, and Community Child Health services, as well as representatives from the two LSCBs. In addition, Dr Butterworth, a Clinical Psychologist specialising in Perinatal and Infant Mental Health, was invited to this meeting to support the exploration of the specific nature of the Perinatal Mental Health issues in this case.

2.5.3 This meeting provided a second helpful discussion where issues around the mental health aspects of this review were clarified and interwoven with the other aspects of provision. This also provided a second opportunity for the wider group of professionals to give their perspective on the Overview Report. This meeting resulted in the commissioning of the Cover Report in order to further integrate these perspectives.

2.6 The Voice of the Family

2.6.1 The Statutory Guidance for completing serious case reviews requires that families should be invited to contribute, and that their expectations and role should be managed carefully and sensitively. At the first scoping meeting it was agreed that parents would be given every opportunity to contribute.

2.6.2 As such, it was considered important for Child M's parents to be invited to contribute. The Crown Prosecution Service (CPS) was consulted in relation to the ongoing investigation and prosecution, and there was an initial agreement that neither parent would be interviewed until these proceedings were concluded. In 2015 the CPS indicated that a plea of guilty to a charge of manslaughter had been entered and at that point they had no remaining objection to either parent being involved in the Review.

2.6.3 The NSCB Business Office wrote to both parents asking them if they would be willing to meet with a Lead Reviewer. Child M's mother indicated that she was not happy to do so. His father initially agreed to contribute, however, he failed to respond to numerous attempts to arrange a meeting and as such it was assumed that he no longer wished to take part.

2.7 Accountability for the Cover Report

2.7.1 The Cover Report author attended the second practitioners' learning event on the 17th February 2016 but prior to this event had no involvement in the review. This

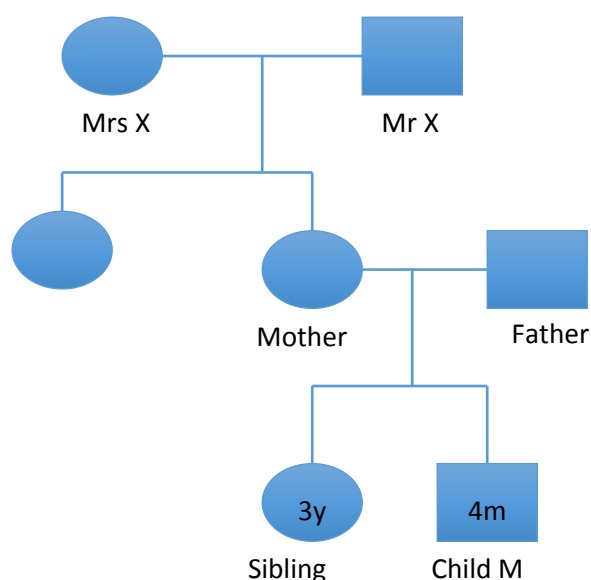
report reflects an independent analysis of all of the evidence provided to the review – including the Overview Report, all agency IMRs and the minutes of all meetings.

2.7.2 While she is responsible for the content and analysis of this report, it reflects the work and perspectives of a number of different professionals all of whom had the opportunity to offer feedback and reflections in order to inform the final draft.

3 Developing a picture of Child M's life

3.1 Genogram

3.1.1 This genogram indicates the family members mentioned within the review, but is not intended to be comprehensive. All titles given here are the pseudonyms used to refer to family members within the body of the report. The ages of the children refer to their ages at the time of Child M's death.



3.1.2 Child M's parents are referred to as 'Mother' and 'Father' throughout this report, to retain an emphasis on the fact that even concerns about their wellbeing as individuals are also being interpreted in relation to their roles as parents.

3.2 Individual Needs

3.2.1 The guidance in *Working Together to Safeguard Children* places appropriate emphasis on the consideration of the individual needs of any child who is subject to a Serious Case Review. In this case, the racial, cultural, linguistic and religious identity of Child M were considered to ensure that any potential learning was reflective of these needs.

3.2.2 Child M and his family are all of White British origin and Child M was brought up within a middle class white British environment. His father worked full time but often from home, and his mother had had a career of her own but was a homemaker during Child M's life. The family appears to have been a close and relatively self-sufficient unit, engaging with services without frequently opening up to those with whom they came into contact.

3.2.3 There was no evidence from any of the evidence presented to the review that issues of race, religion, language or culture impacted on any aspect of the family's care or should have been significant in influencing practice. There was a discussion about

whether Child M's middle class upbringing had influenced practitioners' thresholds for concern, and it is good practice for professionals to question their own motivations where in many cases they shared a common cultural perspective to the family in question. However, there was no evidence identified to suggest that this had influenced decision making in this case.

3.2.4 In summary, there is no evidence that Child M had any individual needs over and above those of any young child of his age.

3.3 'A day in the life' of Child M and his family

3.3.1 Child M lived with his mother and father and three year old sibling in a modern, spacious, detached property. His mother was not working during his lifetime and his father frequently worked at home and was closely involved in Child M's care, with maternal grandparents also visiting regularly.

3.3.2 Other than an infection in his earliest days, he had no known health difficulties. He appears to have been growing well and no developmental concerns were raised.

3.3.3 Several practitioners have identified that Child M was a 'smiley', 'responsive' and 'chilled out' baby. Given that infants' emotional wellbeing is in large part determined by their interactions with primary caregivers (1001 Critical Days APPG, 2015), there is reason to believe that the majority of his experiences of relationships may have been responsive and positive ones. Both Health Visiting staff and those at the Children's Centre noted good interaction between mother, sibling and Child M.

3.3.4 Child M, his mother and sibling frequently attended groups at the Children's Centre where they engaged in singing, story telling and craft activities. His mother was reported to keep him close to her, on her lap or in a bouncy chair by her side. Staff felt that his mother attended the groups to offer a stimulating play experience for her children and it seems reasonable to suggest that Child M would have had a warm, stimulating and enjoyable experience of these events. Staff described Child M's mother as being 'so caring towards him' and his sibling as 'bubbly and confident', 'clever and well developed', suggesting that the sibling had also had rewarding and stimulating experiences with the parents and carers.

3.3.5 Little is known about what Child M's experiences were at home, although his father later reported that he had difficulty feeding and that his parents reported that sometimes he had to be 'forced' to feed. This might be considered to be a stressful experience for both parents and child. When seen on her own, his mother on more than one occasion reported feeling overwhelmed and tearful from lack of sleep. Father later reported his sense that sometimes babies 'cry and cry, they cry so hard you end up wondering what to do'. These instances, in conjunction with Mother's known depression, suggest that at times the family might have felt under considerable stress, and as they are solely reliant on their caregivers for protection this is something that an infant would be likely to be aware of and impacted by (1001 Critical Days APPG, 2015).

3.3.6 There were several references in the IMRs to the family's apparent desire to present as 'fine' and their reluctance to seek support and as such it is hard to be sure what proportion of Child M's time was characterised by these experiences of stress. However, prior to the events that resulted in Child M's fatal injuries, he was reported by his father to have been 'crying on and on' since his immunisations three days previously. This is likely to have been an acutely stressful time both for his parents and for Child M himself.

3.4 Timeline of contacts

3.4.1 Figure 1 presents a summary timeline of the family's contact with services during Child M's lifetime. This makes it clear that this was a family who was relatively visible in the sense of regularly accessing universal services.

3.4.2 What is clear, however, is that 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 is 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.

4 Timeline of key events

4.1 Significant events before Child M was born

IMR Source

4.1.1 Mother received a diagnosis of Depression in 2001 and undertook six counseling sessions at that time.

GP

4.1.2 Parents' older child was delivered in October 2010 by emergency caesarean section.

Maternity

4.1.3 On the 18.11.2010 Mother was diagnosed with postnatal depression and was treated with antidepressant medication. Information from family in the Police IMR indicates that this episode of postnatal depression may have been quite significant and impacted on her initial bond with her first child. She continued on her anti-depressant medication for 2-3 years. It is unclear exactly when this medication was stopped, although one record suggests that it may have been January 2013. She was no longer taking antidepressant medication by the time she attended her booking appointment for the pregnancy with Child M.

GP / Police

4.1.4 At her 'New Baby Review' meeting on the 21.11.2010 the Health Visitor records that Mother is 'a little teary and not really enjoying the early days of motherhood'. However, in a follow up conversation Mother reports feeling 'much better'. At no point during sibling's early years was Mother's diagnosis and treatment for postnatal depression shared with the Health Visitor.

Community Health

4.1.5 During sibling's early weeks, concerns are raised by parents about their response to immunisations and a reluctance to feed. These are common concerns in new parents and are only highlighted here because they reflect similar concerns raised for Child M prior to his death. When follow up contacts were made parents reported that things were now 'fine'.

Community Health

4.1.6 At the age of one year (August 2011) sibling's records are reviewed by the Health Visitor. Child's immunisations were up to date and no notable events were recorded. Parents are sent a letter asking them to make contact if they need support.

Community Health

4.1.7 At sibling's two year (face to face) review in September 2012, their development was recorded as being appropriate and no concerns were raised by parents.

Community Health

4.1.8 At three years of age (towards the end of the pregnancy with Child M), sibling's records are again reviewed by the child's Health Visitor and no concerns are raised. Parents are sent a letter asking them to make contact if they need support.

Community Health

4.2 The Relevant Period of the Review

IMR Source

4.2.1 Mother met with her GP and was referred to the Early Pregnancy Assessment Unit (EPAU) in April 2013 as she had suffered a miscarriage in February 2013 and was now pregnant again. A viable pregnancy was confirmed.

GP / Maternity

4.2.2 Mother had a booking appointment with a Community Midwife on the 02.05.2013. She identified having been on an antidepressant previously but was not currently taking medication and did not wish to. She was asked the Whooley Questions to assess her mental health, which identified that she had been bothered by feeling down, depressed and hopeless in the last month and that she wanted or needed help. She identified that she was 'fine at the minute' as she had a good family support network but might 'require help in the future'. She was advised to see her GP regarding difficulties with sleep. No further action was taken at this time.

Maternity

4.2.3 Mother met with midwives and obstetricians at regular and appropriate intervals throughout her pregnancy. She appears to have attended the majority of these appointments alone as no record of Father's perspective is noted during the antenatal period.

Maternity

4.2.4 On 30.07.2013 Mother met with a consultant midwife to discuss the mode of delivery for this baby. She was reported to feel apprehensive about the birth because of difficulties with her previous delivery.

Maternity

4.2.5 Mother met with an Obstetric Registrar on the 13.08.2013 about the delivery. They discussed her previous use of antidepressant medication and she was reported to have previously struggled with anxiety but to currently be stable in mood.

Maternity

4.2.6 On 01.09.2013 Mother attended an Obstetric appointment where she was reported as being stable in mood, but requested to see the Lead Midwife for Perinatal Mental Health. There is no evidence that a referral to the Lead Midwife was made at this time, or when she saw a Midwife on the 02.09.2013. She later met with her Community Midwife on the 04.10.2013 who appears to have contacted the Lead Midwife at this point with a view to discussing how to cope with potential Postnatal Depression.

Maternity

4.2.7 Mother met with her Community Midwife on the 28th October who recorded that she was due to meet with the Lead Midwife for Perinatal Mental Health later in that week. The midwife offered a referral to the Improving Access to Psychological Therapies (IAPT) service but this was declined as Mother reported that she was coping well. The Community Midwife also reported that she had discussed Mother with the Health Visitor as she would for anyone with a history of depression – although the Health Visiting Service have no record of any antenatal contact.

**Maternity/
Community Health**

4.2.8 The first appointment with the Lead Midwife for Perinatal Mental Health was cancelled and she eventually met with Mother and Father on the 14.11.2013 to discuss her previous postnatal depression and current anxiety. She advised that Mother arrange to see her GP to restart antidepressant medication and gave advice about sleep, diet and exercise.	GP / Maternity
4.2.9 Following this review (on the 20.11.2013) the Lead Midwife for Perinatal Mental Health completed a Confidential Communiqué (a local tool to share information between Midwives and Health Visitors). This recorded that Mother had previously suffered depression following a traumatic event and then postnatal depression, and that she had the information for IAPT if she wished to access that. A postnatal plan is also recorded. On the communiqué she wrote 'copy to midwife to get HV to sign and copy to labour ward file'. However, there is no record in the Health Visiting notes of having received an antenatal Confidential Communiqué.	Maternity
4.2.10 Mother had a telephone appointment with her GP on the 15.11.2013 and was started on antidepressant medication. She reported feeling fine but being able to 'sense it' as she had postnatal depression with her last child. On the 19.11.2013 she saw the obstetric registrar who reported that she was 'feeling better' having started on antidepressant medication.	GP
4.2.11 On the 22.11.2013 Mother was admitted to the labour ward and her history of postnatal depression and current antidepressant medication was documented during this admission process.	Maternity
4.2.12 Later that evening, after approximately seventeen hours of labour, Mother became tearful and anxious about the plan for delivery. An hour later the decision was made to deliver Child M by caesarean section. The caesarean section was straightforward apart from the presence of meconium stained liquor, which meant that Child M had to be monitored for 12 hours after delivery. The family was transferred to the postnatal ward approximately 23 hours after labour had started, at 02.30am on the 23.11.2016. It was again documented in the notes that Mother had a history of postnatal depression.	Maternity
4.2.13 There is a note on the maternity file on the 23.11.2013 to suggest that Mother's antidepressant medication was not prescribed to continue postnatally, although they later state that Mother reports being on antidepressant medication and this is corroborated by the Mental Health Service report.	Maternity
4.2.14 On the morning of 24.11.2013 Child M was diagnosed with an infection requiring intravenous antibiotics. Mother was reported to be unhappy about this decision and felt that she was 'being judged'. She was described as emotional and tearful and agreed for the midwives to contact the Lead Midwife for Perinatal Mental Health. When the antibiotics were discussed with Mother and Father an hour later, Mother reported being depressed and on medication and indicated that she wished to leave the hospital the following	Maternity

day and leave Father with Child M. Midwives were asked to ensure that she was assessed by the Lead Midwife for Perinatal Mental Health prior to discharge.

4.2.15 Mother's mood was monitored regularly over the 24.11.2013 and her mood described as more stable. At 18.55hrs she and Child M were transferred to a side room due to their extended stay. Mother was quite abrupt with the midwife at this point and asked "why are you talking about me" and "I can hear you through the plug sockets". The midwives became concerned that Mother was experiencing a puerperal psychosis and at 20.45 hours the Obstetric SHO was called to assess. The plan at this point was to continue to assess, continue with prescribed antidepressant medication and consider psychiatric review.

Maternity

4.2.16 Mother continued to behave as unsettled throughout the evening, pacing the floor, rubbing her hands and behaving suspiciously towards medication that was administered. She frequently asked to go home. She voiced suspicions to the obstetric SHO about the medication, the midwives, and the noises coming from the radiator, and reported hearing voices. However she denied being in low mood and the doctor felt she was displaying no objective evidence of psychosis and that she was very attentive towards her baby.

Maternity

4.2.17 Given the ongoing concerns, the Psychiatric SHO was contacted at 22.55hrs and a referral made to the Mental Health Hospital Liaison Team (MHHLT). Father was informed and is recorded as saying that he had not seen his wife behave in this way previously. Mother said at this point that 'none of this was about her and she might as well jump out of the window'. At this point Father arranged to stay overnight so that he could look after the baby and let Mother sleep.

Maternity

4.2.18 At 00.10hrs on 25.11.2013 a Psychiatric Nurse from the MHHLT attended the ward to assess Mother. Father is reported to have felt that her difficulties were due to stress and lack of sleep and requested that no direct assessment was completed at that time as it would increase her paranoia, particularly as Child M's antibiotics were also due. He informed the nurse that the antidepressants had been prescribed merely as a preventative measure and that Mother had been fine during the pregnancy. In light of Mother's lack of sleep the Psychiatric Nurse agreed not to attempt to speak with Mother and complete a direct assessment at that late hour but documented in both psychiatric and midwifery notes a plan for Mother to be reviewed by the Lead Midwife for Perinatal Mental Health as soon as possible, to re-refer to a psychiatrist if her mental state deteriorated, and for a referral made to Children's Social Services regarding the concerns. No referral to Social Services was made, either by the MHHLT Nurse or the midwife on duty.

**Maternity /
Mental Health**

4.2.19 Later that morning (25.11.2013) Mother telephoned her midwife requesting a visit. On her arrival, Mother stated that the midwives on the ward had an intercom system in her room and that she had heard them saying that she was 'an unfit mother' and that they 'needed to take her baby away'. The

Maternity

Lead Midwife for Perinatal Mental Health was contacted and spoke to Mother, describing the conversation as 'bizarre'. She telephoned the Postnatal Ward Sister who explained that the MHHLT were on their way to assess.

4.2.20 At 10.15hrs on 25.11.2013 a Specialty Doctor and Psychiatric Nurse from the MHHLT attended to assess Mother, without Father present. Mother denied having heard voices but acknowledged feeling low for 24 hours since finding out Child M was not well enough to go home. She reported some suicidal thoughts but no intention to harm her baby. Her presentation was described as guarded, uneasy and very anxious. The doctor described being concerned that she did not engage well during this assessment. Midwives decided to transfer her back to Labour Ward for 1:1 care because of these suicidal thoughts and a plan was agreed to refer her to a Mother and Baby Unit (a specialist psychiatric in-patient facility for new mothers and their infants) for a specialist assessment and therapeutic plan. At 12.05hrs she was again visited by the nurse and Specialty Doctor who gave her information on the Mother and Baby Unit and prescribed an anti-psychotic medication, which was given within the hour.

**Mental Health /
Maternity**

4.2.21 The Specialty Doctor from the MHHLT later contacted the Specialist Perinatal Practitioner from the Mental Health Assessment and Short Term Intervention (ASTI) service, asking her to join him in a gate-keeping assessment, but she was unavailable. He then made a referral to the Mental Health Acute Home Treatment Team (AHTT) regarding Mother's presentation with 'postnatal depression / psychosis', which requested that if appropriate, plans were made to access a placement in a Mother and Baby Unit. Further investigations followed as to the availability and funding of such a placement.

Mental Health

4.2.22 The following day (26.11.2013) Mother described feeling well in herself, having had a 'blip' because of lack of sleep and apologising for her behaviour. Midwives and Father reported that she seemed to have 'returned to her normal self'. She did not wish to go to a Mother and Baby unit and be separated from her family. The Acute Home Treatment Team (AHTT) assessed Mother at 13.20hrs (with Father present) following the referral from the MHHLT and she was settled in her mental state at this time, reporting that her mood was good and that she had no suicidal thoughts. They agreed to offer an intensive package of support at home as an alternative to admission to an inpatient unit, visiting every 1-2 days. Lead midwives for Perinatal Mental Health and Vulnerable Families and Safeguarding were both informed of this plan.

**Mental Health /
Maternity**

4.2.23 Maternity services provided Mother with a printed copy of her electronic discharge summary to give to the GP and Health Visitor when they visited. There was no mention of the concerns regarding Mother's mental health and MHHLT involvement on the discharge summary.

Maternity

4.2.24 Mother received home visits from the AHTT on the 27/11, 28/11, 02/12 and 04/12/2013, as well as visits from midwives and maternity support staff on the 27/11, 29/11 and 30/11. During all but one of these visits father was present and was described as the 'door guard', vetting visitors to protect his

**Mental Health /
Maternity**

wife. Mother was described as well groomed, with light makeup on and appearing to look rested. Reports from both parents indicated consistently that her she was well and had good support from her husband, and no concerns were raised. Positive interactions were observed between mother and Child M. On one visit (on the 28/11), Father was not present for the first 10 minutes of the appointment. Mother is reported to have immediately asked whether the psychiatric nurse visiting wanted to hold the baby, and placed Child M in her arms 'before she even had the chance to take her coat off'. He remained there for the rest of the visit.

4.2.25 In addition to the face to face visits, Mother also received four telephone contacts from the AHTT, all but one of which were on days where she did not receive a home visit. These were made to Father's mobile phone, which was recorded as being the preferred number to call, and he passed the phone to his wife.

Mental Health

4.2.26 On the 02.12.2013 The Community Psychiatric Nurse (CPN) managing Mother's care spoke with the Consultant Psychiatrist and agreed that as she was settled, they would stop the anti-psychotic medication and continue to review this over the following week. Following the change in medication the CPN made several attempts to make contact with midwifery colleagues over the next two days. She eventually spoke with the Lead Midwife for Perinatal Mental Health on the 03.12.2013 who agreed to a joint review the following day.

Mental Health / Maternity

4.2.27 At some point between discharge from hospital and the 04.12.2013 there was a verbal handover between the Community Midwife and the Health Visitor. There is no record of this conversation, but the Health Visitor recalls being informed that Mother had a possible psychotic episode shortly after Child M's birth. She suggested that she did not receive a detailed description of the episode, that it was presented as more of a 'funny turn' and possible confusional state and that antidepressant medication had been prescribed as a 'safety net'. An alert would have been warranted on the family's records at this point but this was not actioned. The Community Health IMR identifies that good practice would have been to provide a detailed handover including details of the birth, condition of mother and baby, current and planned treatment and care, and names and contact details of additional practitioners. This would also have provided a helpful springboard to discuss these further with Mother.

**Maternity /
Community Health**

4.2.28 A joint review was held on the 04.12.2013 at the family home. Both parents were present, with two CPNs from the AHTT and the Lead Midwife for Perinatal Mental Health. The Health Visitor was not invited to this appointment. Mother reported feeling 'okay' and experiencing no hallucinations, depressive feelings or suicidal thoughts. She had not noticed any significant changes following the withdrawal of the anti-psychotic medication and continued to take her antidepressant. The plan at this point was to continue to review by telephone with the aim to discharge from AHTT the following week and from midwifery care the week after.

Mental Health / Maternity

4.2.29 The family's Health Visitor also visited the home on 04.12.2013 for a new birth visit. She was unaware of the meeting with midwifery and the AHTT that had taken place that morning, and Mother and father did not mention it. The Health Visitor described Mother as 'a bit blunted and passive' and wasn't sure that she said 'anything much' during the visit. She asked both parents about the events in the hospital but described them as seeming to 'gloss over' these, which she interpreted as related to embarrassment. She was concerned about the lack of discussion around these issues, and about Mother's withdrawn presentation, so arranged a follow-up visit for the following week.

Community Health

4.2.30 The AHTT telephoned Mother on the 07.12.2013 where she shared no concerns and was able to identify no ongoing role for the AHTT. They agreed to follow up again at a home visit on the 11.12 but this was never actioned as a telephone call was made on the 10/12 and a message left that was not responded to. On the 11.12.2013 a discharge summary was sent to the GP which summarised the AHTT involvement and asked the GP to monitor and refer to the Assessment and Short Term Intervention (ASTI) service for assessment if needed.

Mental Health

4.2.31 Mother had a telephone consultation with the GP on the 11.12.2013 and reported 'poor sleep and struggling to cope'. She was seen by a colleague the same day because of the concerns identified in the AHTT letter requiring prompt follow-up if under stress. No changes were made to the care plan at this point. It was noted that Mother was not keen on accessing psychological therapies.

GP

4.2.32 The Health Visitor cancelled her follow up meeting on the 10.12.2013 due to sick leave. When she returned to the office she telephoned the family to re-book and left an answerphone message, asking Mother to contact her to arrange another appointment. Neither parent contacted her to re-book and the Health Visitor did not follow up this lack of contact any further.

Community Health

4.2.33 On the 15.01.2014 Child M was brought to the Child Health Clinic by his mother for his 6 week check. There were no concerns raised at this appointment. The Health Visitor had a discussion with Mother for approximately 30 minutes and observed that she handled Child M appropriately and interacted well. She did not complete the Whooley questions to assess Mother's mood at that time because she believed Mother to still be under the care of the Mental Health service and therefore felt that this would be redundant.

Community Health

4.2.34 On the 22.01.2014 a joint visit was undertaken between the Community Midwife and the Lead Midwife for Perinatal Mental Health. Following this visit she was discharged from midwifery care.

Maternity

4.2.35 Mother did not attend the Children's Centre between the 04.03.2014 and the 25.03.2014 (3 weeks) despite having attended the Children's Centre with her children once or twice a week since pregnancy. However, Children's Centre staff were not aware of any concerns about Mother's mental health and

Children's Centre

as such this did not result in her absence being flagged and investigated / support offered (by phoning the parent or contacting the Health Visitor) as it would otherwise have done.

4.2.36 Child M visited the Baby Clinics in two locations on at least five occasions in his early months, for weighing and for his immunisations. He was seen by a health professional on each occasion but no other information is recorded about these visits.

Community Health

4.2.37 Mother attended the Baby Clinic again on the 05.03.2014 to have Child M weighed. She spoke with a different Health Visitor who described her as 'not particularly friendly' and 'giving a lot of one word answers', although she was able to share her worries about Child M waking frequently. Mother was described as handling Child M appropriately but not speaking much to him. This Health Visitor was concerned that she had not been able to help sufficiently, so went to ask for advice from her team leader. In the meantime, Mother left the clinic area and went to the waiting room. She was found by the Administrative Assistant in a distressed state and having been crying. She stated that she 'felt unsupported' and 'had never asked for help before'. She asked to go to a quiet area and explained some of her concerns to the Assistant until the Team Leader entered the room and took over.

Community Health

4.2.38 The Team Leader described Mother as 'a bit upset but...not distraught. She did seem tired'. Mother explained that she felt Child M might be unwell as he was being a bit demanding and not sleeping. The Team Leader did not see any evidence of Child M being unwell and they spoke about sleeping and feeding and broader issues. Mother acknowledged that she was tired and didn't cope well with lack of sleep. The Team Leader asked what she could do to help but Mother was unsure and 'not forthcoming'. Mother described feeling better and a plan was made for the Team Leader to telephone her two days later to review.

Community Health

4.2.39 The Health Visiting Team Leader reviewed the notes before telephoning Mother on the 07.03.2014 as planned. There was no Mental Health Alert on the file and as the electronic file only displayed the previous three months the issues in hospital were not immediately visible. During the phonecall, it was not clear who else was present. Mother said that she was much better, that Child M was sleeping and therefore they were all fine. She was offered a home visit but declined this.

Community Health

4.2.40 Mother contacted her GP on the 10.03.2014, as she was anxious about running out of antidepressant medication. A face to face appointment was arranged for the 13.03.2014 to review. She described being anxious about her husband being away, and about starting a course later in the year. She scored below the cut-off for depression on the PHQ-9 and in the moderate range for anxiety on the Gad-7 and they agreed to refer her for CBT via the IAPT service. Her parenting was reported as good in the meeting with no concerns raised. She was later offered an appointment with the Increasing Access to Psychological Therapies (IAPT) service on the 17.03.2014 but failed to attend.

GP

4.2.41 The Health Visitor who had seen Mother previously in clinic met her again on the 26.03.2014 when he had had his third set of immunisations. She spoke briefly with Mother and recalled that every question was answered with 'Fine, thank you, everything is fine'.	Community Health
4.2.42 On the 27.03.2014 Mother failed to attend a physical health check at her GP surgery.	GP
4.2.43 On the 28.03.2014 Mother, Child M and sibling attended the Children's Centre where no concerns were recorded.	Children's Centre
4.2.44 On the 29.03.2014 the ambulance service was called by Mother to attend to Child M at home. In later history taking Child M's parents gave a history of him being irritable and not himself since his recent immunisations and suggested that he had been feeding poorly for more than a week. During his last feed Child M had suddenly become unresponsive, curled up into a ball with some possible shaking movements and then become pale and floppy with reduced breathing. Mother had called the ambulance and started mouth-to-mouth resuscitation.	Ambulance Service Hospital A
4.2.45 Child M was taken to Accident and Emergency at Hospital A by ambulance and once stabilized was then transferred to a Specialist Paediatric Neurosurgical service at a second hospital some distance away (Hospital B). His parents did not travel with him to the second hospital but did visit soon afterwards.	Hospital A
4.2.46 The Consultant Paediatrician at Hospital A appropriately contacted Children's Social Care and the Police because of concerns about the possibility of Non-Accidental Injury (NAI) although at the time this was not confirmed.	Hospital A
4.2.47 On the 30.03.2014 both Parents agreed with doctors' decision to take Child M off the ventilator in his best interests. They described feeling too distressed to stay for this undefined period as he died and therefore said their goodbyes at this point. Child M died on the 31.03.2014 at 15.48. He had been made comfortable during his final hours and nursing staff had remained with him, holding his hand as he died.	Hospital B

4.3 Timeline of events at the end of Child M's life

4.3.1 Limited information from this period has been included in Section 4.2 because very little of it refers to Child M himself or directly impacted on his experience. There is, however, important learning to be gained here both with respect to the functioning of systems as a whole and in relation to the management of sibling's care in the aftermath of Child M's injuries.

4.3.2 29th March 2014

4.3.2.1 At the point where the Ambulance service transferred Child M and his mother to hospital they also called the Police to inform them that Child M had suffered a cardiac arrest. As the incident was referred to as a cardiac arrest and no injury was specifically mentioned the call was logged and then closed rather than followed up.

4.3.2.2 At approximately 13.45 Child M arrived at the hospital Emergency Department at Hospital A by ambulance with his mother. Father soon arrived. The focus on admission was to resuscitate and then stabilise him as he was in cardiorespiratory arrest. A number of potential diagnoses were held in mind at this point including Non-Accidental Injury (NAI). At approximately 17.00 he was taken to theatre for stabilisation prior to being transferred to a specialist neurosurgical unit. The Consultant Paediatrician also requested that the nurse contact the local Children's Social Care department and inform them of his admission. Children's Social Care confirmed at this point that the family were not known to them.

4.3.2.3 At 17.15 a verbal report of the CT scan showed acute bleeding on the brain. At 18.00 the Consultant Paediatrician met with Child M's parents with nursing staff present. They were asked if he had sustained any injuries and said that he had not. The doctor informed them of the concerns about possible NAI and explained that this would be referred to Children's Social Care and to the police. Two nurses remained with the family and supported them as they were very distressed.

4.3.2.4 At 18.15 a verbal referral was made to Milton Keynes Children's Social Care and to the police. At that point the priority was to stabilise Child M so the written paperwork was not completed until 18.35, shortly after his care was transferred over to the team transporting Child M to the other hospital. Both Children's Social Care and Police later praised the Consultant Paediatrician for giving a clear picture of potential NAI.

4.3.2.5 Shortly after the verbal referral was made to Milton Keynes Children's Social Care, it was established that Child M was a Northamptonshire child and as such the Social Worker passed this message to Northamptonshire in a timely manner, also forwarding the written referral once it arrived.

4.3.2.6 There is confusion within the accounts about what was known and communicated by Children's Social Care, the Hospitals and Police at different points. The Northamptonshire Police IMR clearly indicates that the police knew on the 29.03.2014 that the injury to Child M was believed likely to be an NAI. Children's Social Care reported having struggled to get through to either hospital (although there was no specific record of their calls) and instead relied upon Police information because of their existing close links. However, despite these links, Children's Social Care staff appear to have believed that NAI was not a strong possibility until the strategy meeting on the evening of 30.03.2014. As such they took no further action on the 29th.

4.3.3 30th March 2014

4.3.3.1 Both parents spent the afternoon of 30.03.2014 at Child M's bedside at Hospital B. Compassion and support was provided to parents at this time - there was a blessing performed by the chaplain and they also spoke with bereavement services; and discussions took place with the on call psychiatrist about pathways for supporting Mother if needed.

4.3.3.2 At 16.20 the decision was taken to withdraw intensive care. At 17.00 parents explained that they were too distressed to stay as he was removed from the ventilator, that they had said their goodbyes to Child M and did not want their last memories to be of him dying. They did ask to be informed of when care was withdrawn and what happened afterwards. Father telephoned for an update at 19.15 and was telephoned at 20.00 once Child M had been taken off the ventilator to inform him that Child M was breathing by himself.

4.3.3.3 At 14.10 on 30.04.2014 the handover notes within Children's Social Care indicate that medical staff are still not giving a clear assessment of likelihood of NAI, although Children's Social Care are aware that police have already treated the parents' home as a potential crime scene. There again appears to be a discrepancy in understanding here. Children's Social Care records indicate that at 16.56 Police informed Children's Social Care that they were transferring the case to the homicide team as Child M was not expected to survive and that at 17.30 Police notified Children's Social Care that an NAI was most likely.

4.3.3.4 At 18.30 the first strategy meeting was convened between the Consultant Paediatrician, Children's Social Care and Police. The paediatrician indicated that her understanding was that when Child M left the Hospital A there were already sufficient concerns to indicate a strong possibility of NAI. The Social Worker disputed this suggesting that NAI as 'most probable cause' was only indicated to her at 17.30 on 30.03.14.

4.3.3.5 As a result of this strategy meeting Section 47 enquiries were initiated with respect to both Child M and his sibling. Sibling was taken to Hospital A as a place of safety and to be examined, with a child protection medical examination arranged for that night and skeletal survey the next day. Staff on the ward were informed that a Social Worker would be accompanying the parents and child with a clear plan of care. Sibling was admitted at 21.00 hours with Father and grandfather. They believed that Sibling would be going home with them after the examination, but the nurse had to inform them that this was not what the nursing staff had been advised. At 23.00 the Social Worker arrived and the medical was carried out at 23.30 hours, following which Father stayed at the hospital overnight with sibling under observation from nursing staff.

4.3.4 31st March 2014

4.3.4.1 At approximately 08.30 there was a MASH strategy discussion. There was no record of additional information being added at this meeting, or of the previous meeting's actions having been reviewed. At this point the case was transferred to the Joint Child Protection Team (JCPT).

4.3.4.2 At 09.15 Father telephoned Hospital B to check on Child M's condition and was informed that Child M was still alive. He suggested at this point that he would visit later in the day but this ultimately did not take place because of other events.

4.3.4.3 At 09.40 Sibling attended for a skeletal survey, accompanied by Father and at 11.40, the Consultant Paediatrician saw sibling with the parents on the ward round. He explained that the results of the medical examination had been normal but that the skeletal survey may take some time. The Consultant informed them that Child M was still alive although he was expected to die later that day. The attending nurse recalled that Mother was not aware that Child M was still alive and was very upset at hearing this. Father was aware and had not informed her because he did not think that she would have been able to cope with this after she had said her goodbyes.

4.3.4.4 Shortly afterwards, police came to Hospital A to arrest Mother. She agreed to this, saying 'Yes, that is fine'. Father went to make a statement and Mr and Mrs X returned to be with sibling. They were overheard saying that Mother had asked for help and 'why hadn't they helped her'.

4.3.4.5 At 11.53am there was a third strategy meeting held between Children's Social Care and the Police, again without health representation.

4.3.4.6 At 13.00 the Named Doctor for Child Protection at Hospital A telephoned the Social Worker for an update and was informed that they were going to court to request a foster care placement for sibling. The doctor asked that this was completed the same day for sibling's own benefit and also because sibling was inappropriately placed in a medical bed.

4.3.4.7 Child M was pronounced dead at 15.48 at Hospital B. Senior nursing staff had been present with him throughout the day and one was holding his hand until he died. Hand and foot prints were taken following his death and put in Child M's notes for his parents.

4.3.4.8 At 15.15 and then at 17.45 nursing records from Hospital A note that they have telephoned the Social Worker for an update as they had received no information about plans for sibling. They were told at this point that plans for foster care had been agreed but there was no foster carer available so it was agreed that sibling would spend another night on the ward.

4.3.4.9 At 18.30 nurses at Hospital A were given the information that no family members were allowed to stay overnight with sibling. They asked the Social Worker to inform the family of this change of plan but it is unclear whether this happened. At 23.50 the police officer on duty in the hospital telephoned Children's Social Care to clarify visiting arrangements and had to inform the family that they could not stay. Sibling was distressed by this but did eventually settle to sleep.

4.3.5 1st April 2014

4.3.5.1 There is a potential discrepancy in the notes in that at 13.00 the Social Worker notes indicate that she attended Hospital A to visit Father and Sibling to discuss the foster care plans, whereas the nursing staff reported that they did not see the Social Worker until much later. At 17.05 the Social Worker arrived on the ward to take sibling into foster care. Nurses did not feel that this was handled sensitively; suggesting that the Social Worker did not respond with warmth and that the process felt rushed and not managed well. The nurse and play specialist who had a relationship with sibling were able to facilitate this process but it would nonetheless have been a distressing experience for Sibling.

5 Analysis of Practice

5.0.1 This analysis is divided into four core areas where contact with professionals from a range of services had an impact on Child M and his family. Examples of good practice and missed opportunities are both noted.

5.1 The role of physical health care professionals throughout Child M's life

5.1.1 Lack of communication presented a missed opportunity even before Child M was born. His mother's diagnosis of postnatal depression following the birth of his older sibling was not passed on to the Health Visitor at that time, meaning that Mother does not appear to have received any additional support during sibling's early life, and that she was not flagged as vulnerable from a Health Visiting perspective when pregnant with Child M.

5.1.2 It is unclear from any of the IMRs exactly when Mother stopped her antidepressant medication, but it would appear that this coincided with the pregnancy immediately prior to that with Child M, which unfortunately resulted in miscarriage. There is no record of the issue of medication having been discussed at the initial GP appointment for the pregnancy with Child M, which was Mother's first contact with this GP. It is common for mothers to decide independently to come off antidepressant medication when they become pregnant because of concerns about the risk to the foetus (Flynn, Blow & Marcus, 2006). Given that Mother's mental health appears to have been stable on this medication since sibling's birth, it might have been helpful for this to continue through the pregnancy with Child M. However, at her booking appointment with the Community Midwife this was raised and she reported not wanting to take medication – it is unclear whether a full discussion of risks and benefits would have influenced this decision.

5.1.3 It was good practice that midwives and obstetricians reviewed Mother's mental health at every appointment during the pregnancy, suggesting that they had a good awareness of the importance of perinatal mental health. After the first appointment she responded positively to two of the Whooley questions, which screen for Mental Health concerns. After that point she tended to report that her mood was 'fine', although she also repeatedly asked to see the Lead Midwife for Perinatal Mental Health. This may have been the first sign of Mother minimising her mental health needs.

5.1.4 Mother was eventually appropriately signposted to the Lead Midwife for Perinatal Mental Health and it was identified as good practice that this midwife was able to spend a lengthy appointment with Mother and Father discussing her mental health and putting together a plan of care. As a result of this meeting Mother also contacted her GP to recommence her antidepressant medication.

5.1.5 The Lead Midwife for Perinatal Mental Health was the first professional to complete a Confidential Communiqué regarding Mother, which included a postnatal plan. There were missed opportunities to do so earlier by midwives and obstetricians, and unfortunately the Communiqué does not appear to have reached the Health Visitor, who was unaware of Mother's mental health issues and was not in contact with Mother in the antenatal period.

5.1.6 When she was admitted to the antenatal, labour and then postnatal ward, it was good practice that Mother's history of Mental Health difficulties was identified and recorded in each set of notes. Throughout the antenatal period and the labour itself, it was good practice that staff were aware of her anxieties about this delivery and were closely involving her in decision making in order to manage this anxiety.

5.1.7 When Child M was diagnosed with an infection Mother became tearful and unhappy and her mental health appears to have deteriorated rapidly from here. Midwifery records document frequent fluctuations, and the Obstetric team were asked to assess before ultimately the mental health team were called. The maternity IMR raises concerns that communication and record keeping between hospital staff was not as effective as it could have been, and that Obstetric staff appear to have taken a back seat in Mother's care once the mental health team were involved.

5.1.8 It was good practice that mother and Child M were provided with a private room once it was determined that they would need an extended stay. This allowed for more privacy, improved opportunities to sleep and for Father to stay and take a more active role with Child M. It was also good practice that when the level of suicide risk was escalated she was nursed on a 1:1 basis to monitor this risk.

5.1.9 The Maternity IMR noted that two opportunities were missed to refer the family for a Safeguarding assessment – at the point where the nurse from the MHHLT first suggested it and when Mother was considered a sufficient suicide risk to require 1:1 care.

5.1.10 The decision making process around discharge happened very quickly given the severity of concerns only a day previously. There is no reason to believe that the speed of discharge had any impact on later events – and indeed, given mother's distress about staying in hospital, it may well have been beneficial for her mental health to return home. However, it is of concern that there is no documented Obstetric involvement in Mother's discharge or liaison between the Obstetric and Mental Health services, particularly as Mental Health Services have gone on to query whether this 'mental health episode' was an acute post-operative confusion, which would have merited further investigation and monitoring in hospital.

5.1.11 Despite the good internal transfer of information about Mother's mental health, the discharge paperwork (designed primarily for the GP and Health Visitor)

made no mention of either her history of postnatal depression or what at that point was described as her acute psychotic episode on the postnatal ward.

5.1.12 While on the ward, the decision was made to offer daily midwifery visits once Mother was discharged. In the end, visits were less frequent and not always completed by a midwife (some were from support staff). While the Maternity IMR appropriately raises this as a concern, in this case there were also frequent visits from the Mental Health AHTT and in practical terms this may have avoided the family being overwhelmed with visitors. It does raise questions about the unique role of the qualified midwife and what additional information might have been gained if those visits had taken place (for example, to assess and support parent-infant interaction).

5.1.13 There were numerous issues with regard of handover of information to the Health Visitor. She was not informed about Mother's depression by the GP following the birth of Child M's older sibling. Although a Confidential Communiqué was generated by the Lead Midwife for Perinatal Mental Health towards the end of Mother's pregnancy with Child M this does not appear to have been received by the Health Visitor. A verbal handover was given by the Community Midwife in Child M's early weeks but this was not recorded by the Health Visitor, who recalled the mental health episode after delivery being mentioned but downplayed.

5.1.14 Although there were failures to communicate with the Health Visitor, the Community Health IMR also identified that she failed to put an alert on Child M's record when she first heard of the events on the postnatal ward. Although these were minimised, she recognised that an alert would still have been warranted at that point.

5.1.15 The Health Visitor was not informed about the Mental Health discharge planning meeting by the Mental Health Team, the Lead Midwife for Perinatal Mental Health or her Community Midwifery colleague. She visited for her New Birth Assessment on the same day as the former had been completed. Parents did not mention this meeting and also played down the episode on the ward. Not only would it have been good practice for the Health Visitor to have been present at this meeting, not knowing about it was also a missed opportunity for subsequent professional curiosity about why parents had failed to mention the meeting themselves. This would have reinforced the Health Visitor's perception that they were down playing Mother's mental health difficulties, and perhaps influenced her later practice.

5.1.16 Despite not knowing about the review meeting, the Health Visitor was sufficiently concerned about Mother's presentation at her own visit that she arranged a follow up visit with the intention of completing a more detailed mental health assessment. She did not, however, put an alert on the file at this point. The follow-up visit was unavoidably cancelled due to the Health Visitor's sickness. When she telephoned to arrange a further follow up visit and received no response, she left a message and relied upon the family to ring back if they wished to be seen. As the Community Health IMR identifies, given the mother's vulnerability this may have been

difficult for her to achieve even if she had not been someone who was known to minimise her own needs.

5.1.17 There was a period of several weeks during December 2013 and January 2014 where Mother was under the care of both Midwifery and Health Visiting services and yet no further liaison occurred. The GP also saw her during this period and again did not liaise with either service. The Health Visitor saw Mother in the Child Health Clinic towards the end of this period but did not formally assess Mother's Mental Health because she believed Mother to still be under the care of the Mental Health team – where both the Midwife and GP knew that she was not. The Health Visitor is clear that, had she known that Mother was no longer receiving this support, she would have been more proactive in trying to maintain contact with this family.

5.1.18 Child M and his mother attended several baby clinics during his early months to be weighed and to have his immunisations. No further details of these visits were recorded. While this is standard practice, it may be that an alert on his file, or other identification of this family by the team, may have prompted more active involvement with the family during these contacts.

5.1.19 When Mother visited the baby clinic in March, it was good practice that the first Health Visitor to see her picked up some concerns about not having met mum's needs and contacted her Team Leader. By now there is a picture that this mother can be hard to read and may resist accessing support for herself, instead focusing on her baby, so to pick up on these cues in a busy clinic environment demonstrates her skill. It was also good practice that there were signs offering parents private space to talk, and that when the administrative assistant came across this mother she gave her access to this space and listened to her concerns.

5.1.20 The Team Leader again listened well to Mother and allayed some of her fears about Child M. She asked Mother about what she could do to help and offered to ring her two days later to follow up, which was good practice and is likely to have meant that Mother felt heard.

5.1.21 When the Team Leader reviewed the notes briefly before her telephone call two days later, there was no alert on the file and no record in the previous three months' notes (which appear on the front of the electronic record) about the earlier mental health concerns. When she telephoned, Mother described being 'fine'. It was good practice to offer a home visit at this point but this was declined.

5.1.22 When Mother met with the GP the following week, standardised assessments of her mental health were used and identified her significant anxieties. A referral to IAPT was agreed, although Mother had been very reluctant to access IAPT previously. In the IMR the GP expressed her frustration that she was unable to access any service other than IAPT for patients with this level of need (although she appropriately identified that the crisis team would have been available if there had been more

serious concerns identified). However, in the discharge paperwork from the Mental Health team the option to refer back to the Assessment and Short Term Intervention Team had been offered should this be needed. This opportunity was missed, although the relative benefits of this potential referral route are unknown.

5.1.23 It was good practice that the Health Visitor who had previously met with Mother specifically sought her out at the immunisation clinic and asked how she was, although Mother reported being fine. This also gave Mother the opportunity to raise any anxieties about immunisations (as she had found these difficult previously) although she did not take this opportunity.

5.1.24 Mother failed to attend a physical health check with the practice nurse at the GP surgery the day after Child M's last immunisations (when he was later reported to have been 'crying and crying') and two days before he was injured. There is no evidence to suggest that this should have been managed differently but it does raise questions about how best patients known to be vulnerable can be tracked and flags raised.

5.2 Role of specialist mental health services in supporting the family

5.2.1 The first involvement of Mental Health Services was by a Psychiatric Nurse from the MHHLT. There was some debate in the process of the SCR about the fact that she attended at 00.10 hours to complete an assessment. While the Mental Health IMR commented that she might have waited until the morning, the maternity professionals were clear that this was helpful as a timely response to their concerns.

5.2.2 At this assessment, the nurse spoke with Father who asked her not to disturb Mother at the late hour as this might have exacerbated her distress. This was an understandable request, although it meant that the nurse subsequently discharged Mother from her team (as is standard practice within the MMHLT at the end of each episode of contact) without having interviewed her directly. The Mental Health IMR asks the question of whether it is possible to assess a patient's mental health without seeing them and whether another plan would have been more effective.

5.2.3 When discharging mother the same evening, the nurse completes a plan which is clear, appropriate and well communicated in the Maternity notes. The final action in this plan is to refer the family to Children's Social Care for assessment given the concerns about potential postpartum psychosis. She did not complete this referral herself, although it is well recognised within the trust that each practitioner holds responsibility for making safeguarding referrals where they are warranted, no matter what time they arise.

5.2.4 Later the same morning, she was re-referred to the MMHLT and a Specialty Doctor and Psychiatric nurse attended. This doctor was one of the few professionals to speak with Mother alone, and he had significant concerns that the delusional beliefs

and hallucinations that she was describing, and her agitated and mistrustful presentation were indicative of a psychotic episode in the context of known perinatal depression. He and Mother agreed that he would investigate the possibility of her accessing a place at a psychiatric mother and baby unit (MBU) for further assessment in an environment that was designed to meet the needs of both mother and baby.

5.2.5 There has been much debate during the SCR process about the validity of this diagnosis and plan of action. Although he was not a Consultant Psychiatrist, there has been a robust assertion from the mental health service that the Speciality Doctor had significant experience in psychiatry and was the appropriate person to complete this assessment. The author of the Mental Health IMR has, however, identified that it would have been good practice for him to consult with the Consultant Psychiatrist before following up on his plan in order to allow for critical reflection and evaluation of decision making, particularly given the vulnerability of the very young infant.

5.2.6 The Clinical Director of the Mental Health service has clearly stated in the IMR that in her opinion the symptoms described were unlikely to have been evidence of a postpartum psychosis. She believes that this was part of a differential diagnosis and was never confirmed. However, the Speciality Doctor made a referral to AHTT as well as setting the wheels in motion to access an MBU placement, suggesting that if this diagnosis was not yet confirmed, there was an intention for it to be confirmed by follow up with one of these specialist teams.

5.2.7 The Clinical Director on the Mental Health Services has suggested that the clinical picture portrayed was more likely to have been reflective of an acute post-operative confusional state (following the caesarean section), in which case it could have been detrimental to transfer Mother to an MBU rather than having her assessed by obstetric staff on the ward. If this were the case, then opportunities were missed to liaise more closely with obstetric staff to confirm the diagnosis and make an appropriate treatment plan. Given that Mother did not have any known risk factors for a post-operative confusional state (NICE, 2010) but did have documented concerns around her mental health, post-partum psychosis appears to have been a reasonable initial diagnosis. It is possible, however, that in the absence of collaboration assumptions were made by both obstetric and mental health staff who may not have had significant experience or specialist training in managing acute and fluctuating mental health difficulties in the perinatal period.

5.2.8 It was good practice that the MHHLT team at this point made a number of parallel plans, including starting a trial of antipsychotic medication, contacting the AHTT for assessment, contacting the Perinatal Mental Health lead with a request for joint working, and exploring options for accessing further assessment at an MBU. The Midwives also arranged for Mother to be moved to labour ward to receive 1:1 nursing care because of the concerns about suicide risk and so that they could observe Mother and Child M together. This would also have been helpful to ensure monitoring of risk to the baby although no specific concerns were identified.

5.2.9 Whatever the 'correct' diagnosis, the Specialty Doctor and Psychiatric Nurse did not make a safeguarding referral at this point, despite having considered Mother to be at sufficiently high risk to warrant 1:1 nursing.

5.2.10 The AHTT became involved at the point when Mother's unusual presentation appeared to have resolved, and it was good practice that despite this, they agreed to offer an intensive period of home visiting in order to monitor her mental health during the high-risk period following discharge.

5.2.11 Father was present at all of the home visits and was seen as very supportive of Mother, acting as a 'door guard' to prevent visitors from causing additional stress. However, opportunities were therefore missed to speak with Mother alone and to ascertain whether her perspective was different when not with her husband. On one occasion, Father was out for the first 10 minutes of an appointment and mother gave Child M to the nurse to hold 'before she had her coat off', seeming content for the nurse to hold him throughout the meeting in a way that was seen as unusual. It may be that an opportunity was missed to investigate this further – gentle prompting might have allowed Mother to acknowledge any ambivalent feelings which could then have been addressed.

5.2.12 The Mental Health IMR did acknowledge the good practice of all of the Mental Health staff in taking a caring approach to their work, using skills in assessing both verbal and non-verbal communication and being flexible to the needs of the family in the way that visits were arranged.

5.2.13 At the point of discharge from the AHTT, Mother had been followed up in the community for eight days of face to face contacts plus a further five days of telephone contacts. During this period neither parent had shared any concerns about her mental health and other than the incident where she handed over the baby, no other concerns had been raised by her presentation. Seven days before discharge the antipsychotic medication had been stopped following a review by the Consultant Psychiatrist and there had been no ill-effects of this withdrawal. The discharge from Mental Health services at this point therefore seems warranted and an appropriate plan was sent to the GP.

5.2.14 There has been some debate within the SCR process about whether Mother should have been reviewed by a Consultant Psychiatrist, either in the hospital or at discharge. In the hospital, due to the acute nature of the concerns it may have been helpful for a consultant to have been approached around decision making, even if this did not ultimately result in a direct assessment. At the point of discharge, the Mental Health IMR is clear that skilled Community Psychiatric Nurses (CPNs) were completing frequent visits in pairs, and consulting with the team Consultant Psychiatrist, and that no concerns were highlighted at any of these appointments. Therefore it is unclear if

an individual assessment with a Consultant Psychiatrist would have had a significant impact on decision making.

5.2.15 It was good practice that the CPN went to considerable effort to contact the Community Midwife and Lead Midwife for Perinatal Mental Health at the point where discharge was being considered. This led to a multidisciplinary meeting with the family which was undoubtedly helpful for shared care planning. However, no information was shared with the Health Visitor and this was a missed opportunity – it should be standard practice for Health Visitors to be informed of the involvement of Mental Health services and aware of the care plan with any family but particularly those with a very young and vulnerable infant.

5.3 Role of the Children's Centre and its integration with other services

5.3.1 The family clearly enjoyed their involvement with the Children's Centre and there are numerous descriptions of Mother, Child M and sibling gaining a great deal of pleasure, stimulation and learning from attending sessions there. The timeline in Section 3 makes it clear that Mother attended sessions at the Children's Centre and appeared to enjoy these even when there were indications elsewhere that she was in some distress – suggesting that this may have been a place that offered something of a 'lifeline' for her and the children. The Children's Centre IMR notes that changes in commissioning arrangements mean that these universal services will now be provided in a different format across the county, and it is imperative that the staff providing these services continue to have the knowledge and skills to engage effectively with families and identify and respond to vulnerability.

5.3.2 The Children's Centre IMR identified some general areas of excellent practice which unfortunately did not result in support for this family because of a lack of communication. The Health Visitor reported at interview having mentioned this family to the Children's Centre but they deny having received any information and did not have any record of this.

5.3.4 The Children's Centre staff described Mother as somewhat reserved, but did not have any concerns about her interaction within the groups. She was described as being focused on playing with her own children and some clear examples were given of positive interactions having been observed. There was a recognition within the IMR that some of the groups were quite large and that therefore without having a specific reason to look out for an individual family, they may not receive much individual attention.

5.3.5 The Children's Centre have mechanisms in place to share information with Health Visitors and referral routes for targeted support, but these were not actioned in this case. This was undoubtedly a missed opportunity – these were staff with whom

Mother had regular low key and supportive links, without Father present, and might have provided an ideal opportunity to share her anxieties if this had been facilitated.

5.3.6 Targeted families also receive an assessment which explicitly explores family support needs, in terms of parents' emotional / mental health, family conflict, supporting participation at the Children's Centre, etc. The evidence from other IMRs suggests that when targeted assessments were completed with this mother on her own, she was more likely to acknowledge her needs, meaning that this could have been an opportunity to complete a holistic assessment and access a range of support for the family.

5.3.7 There was a period of three weeks towards the end of Child M's life where the family did not attend the Children's Centre, having attended once or twice weekly for several months. Had this family been flagged as vulnerable, this would have been followed up, either by liaising with the Health Visitor or telephoning the family directly. While there is no certainty that this period of absence was significant, this may have been another missed opportunity for Mother's needs to be identified and supported.

5.4 Support and safeguarding at the end of Child M's life

5.4.1 Communication

5.4.1.1 Communication is the central concern at the end of Child M's life. A number of examples of ineffective communication meant that enquiries progressed more slowly than they otherwise might have done and that opportunities to safeguard both Child M and his sibling were missed.

5.4.1.2 When the Ambulance staff informed the Police Force Control Room that they had transported a child with a serious unexpected health concern, this was not treated as a safeguarding issue by either the Ambulance service or the Police. There was a delay before the referral was made to the Police and Children's Social Care by the hospital and in this time the house (a crime scene) had been tidied by a neighbour and Child M had been transported to Hospital B meaning that officers had to travel considerably further to commence their investigation.

5.4.1.3 Perhaps the most striking lack of communication in this period was the lack of a strategy meeting for the first 24 hours after the referral to Children's Social Care was made. There was an initial delay in the referral being received because the referrals went first to LA Area 1's Police and Children's Social Care services before being re-directed to the Northamptonshire services. A strategy meeting should have been convened between Children's Social Care, Police and Health services as soon as the referral came in to Northamptonshire, as direct discussion would have clarified the degree to which NAI was considered the most likely cause at this early stage. This would also have allowed for a consideration of how best to safeguard both children. Difficulties arose in this process due to the Police and Children's Social Care being

based in LA Area 2, but all other agencies being based in LA Area 1 or further afield, meaning that pre-existing systems for sharing information were ineffective. There was no health involvement in Children's Social Care planning until the strategy meeting nearly 24 hours later and as well as not having adequate medical information to work with, this also represented a missed opportunity to have observational information about both children (as social workers had seen very little of either child). It was, however, good practice that once the decision was taken to convene an initial strategy meeting, that meeting considered several of the key risks and clear actions were identified.

5.4.1.4 The Children's Social Care IMR raises the prospect of thresholds being too high, if they required confirmed evidence of NAI before they were willing to investigate. If the strategy discussion had not identified sufficient evidence of NAI there could at least have been a clear communication about what action should be taken if and when it was considered a primary diagnosis.

5.4.1.5 There appear to have been several points at which communication between Children's Social Care and Hospital A (where sibling was being assessed) was inadequate and caused distress both to staff and to family members. On numerous occasions it appears that communication between the family and Children's Social Care was facilitated via hospital staff rather than directly, putting hospital staff in a very difficult and vulnerable position and increasing sibling's distress at an already difficult time. There is recognition in both the Children's Social Care and Hospital A IMRs that these processes did not have sibling's needs as their focus.

5.4.1.6 It was good practice that on the 1.03.2014 the hospital's Named Nurse for Child Protection contacted Children's Social Care to escalate concerns about lack of communication and the distress caused to Sibling due to inconsistent management. The Children's Social Care IMR has raised the possibility that this challenging from health agencies and from the police could have been undertaken at an earlier stage and may have helped to clarify the level of concern. As the referring doctor had telephoned for an update and been assured that the referral was 'being dealt with' it seems reasonable to assume that Hospital A believed processes were taking place within Children's Social Care when this was not the case. However, it would have been good practice for other agencies to push for a strategy meeting at an earlier stage so that the extent of concerns could have been clarified within a multiagency forum.

5.4.1.7 It was good practice that staff at both hospitals communicated well and regularly with parents, being mindful of their emotional needs. Conversations between parents and hospital staff were observed by other staff to ensure that accurate information was recorded and that appropriate support could be provided to parents at what was a distressing time. This was clearly also an emotive case for many professionals involved and it was good practice that the lead chaplain in Hospital A facilitated a debrief for all involved.

5.4.1.8 There was very little information in the Children's Social Care case file about what happened in Child M's final hours. No-one from Children's Social Care visited him to determine his care plan or consider whether anything else could be offered to support the family. It was good practice that the hospital staff took hand and footprints for the family to have as a keepsake but no additional bereavement support was provided by Children's Social Care.

5.4.2 Record keeping

5.4.2.1 On the whole, Police, Ambulance and Hospital records during this period appear to have been clear, comprehensive and timely. There are, however, some concerns about the ways in which record keeping and wider communication systems within Children's Social Care impacted on the quality and efficiency with which the case was managed. The way in which information was recorded in Child M and sibling's files was inconsistent and often limited, making it difficult for the IMR author to locate a coherent 'story' for the assessments and decisions that were taking place.

5.4.2.2 There were concerns that because the Out of Hours Team (OHT) did not have a direct line, but instead relied on messages, there was frequently a delay on these being received and therefore acted upon. In this case, there was also an issue with the technical systems which meant that the original written referral for Child M was not passed on for several days, meaning that staff were working with insufficient information. Furthermore, recording systems were such that there appear to have been gaps in communication between the OHT and the daytime team which may have contributed to the fragmented picture.

5.4.2.3 The IMR also criticised the minutes of the four Strategy Meetings for not containing SMART goals, and not following on sufficiently from the minutes of the previous meeting in order to demonstrate a coherent approach to case management.

5.4.3 Cross-border working

5.4.3.1 Overall there has been limited evidence that the cross-border nature of this case has caused significant delay or disruption to the care provided, other than potentially following Child M's injuries. There was some confusion within Hospital A about where to send the original safeguarding referral but this was facilitated well and a message relating to the referral was received in a timely manner.

5.4.3.2 There was something of a delay in holding effective strategy discussions between agencies post-injury and it seems likely that these were exacerbated by the fact that Police and Children's Social Care services were having to liaise with hospital staff from Hospital A and further afield where collaborative working practices were not already established. There was also a query as to whether one reason that Social

Workers were more remote from both children was because of the distances involved in visiting them, and that this might have been a missed opportunity for developing a more detailed understanding of their needs within face to face meetings, and for facilitating multi-agency care planning.

5.4.4 Thresholds and capacity

5.4.4.1 There are concerns raised within the Children's Social Care IMR about the degree to which thresholds and capacity of individual Social Care professionals impacted on the care that they were able to offer. There are references to extremely long days, high levels of work, and variable staffing levels within the Children's Social Care Out of Hours Team in particular. Inevitably when staff are juggling very high levels of work it is more difficult for them to be able to reflect on the work that they are doing and critically appraise their own decision making 'in the moment'. In this case, the IMR author also queried whether it had prevented Children's Social Care professionals from spending as much time in face to face contact with the family and other professionals as they might otherwise have done, particularly because of the travelling distances involved.

5.4.4.2 There also appear to have been issues with regards to the thresholds that were being employed to manage workload. The Children's Social Care IMR identifies that staff were relying on a confirmation that Child M had suffered an NAI before investigating further, rather than focusing on the needs of the child and investigating the potential risk to both children while waiting for this confirmation. Because of this, there was a delay in safeguarding sibling and the child was placed under increased stress by being brought into hospital for a medical late in the evening. There was also a delay in finding a foster placement for sibling, which meant that they spent two nights in a hospital bed despite not being unwell and not having a clear understanding of what was happening.

6 Core themes and learning points

6.0.1 This section explores some of the wider themes that emerged from the analysis. Given the length of time that the SCR has been ongoing, a number of actions have already been taken to address issues raised by the individual service IMRs. This section therefore also provides an overview of some of the actions that have already been taken in relation to each theme. A series of overarching recommendations are then outlined briefly and expanded upon in section seven.

6.1 Lack of a clear pathway to support

6.1.1 *Coherence and continuity: Perinatal Mental Health as ‘Everyone’s Business’ (Maternal Mental Health Alliance, 2015)*

6.1.1.1 All of those who had involvement with the family during Child M’s lifetime demonstrated evidence of good practice. A range of important skills were evident in the IMRs, including Midwives and Obstetricians managing well Mother’s anxieties about delivery and screening for mental health difficulties; the Lead Midwife for Mental Health completing a robust assessment and care plan for Mother; MHHLT and AHHT staff assessing risk, an initially complex presentation and a fluctuating picture and providing responsive management; Health Visitors picking up on non-verbal cues from Mother, assessing and containing Mother’s anxieties when presented, and Children’s Centre staff engaging a parent who in other contexts was seen as ‘hard to get close to’. However, the lack of coordination means that these skills and perspectives were never considered as a holistic picture or package of care.

6.1.1.2 There were numerous examples of GPs not communicating with Midwives, Midwives and Mental Health Services not communicating with Health Visitors, Health Visitors not communicating with each other and no agency communicating with the Children’s Centre. Several opportunities were missed to create a clear, integrated picture of the family’s needs, and the specific issues around engagement, the openness of the family and Mother’s potentially different presentation when alone.

6.1.1.3 Every professional who made contact with this family had a particular set of specialist skills, but too often practitioners relied on others to take a role without clarifying what that role might be. Opportunities were lost to make use of specialist skills because of an assumption that someone else would meet a need.

6.1.1.4 There appears to have been too much reliance on the Lead Midwife for Perinatal Mental Health, who had a special interest but limited specialist mental health training and at the time was also responsible for mothers with substance misuse issues. It was not realistic for her to meet the needs of all women with all levels of mental health difficulty, although her involvement with this mother was very helpful.

6.1.1.5 While the capacity of the Lead Midwife for Perinatal Mental Health has since been increased, rather than relying solely on one practitioner it is important that all staff feel skilled themselves, and have appropriate sources of support and referral, to identify, assess and manage women with mild to moderate mental health conditions in community clinics.

6.1.1.6 When Mother presented as paranoid and agitated on the postnatal ward, it appears from the Maternity IMR that the Obstetrician was called to do a screening assessment, and despite not seeing any objective evidence of psychosis then (appropriately) referred to the MHHLT to assess further. It would appear, however, that after this point Mother and Child M were solely managed between Maternity, the Neonatal team, and the MHHLT and AHTT, and that obstetricians took a back seat. This was questioned by the Clinical Director of Mental Health Services who suspected that Mother may have been experiencing a post-operative confusion rather than a psychotic episode – but the apparent transfer of care to mental health teams was a missed opportunity for the two specialties to work together to complete a holistic assessment and agree a plan for Mother's care both on the ward and afterwards.

6.1.1.7 The Health Visitor also described having completed less formal Mental Health assessment with Mother than she might have done because of an assumption that the Mental Health Team were managing this. While this raises the issue of lack of communication, it also implies that the Health Visitor would have nothing to offer here – whereas, to the contrary, she will have had skills in assessing and promoting parent-infant interaction that members of the AHTT were unlikely to possess.

6.1.1.8 When postpartum psychosis was suspected, there was some confusion around the process for accessing a specialist Mother and Baby Unit placement. This did not impede this mother's care, but clarifying this may have taken up time that could otherwise have been spent on clinical care.

6.1.1.9 Mother repeatedly asked to see the Lead Midwife for Perinatal Mental Health in pregnancy. This may well have been due to this professional's own specific skills but might also be considered to relate to Mother's desire to minimise the number of people with whom she had to discuss her story and perhaps her need to develop a trusting relationship before she felt able to share her vulnerability.

6.1.1.10 Mother also met with numerous staff from two different Mental Health teams over the two weeks between Child M's birth and her discharge from Mental Health services, which may have made it more difficult to share difficult feelings openly.

6.1.1.11 It is unclear whether the lack of information sharing with the Children's Centre related to a simple breakdown in communication, or a concern about sharing information too widely. There is inevitably a need to manage confidentiality and yet in this case the Children's Centre had in place robust measures to reflect on families in need, to take a 'whole family' approach, and to respond to need in a relatively low-key

and welcoming environment. They were also the agency with by far the most consistent engagement with this family. The Children's Centre IMR identifies that the issue of health services not sharing information effectively with Children's Centres is a national issue that has been highlighted in other SCRs.

6.1.2 Professional curiosity and asking difficult questions

6.1.2.1 Mother was variously described by Health Visitors at interview as 'shattered, blunted, passive, tearful, anxious, tired' and 'not someone to draw attention to herself'. When asked, however, both she and Father repeatedly suggested that she was 'fine' and on the whole this was not explored further.

6.1.2.2 Even after Child M's injuries were sustained, Mother predominantly presented as withdrawn and 'blank' rather than visibly upset, further underlining that her level of distress may have not been easy to infer from her visual presentation alone. Although parents always have the right to refuse intervention, given the clear evidence that perinatal mental health difficulties can have a significant adverse impact on children's outcomes (NSPCC, 2011) a family support approach such as the 'Think Family' model must allow practitioners to use their skills and experience to explore any concerns as fully as possible.

6.1.2.3 When more formal assessments were completed – for example, the Community Midwife using the Whooley Questions or the GP using standardized assessment measures, Mother appears to have been more able to identify that she was struggling and seek support.

6.1.2.4 Both the Health Visiting and Mental Health IMRs indicate that when Mother was on her own there were a number of occasions where she acknowledged struggling, although there were several others where she returned to insisting that things were 'fine'. Very few contacts were held with Mother individually, as Father presented as wanting to protect and support his wife, to the extent that it was his telephone through which professional contact was made.

6.1.2.5 It was important and helpful that services were willing to engage with Father and valued his involvement. However, when there was clear evidence that his perspective did not fit with that of professionals (for example, when he reported that Mother had been well in pregnancy when both the GP and midwife knew otherwise), it would have been helpful for professionals to ask questions of their own understanding and consider exploring this with parents. It is not clear whether Father was unaware of Mother's mental health needs; was aware of them but struggled to acknowledge them and therefore played them down; or whether he was trying to present a specific picture to professionals for an unknown reason despite being fully aware of her level of distress. Parents frequently, for example, report feeling concerned about stigma or that their baby may be removed if they acknowledge struggling with their mental

health (Khan, 2015) and this may have impacted on both parents' willingness to express their needs more openly.

6.1.2.6 Little is known about Father in any respect and as such we cannot be sure what impact he had on the experiences of Child M and the outcome of this case. This is reflective of the experiences of many fathers who often see themselves as 'outsiders' within the professional systems surrounding new families (Ganapathy, 2016).

6.1.3 Need to understand key perinatal mental health themes

6.1.3.1 There has been a great deal of discussion during the process of the SCR about Mother's mental health diagnosis, how accurate this was and what involvement it should have predicted. Less attention, however, has been given to the language and themes that were present in her requests for help.

6.1.3.2 It was good practice that the maternity services appear to have taken Mother's concerns about a second caesarean section seriously, and involved her in decision making to improve her sense of control. Other messages, such as 'not really enjoying her baby' when sibling was born, and soon after Child M's birth reporting a fear that people were 'judging her', describing her as an 'unfit mother', or were going to 'take her baby away', may have offered insight into how she was feeling about herself as a parent at that time. There were also references wanting to leave the hospital and leave Child M behind, later played out by her desire to hand him over to a CPN as soon as she arrived.

6.1.3.3 All of these emotional responses are relatively common in new mothers, and particularly so in those who have a depressed, anxious and self-critical perspective on themselves as parents. They paint a picture of a mother who was struggling and who might find it difficult to ask for help for fear of being judged. If professionals had been confident to recognise, name and support Mother to explore these beliefs (as well as sharing them within a multiagency holistic assessment) this may have given her 'permission' to be more open about the difficult feelings that she was experiencing.

Section 6.1 – Lack of a clear pathway to support

Learning that has already taken place

A number of actions have already been taken in response to the concerns raised by individual service IMRs. These include:

- Improvements in the Confidential Communiqué system between Midwives and Health Visitors. This is now available in all clinical areas and can also be sent electronically.
- Plans are being developed to improve the communication between Health Visitors and Mental Health Teams who are employed within the same trust, with a particular focus on Perinatal Mental Health
- The GP practice has developed a regular Practice MDT Meeting with Midwives and Health Visitors specifically to share information in relation to vulnerable families.
- The Maternity Service has improved its systems for managing women with complex needs, introducing a Complex Cases Team within which the Lead Midwife for Perinatal Mental Health can focus solely on this specialty within more clearly defined criteria; thus increasing her capacity to respond effectively.
- The content of Mental Health Training for maternity staff has been reviewed and incorporates developments from the NICE (2014) Antenatal and Postnatal Mental Health Guidelines.
- The AHTT have now developed a flow chart to clarify the process for accessing a bed on a Mother and Baby Unit.
- 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.

Recommendation 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.

Recommendation 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.

6.2 Need for specialist perinatal mental health skills

6.2.1 There were some indications that Mother may have not received optimal care because of a lack of specialist knowledge – for example, she came off her antidepressant medication prior to pregnancy, which may have been because of a lack of access to information about relative risks and benefits. NICE guidelines (2014) now also recommend that specialist psychological therapy is available for parents as an alternative to medication in the perinatal period. Child M was also bottle fed from the outset because of Mother's antidepressant use, which again may not have been the case if she had seen a prescriber with specialist perinatal knowledge.

6.2.2 From the evidence available to the review, it appears that the decision to discharge Mother from the AHTT after 10 days was entirely appropriate given her presentation at that point. However, the Mental Health IMR raises the question of whether there should be another 'step-down' provision available to support patients at the point where they are discharged from the AHTT, particularly during the vulnerable perinatal period. This was echoed by the GP who bemoaned the lack of options for accessing additional support for women who had significant mental health difficulties but were not in acute crisis and were reluctant to attend the non-specialist IAPT service.

6.2.3 The Mental Health IMR author also questioned the relative invisibility of Child M in the Mental Health teams' involvement and whether as adult mental health practitioners it was realistic to expect members of the MHHLT or AHTT to maintain skills in the specific and complex nature of perinatal conditions, and to 'keep the baby in mind'. There is evidence that even when non-specialist services are effectively improving Mother's mental health, this will not automatically address the impact on the child (NSPCC, 2011).

Section 6.2 – Need for specialist Perinatal Mental Health Skills

Learning that has already taken place

The local Mental Health Service are planning to develop the specialist Perinatal Mental Health provision available within their existing structures. In the meantime they are looking to strengthen the role of the Specialist Perinatal Psychiatric Nurse and give her more time to support practice in this area.

Recommendation 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.

6.3 Improving record keeping and opportunities to share

6.3.1 There were several examples of poor record keeping, meaning that it was difficult to maintain a coherent picture of need from the records available. This has been robustly addressed within individual agencies.

6.3.2 There were a number of issues raised in the way that information was formally communicated between agencies. For example, the Confidential Communiqué system was ineffective, the handover between Obstetric and Midwifery colleagues was patchy and the discharge from hospital was incomplete. The IMR process has highlighted these concerns and several improvements in reporting systems have been developed.

6.3.3 When the Health Visitor missed the opportunity to place an alert on Child M's file after hearing of Mother's Mental Health difficulties, this made it more difficult for practitioners picking up the care of the family to see concerns as part of a bigger picture.

6.3.4 At the end of Child M's life a number of opportunities were missed in relation to sharing information. There was confusion about the threshold at which Ambulance and Police Force Control Room staff should consider a referral to Children's Social Care where it was unclear whether a young child's illness was potentially triggered by an NAI. Both agencies have now clarified the importance of making a safeguarding referral for any pre-mobile infant who is presenting with serious and unexpected ill-health.

6.3.5 A number of specific concerns about the way in which information was collated and managed were identified by the Children's Social Care IMR, and a number of specific actions have been undertaken to improve practice in this area.

6.3.6 There is some evidence that assumptions were made about others agencies' actions and that a degree of professional challenge may have been helpful to accelerate the safeguarding process at the end of Child M's life.

Section 6.3 – Improving record keeping and opportunities to share

Learning that has already taken place

A number of actions have already been taken in response to the concerns raised by individual service IMRs. These include:

- The new midwifery Complex Cases team now automatically copies a letter indicating their involvement to all associated agencies following an assessment.
- A new handover system has been introduced on the Maternity Wards where patients are formally reviewed and handed over by medical staff at least twice per day, with an improved electronic recording system for documenting these handovers.
- New discharge paperwork is being developed by the Maternity Service to ensure that a full picture of the needs of both mother and baby are included.
- The Health Visiting IMR proposes a number of potential methods for improving liaison and integrated care, which they plan to investigate. These include:
 - Considering allowing Health Visitors and School Nurses access to some elements of Parental Mental Health records as appropriate (as these are held by the same trust)
 - Improving the use of alerts on Child Health records when either parent has a mental health difficulty
 - Developing Perinatal Mental Health Guidelines for Health Visitors around their roles and responsibilities
- The GP practice has developed a regular Practice MDT Meeting with Midwives and Health Visitors specifically to share information in relation to vulnerable families.
- The GP Practice now also has a specific member of staff to deal with safeguarding concerns to ensure that these are effectively responded to.
- The Named Doctor for Child Protection in the region will present a summary of this case to the local Safeguarding forums, highlighting the benefits of highly organised meetings between GPs, Health Visitors and Midwives.
- The Ambulance Service IMR identifies that the Ambulance crew should have made a safeguarding referral due to the severity of Child M's condition even in the absence of other safeguarding concerns and will clarify this threshold issue with all staff.
- It is now recommended that any case of this type is referred to the Force Control Room in the first instance as a means of coordinating an ongoing multi-agency strategy as this is a 24/7 number.
- 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.
- Children's Social Care plan to review the notifications used between the Out of Hours (OHT) and daytime team to ensure that information is shared effectively.
- Children's Social Care are considering providing a secure email inbox for the OHT so that referrals can be sent directly (in addition to telephone referrals being made).
- Strategy meetings will now be convened using a standard template, which highlights priority areas that must be addressed. The importance of health being invited and participating has also been reinforced within this new template.

Recommendation 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 multidisciplinary context to facilitate awareness of shared responsibility.

6.4 Safeguarding and Thresholds

6.4.1 At least two clear opportunities were missed to make a referral to Children's Social Care with respect to safeguarding concerns in this case. The first of these was when the first member of the MHHLT visited the Postnatal Ward to see Mother and highlighted the need for a referral, and the second was when her suicide risk was considered to be sufficiently high to warrant 1:1 care. In the first of these examples, there seems to have been an assumption between the Mental Health and Midwifery staff that the other would take responsibility for making the referral.

6.4.2 There is no reason to believe that if these referrals had been made, they would have met the threshold for further involvement of Children's Social Care, given that the mental health episode in hospital quickly resolved and no other professionals raised serious concerns. However, they represent missed opportunities for a full picture of the concerns to be drawn together, and to identify a pattern of need that had been evident over a number of years. They also indicate that the needs of the child may have become overshadowed at this point.

6.4.3 Some concerns were raised that the Police failed to act sufficiently quickly to safeguard Child M's Sibling when the investigation was initiated, due to a lack of certainty about the possibility of NAI. Similar concerns were raised about Children's Social Care staff's understanding of the threshold for initiating an investigation where there was an unconfirmed possibility of NAI in a pre-mobile infant. They have both initiated developments to clarify procedure and reinforce the importance of considering the safeguarding of all siblings in a case of this type, as a priority.

Section 6.4 – Safeguarding and Thresholds

Learning that has already taken place

A number of actions have already been taken in response to the concerns raised by individual service IMRs. These include:

- 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.
- The Police have improved their procedures and guidance to ensure that the safeguarding of siblings is a priority action for investigating officers
- Force Control Room Training is being developed to emphasise the importance of identifying risk in all young infants.
- The Children's Social Care Out of Hours Team has undertaken a training needs analysis in respect of each worker to ensure that threshold training is consistent and robust.
- Children's Social Care have issued guidance to staff re-emphasising the need to complete independent investigations based on the safeguarding needs of the child, irrespective of the status of the diagnosis.

7 Conclusions and Recommendations

7.1 Child M died on the 31st March 2014 as a result of injuries sustained while in the care of his mother. It is believed that these were consistent with Child M having been shaken, and his mother later acknowledged this having happened.

7.2 This Serious Case Review paints a picture of a mother who had experienced significant anxiety and depression over a number of years, and had particularly struggled with these issues in the perinatal period. Shortly after Child M's birth, these feelings escalated temporarily to the point where she was voicing persecutory beliefs and becoming agitated – it remains unclear whether this was as a result of a post-operative reaction or an acute psychotic episode linked to her ongoing depression and anxiety.

7.3 It is impossible to know what led to the events on the 29th March when Child M was assaulted, but there is evidence to suggest that he had been unsettled, crying and not feeding well for a number of days. This is an overwhelming experience for any parent, but particularly for a mother who is already struggling emotionally and who has voiced ideas (albeit in a state of agitation) about being seen as an 'unfit mother'.

7.4 It is clear throughout this report that Child M's mother and father both seemed keen to downplay the degree to which Mother was struggling with her mental health. On occasion she would open up to professionals (usually at points of crisis, and when Father was not present), but would soon shut down these conversations and declare that things were 'fine'. Undoubtedly they had their own reasons for doing so – perhaps related to stigma or shame, or to simply preferring to manage as a private family unit.

7.5 It is difficult to know whether any individual agency could have prevented the death of Child M, even if additional support had been offered. Better communication and collaboration would have given agencies a clearer perspective on Mother's needs, and allowed for a more effective package of support to be offered. However, professionals are ultimately reliant on parents agreeing to take up the support available. It is clear that Mother and Father were reluctant to access support, and once the family had left hospital after Child M's birth there were no indicators that Mother's mental health concerns were sufficiently severe to warrant a safeguarding assessment or mandated intervention of any kind.

7.6 This SCR has, however, highlighted a number of areas where practice can be developed to increase the chances that families in the same circumstances might be more likely to access effective support in the future.

7.7 Recommendation 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.

7.7.1 Efforts should be made to develop a local multi-agency Perinatal and Infant Mental Health Strategy/Pathway that involves both primary care and specialist health, social care and voluntary sector services.

7.7.2 This should aim to:

- Clarify the roles and responsibilities of all agencies and professionals
- Provide or strengthen clear pathways for the provision of integrated services, prioritising continuity of care wherever possible
- Develop systems of communication – which may include existing systems of confidential communiqués or other ‘alert’ systems to highlight parents who struggle with mental health difficulties - in order to improve monitoring.
- Place appropriate emphasis on the needs of both parent(s) and infant and on the complex interplay between the two – ensuring that the child is always ‘held in mind’
- Emphasise the importance of seeing parents individually as well as together and of not relying on the reports of family members to complete an assessment of need
- Where possible, provide opportunities to engage in reflective practice in order to develop and share knowledge and skills and manage the emotional impact of the work

7.7.3 Recommendation 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 that:

- Enables all professionals offering universal services to identify vulnerable parents and infants at the earliest possible point
- Provides them with standardised assessment measures and promotional guides that they can use creatively according to professional judgment to explore parents’ mental health needs (as recommended by the Department of Health, 2015)
- Identifies the unique and complementary needs of mothers and fathers and supports professionals to assess and respond to the needs of all family members
- Gives them an awareness of parent-infant interaction at an appropriate level for their job role and enables them to identify any areas of concern
- Allows them to support and monitor parents with varying degrees of mental health difficulty and signpost to other services as appropriate

- Provides them with a clear understanding of specific safeguarding issues in this context and an ability to more confidently manage risk.

7.7.4 Local and national templates are available to guide the development of the model.

7.8 Recommendation 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.

7.8.1 It was clear during this SCR that while some provision was made for Mother's mental health, there was no one agency able to focus on the mental health needs of both Mother and Child M as a unit. There is an increasing body of evidence to suggest the importance of providing effective Perinatal and Infant Mental Health Care (NICE 2014, 1001 Critical Days APPG, 2015). In this case, specialist perinatal mental health provision would have offered the opportunity to:

- Respond in a timely manner to concerns identified in pregnancy and follow Mother through this vulnerable period
- Provide a tailored package of support to meet the needs of both Mother and Child M simultaneously, based on specialist perinatal knowledge (e.g. in relation to diagnosis, prescribing, specialist psychological interventions, parent-infant therapy)
- Offer continuity of care across levels of severity, recognising the perinatal specific aspects of Mother's fluctuating presentation to avoid the need to move between teams as different presentations took priority
- Identify, monitor and intervene with issues within the parent-infant relationship and work collaboratively with frontline services and within a safeguarding framework as required.

7.8.2 Inevitably, developing additional services relies not only on reorganisation but also on the provision of additional financial resources. The UK Government recently committed to providing significant additional funding for Perinatal Mental Health (NHSIQ, 2015) and it is imperative that local services are in a position to make effective use of these funds as and when they become available. This will require an analysis of the gaps in current service provision and the development of a model that will meet local needs and make use of existing assets.

7.9 Recommendation 3

All agencies should ensure that their staff are aware of the 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 multidisciplinary context to facilitate awareness of this shared responsibility.

7.10 Recommendation 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.

8 References

1001 Critical Days All Party Parliamentary Group (2015). Building Great Britons: Conception to Age 2.

Cuthbert, C., Rayns, G., & Stanley, K. (2011). *All Babies Count: Prevention and Protection for Vulnerable Babies*. London: NSPCC

Department of Health, UK (2015) Early Years High Impact Area 2: Maternal (Perinatal) Mental Health.

Flynn HA, Blow FC, Marcus SM (2006). Rates and predictors of depression treatment among pregnant women in hospital-affiliated obstetrics practices. *General Hospital Psychiatry*, 28 (4), pp 289-29.

Ganapathy, T. (2016). *Exploration of first time fathers' experiences during the child's first year*. Muller J Med Sci Res; 7, 23-31

Khan, L. (2015) *Falling through the Gaps: Perinatal Mental Health and General Practice*. London: Centre for Mental Health

"Maternal Mental Health: Everyone's Business" – Maternal Mental Health Alliance Campaign. www.everyonesbusiness.org.uk

NHS Improving Quality (2015). *Improving Access to Perinatal Mental Health Services in England - A Review*. London: NHSIQ

National Institute for Health and Care Excellence (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. London: NICE

National Institute for Health and Care Excellence (2010). *Delirium: Prevention, Diagnosis and Management*. London: NICE

Appendix 1 - Terms of Reference

Introduction

The Serious Case Review Panel took the decision, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2013), that the threshold was met to commission a Serious Case Review in respect of the death of Child M.

The purpose of the review is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations will need to translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

Principles underpinning the review

The following principles should be applied by the LSCB and its partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

SCRs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

Methodology

The methodology agreed for this review is a blend of traditional and new approaches. Agencies significantly involved with the family are required to complete Internal Management Reviews that should be clearly focussed on the issues for consideration outlined below. They should be informed by records, research and direct contact with relevant members of staff. There will also, and in parallel, be a process of greater collaboration through conducting conversations with the practitioners and clinicians involved, and holding multi-agency events at the outset and during the process. All these steps aim to identify learning and encourage reflection. to examine actions and decisions taken and to understand the context.

Localities involved

This SCR is being led by the Northamptonshire SCB because the family are a Northamptonshire family. Some of the agencies involved with the family are located in Milton Keynes. It was therefore agreed that this SCR would be completed as collaboration between the Northamptonshire and Milton Keynes Safeguarding Children Boards. The final report is to be published as a joint report by the two LSCBs.

Issues to be addressed in the reports from IMR Authors and the Lead Reviewers

A day in Child M's life

What did agencies really know about Child M's circumstances and the way the family lived? What can your service contribute to the account to be provided in the Overview Report of "a day in Child M's life"?

Assessment, planning and review

What was the quality of assessments carried out? Did assessments lead to appropriate services being offered? Were assessments and follow-up sensitive to any issues of identity and diversity for this family? Were service arrangements kept under review?

Mother's mental health

What contact did mother have with services in respect of her mental health? Were interventions adequate and appropriate? What local guidance and specialist support is available to services working with pregnant women and mothers who may have mental ill health?

"Think family"

Were mother's problems seen and addressed in the context of her family? What impact did her family have on her decision making? Was father's situation adequately assessed and addressed? Were the needs of their other child considered? Were members of their extended families involved at any point and, if so, did agencies work

well with them? Were the needs of the child balanced appropriately with the wishes of the family? If not, why was that?

Professional Curiosity

How did professionals consider adult decisions and the impact on those to the child? Were there opportunities to challenge parental behaviours, comments or decisions? Was there adequate multiagency, multidisciplinary working and was there professional curiosity in decision making?

Management and resources

Were there any organisational difficulties within or between agencies? Were there any resource issues? Were managers, supervisors and specialist advisors available and involved where appropriate?

Cross border working

Agencies from two localities are contributing to this review. Did this lead to any difficulties in communication or co-operation between agencies?

The end of Child M's life

How well was the situation managed when Child M was brought to hospital with his fatal injuries? Did agencies co-operate and work well together in these difficult circumstances, taking account of the different pressures they faced? Were decisions made appropriately and sensitively?

Had agencies learned lessons from previous reviews?

Agencies should consider this case in the light of any other relevant SCRs, locally or nationally. Are there any similarities between the key issues in this case and those which have arisen in any previous reviews (including internal reviews and "near misses") to which the agencies in this case have contributed? If so, can the agencies demonstrate that they had learned lessons and taken action to address those issues?

Period under review

Detailed chronologies should cover the period from 1 February 2013 – 1 April 2014

This starts from the approximate point that Child M's mother would have become pregnant and concludes just after his death.

IMRs should include:

- Any relevant historic background information regarding the family prior to 1 January 2010
- Issues of concern that could impact on the parents' parenting capability of Child M from 1 January 2010 – 1 February 2013
- Detailed information from the approximate conception of Child M 1 February 2013 – 1 April 2014

A template for the chronology, IMR and Health Overview reports will be provided.