Briefing on Serious Case Reviews

Child L (Published by Hull LSCB, January 2014)

Background

In October 2012 a nearly 6 week old baby girl (Child L) died as the result of a severe skull fracture. Her mother (Adult N) admitted to a charge of infanticide due to post natal depression and received a community order with a supervision requirement for three years. The help and support which Child L and her family received was largely routine help from universal services and Children's Social Care had no involvement. The majority of this help and support was provided to the expected standard, with some notable examples of good practice.

The conclusion of the Review is that local agencies and services could not have anticipated or prevented this tragic event. The Board cited that the offer of additional support would have been beneficial, following a diagnosis that Child L's mother had post natal depression. However, this and other lessons learned about practice would have had no bearing on the outcome in this case, but might be more significant in other circumstances.

Key Learning Points:

Continuity of Support & Care

Services should be planned and delivered so service users are able to be seen by the same person as much as possible. As an example, 8 out of 11 of the community midwifery contacts with Adult N were carried out by the same midwife which provided a high standard of continuity of care within community midwifery.

Mothers and New Babies

- When a mother presents with depression and indicates she is not coping with a new baby - even if there are no indicators of increased risk of child abuse or neglect – practitioners should consider there are likely to be safeguarding issues associated with, for example, low mood, having a new baby and post natal depression. This should trigger an assessment and information sharing between key agencies involved with the child and family. In this case it would have been good practice for the GP to have discussed Adult N with the community midwife or health visitor to enable them to contribute towards an assessment and provide additional support.

- The Serious Case Review Overview Report on page 40 provides succinct and authoritative reading on the inter-relation between the spectrum of perinatal depression and common post-birth events likely to be experienced by a mother. The Review states, "Although the symptoms exhibited by Child L are relatively common and mild, the effects on an individual's coping skills in the early postnatal period should not be under-estimated and should be a trigger factor for the offer of additional support."

- The Government have announced that to help identify and support women who may be at risk of postnatal depression, every maternity unit in England will have a dedicated mental-health midwife by 2017. For more information see 'Closing the Gap: Priorities for essential change in mental health' (February 2014, Department of Health)

Working Together to Safeguard Children
The knowledge held by an individual agency may not, on its own, appear concerning but, when collated and analysed, the overall picture may indicate a more significant level of concern and risk. This should the lead professional to a more informed and coordinated response. It will ensure the professional network is aware of key information and interventions. It will also avoid the family or individual being overwhelmed and prevent confusion in the professional network.

Engaging Fathers and Male Figures
All agencies working with children and their families should consider the role of fathers and men in households in assessments and when providing services. The status and the role of males and new partners in the same household should be understood in terms of their potential for protection and nurturing - as well as any adverse effect they may have on the safety of the child and the mother. A worrying factor of case reviews and audit work nationally is the repeated finding that fathers and male figures are often absent in recording, assessments and care plans.

Domestic Violence
The NHS often facilitates settings where adults or children feel able to disclose about harm that they or others in their family have experienced or are at risk of. Whilst not an issue in this case, the Review reinforces the importance of all services being aware of the need to provide safe spaces for the early identification and prevention of domestic abuse. The Department of Health introduced the Routine Enquiry and such screening is likely to increase the number of women identified as experiencing domestic violence and ensure appropriate support and advice is provided or signposted. See 'Responding to domestic abuse: a handbook for health professionals' (Department of Health. December 2005).

Response to Unexpected Child Deaths
The Review highlights examples of good practice by agencies from the emergency call through to soon after the child being pronounced dead. These relate to good coordination, information sharing and inter-agency working as well as respect for the deceased child and her family. In summary, good practice is noted as:

- The pre-alert call made by the ambulance staff to the hospital which facilitated the arrival of key medical staff in the resuscitation room before Child L arrived.
- The direct referral to the Detective Inspector of the Public Protection Unit – rather than 999.
- The co-location of the Police and Children's Social Care enabled prompt and effective information sharing and decision making to inform the joint investigation and the start of the criminal investigation.
- The direct referral to the Children's Social Care Team Manager.
- Information sharing between the Police and other agencies, including the hospital.
- The same senior doctor examining Child L and Adult N.
- The respect of cultural and religious matters following the death of Child L. The Review states, "There is evidence of sensitive practice in relation to arranging a blessing for Child L by the hospital chaplain and ensuring the privacy and dignity of Adult N whilst in the A&E department under police escort." And, enabling other members of the family time with Child L in a quiet environment.
- Emotional support for hospital staff involved following the child's arrival at hospital.