BUCKINGHAMSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

SERIOUS CASE REVIEW

‘BABY S’

FERGUS SMITH

August 2018

1 INTRODUCTION

1.1 TRIGGER EVENT & NEED FOR SERIOUS CASE REVIEW

1.1.1 Baby S (a female of Indian ethnic origin whose parents' religious affiliation is to Sikhism) had been born prematurely at 25.5 weeks gestation and spent the first 4 months of her life in West Middlesex University Hospital, Chelsea & Westminster Hospital and, later, the more local Stoke Mandeville Hospital. On 03.04.16 (aged 5 months) the parents' report of baby S being unresponsive triggered emergency re-admission by ambulance to Stoke Mandeville Hospital where resuscitation attempts were unsuccessful.

1.1.2 An initial Coroner's paediatric post-mortem was halted when the pathologist became suspicious of the condition of baby S's skull. A Home Office post-mortem was undertaken and concluded that the cause of death *could* have been blunt trauma to the head. The parents were subsequently arrested on suspicion of murder. Immediately after the tragic incident, the Local Authority initiated care proceedings on baby S's elder siblings.

1.1.3 Buckinghamshire Safeguarding Children Board's Serious Case Review (SCR) sub-group was made aware in June 2017 of medical reports commissioned for the Care Proceedings. Those reports apparently indicated that Baby S may have suffered an inflicted injury. Consideration of the need for an SCR was then significantly constrained by delays in the receipt of expert medical advice. No other concerns about the family had been identified in Buckinghamshire or Hounslow, where the family had previously lived, and a recommendation about the need for a SCR was deferred.

1.1.4 The BSCB's SCR sub-group subsequently determined on 23.08.17 that the statutory criteria for a SCR[1] *were* met and recommended such a review be completed.

1.1.5 On 30.08.17 the above recommendation was ratified by the independent chairperson of Buckinghamshire's Safeguarding Children Board who duly notified the Department for Education (DfE), regulatory body Ofsted and central government-appointed 'National Panel of Independent Experts' (NPIE). This serious case review was subsequently completed between November 2017 and June 2018 in accordance with terms of reference reproduced in section 3.

[1] Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with *Working Together to Safeguard Children* HM Government 2015. A 'serious case' is one in which, with respect to a child in its area, 'abuse or neglect is known or suspected and the child has died' [as in this case] or been 'seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard her/him'.

1.2 PURPOSE, SCOPE & CONDUCT OF THE SERIOUS CASE REVIEW

PURPOSE

1.2.1 The purpose of a SCR is to identify required improvements in service design, policy or practice amongst local, or if relevant, national services. SCRs are *not* concerned with attribution of culpability (a matter for a criminal court), nor cause of death (the role of a Coroner).

SCOPE

1.2.2 The period of review was 01.01.15 to a point 24 hours after the baby's death. Any emerging information pre-dating that period and believed to be relevant has also been considered. An independent report was commissioned from CAE Ltd www.caeuk.org. It was agreed that upon receipt of material, lead reviewer Fergus Smith would:

- Collate and evaluate it
- Seek to arrange and facilitate meetings with family and professionals (ensuring that in so doing, any ongoing criminal investigation was not compromised)
- Draft for consideration by the SCR panel a narrative of agencies' involvement, an evaluation of its quality and conclusions and recommendations for Buckinghamshire's Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

1.2.3 Anticipated lines of enquiry were:

- Baby S's prematurity and additional needs – was the level of support provided sufficient?
- Was parental learning difficulty / disability identified?
- Did moving across authorities impact upon the level of support or any transfer of information?

CONDUCT

Agencies contributing information & involvement of professionals

1.2.4 The following were asked to supply a chronology and a proportionate evaluative report of respective involvement:

- Clinical Commissioning Groups (CCGs) (GP healthcare)
- Midwifery Services (ante / immediate post-natal services)
- West Middlesex University Hospital, Chelsea & Westminster Hospital and Stoke Mandeville Hospital (medical, including intensive care)
- Buckinghamshire Healthcare NHS Health Trust (health visiting)
- South Central Ambulance Service (emergency transportation on day of trigger incident)
- Thames Valley Police Service (responses following the trigger event)

1.2.5 During the course of this SCR the expert report of a clinical psychologist instructed by the court to assess mother's cognitive functioning was shared with panel members. It revealed that mother's overall cognitive ability was very low and yet she manifested very few signs of that. The 'Fact Finding Judgement' in the Care Proceedings was also shared (at the time in confidence) with members Mother stood trial at Reading Crown Court between 2nd and 24th October 2019. She was found not guilty of manslaughter and duly acquitted.

1.2.6 A consultation event for those professionals who had met the family and who could be traced was convened in May 2018. In collaboration with Thames Valley Police Service, a presentation and subsequent debate was carefully managed to avoid undermining the value of evidence that some of those present had provided for the criminal investigation.

1.2.7 Individuals' memories and debate added useful detail to the records already supplied. A possibility that West Middlesex Hospital might have further relevant information was immediately followed up but added nothing to what had already been established.

1.2.8 The event provided an opportunity for health professionals across organisations and geographical boundaries to re-examine critically, the totality of what had been known and actually shared at the time of respective agency involvement. As described and evaluated below, there were missed opportunities for optimum practice, some more significant than others. The overall picture that emerges though is of a high level of medical and nursing expertise, with some limited scope for improved recognition and communication of needs e.g. parental capacity to manage the collective demands of 3 very young children and a more clearly recorded appreciation of relevant cultural issues.

Serious Case Review (SCR) Panel

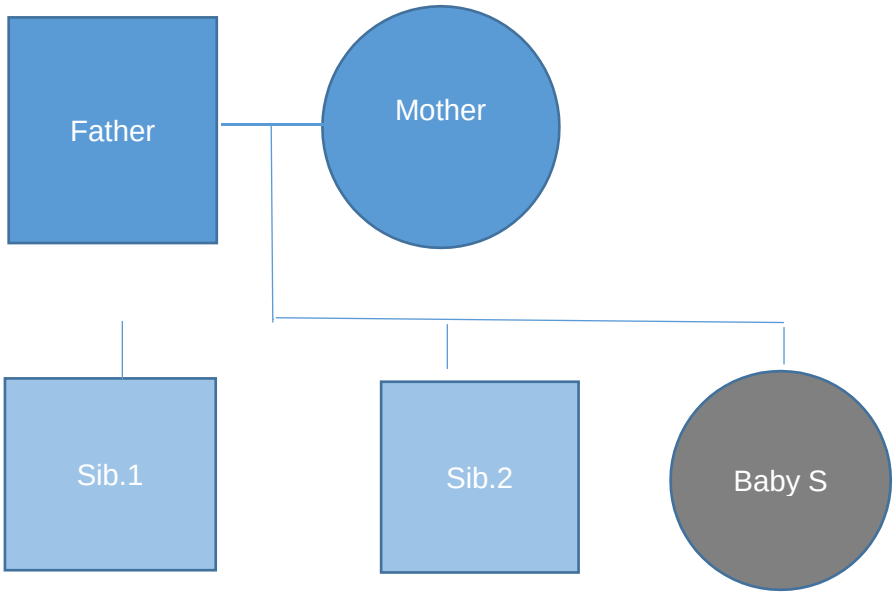
1.2.10 The following representatives made up the SCR panel:

- Legal Service (HB Public Law): Senior Solicitor (chairperson)
- Thames Valley Police: Detective Inspector
- Buckinghamshire Healthcare NHS Trust: Associate Director for Adult & Children's Safeguarding
- Buckinghamshire Healthcare Clinical Commissioning Groups (CCGs): Designated Doctor
- Buckinghamshire Safeguarding Children Board
- Buckinghamshire Children's Social Care: Independent Reviewing Officer
- Independent Lead Reviewer / Author

1.2.11 The panel met on 4 occasions and members provided professional expertise and later challenge of draft SCR reports. This final version has been agreed by Buckinghamshire's Safeguarding Children Board and a copy sent to the national panel of experts (NPIE) and Department for Education (DfE).

FAMILY OF BABY S

Structure



Involvement in SCR

1.2.12 The parents were informed in writing that a SCR was being completed and invited in subsequent correspondence to contribute to it. A formal request for access to mother's medical records (potentially relevant to the issue of recognition of cognitive deficits) was made and refused. A later suggestion that mother might allow the doctor on the SCR panel to share only what appeared relevant to the issue of cognitive deficits was also refused.

1.2.13 The possibility of the Safeguarding Children Board seeking (in the public interest) to override mother's refusal was considered, and rejected as being disproportionate and a possible breach of her human rights.

1.2.14 In anticipation of a meeting with one or both parents and/or grandparents, issues to be explored or avoided had been negotiated with the Police 'senior investigating officer' (SIO) with the aim of enabling learning to be derived without prejudicing the criminal investigation.

1.2.15 However, in spite of the efforts made to involve them, (and understandably in view of the serious criminal charges potentially faced) no member of the immediate or extended family elected to contribute to the SCR.

2 SIGNIFICANT EVENTS

2.1 FAMILY BACKGROUND

2.1.1 Baby S had 2 older siblings:

- Sib.1 (male, aged 3 at the date of his sister's death) about whom there were concerns with respect to rate of growth and whose diet and eating were being looked into
- Sib.2 (male, 18 months at the date of his sister's death and who had been born at 28 weeks gestation)

2.1.2 Both parents have large extended families. Father is understood to have worked full-time on night shifts and mother was a full-time parent. Until the incident triggering this SCR, no concerns about mental health or any substance misuse had been identified in either parent, neither of whom has any criminal record.

2.2 ANTE-NATAL CARE

2.2.1 West Middlesex Hospital provided a predominantly technical document outlining details of mother's ante-natal care. Its response to a subsequent request for a more evaluative report of staff interactions with, and any observations or concerns about baby S's family, was that there were no additional records and that all relevant staff who might be able to draw on their memories had moved on to employment elsewhere.

Comment: *nothing of relevance to the SCR has been derived from the ante-natal notes and it is of real concern that the hospital's Midwifery Service apparently kept no records of the familial / social / cultural circumstances of the unborn baby S; an evaluation of any identified social stressors / needs (and if relevant, risks) would be expected good practice.*

2.3 BIRTH & POST-NATAL CARE

HOSPITAL SUPPORT

2.3.1 Baby S was delivered prematurely (25.5 weeks gestation) on 07.10.15 by means of an emergency Caesarean at West Middlesex University Hospital. Father was in attendance at the birth. As a result of her low birth weight, baby S was admitted to the Special Care Baby Unit (SCBU) and later that day transferred to Chelsea & Westminster's Neonatal Intensive Care Unit (NICU). After approximately 5 weeks, baby S was transferred back to the SCBU at West Middlesex University Hospital. No records of the family's visiting or any other observations have been supplied by Chelsea and Westminster Hospital.

2.3.2 On the day baby S returned to West Middlesex Hospital, mother visited and was shown around the SCBU. In the approximately 9 weeks prior to the discharge of baby S to Stoke Mandeville Hospital, the frequency of visits has been calculated to have been approximately:

- Mother 16
- Father 4 +
- Mother with father 3
- Father and grandparents (maternal or paternal not specified) 1

2.3.3 Assuming the figures to be accurate, baby S was visited by a parent on about 50% of the available days (there were in addition, a number of phone contacts). The relatively low frequency of what were often brief family visits, was noted by ward staff and was raised with the 'safeguarding midwife' who advised further observations of the parents.

2.3.4 Ward staff were informed in mid-December of the family's imminent house move. Mother declined the offer of 'rooming in'[2] because she said, of her need to care for the older 2 children. It is thought that the family was at that time living with baby S's reportedly supportive grandparents (whether maternal or paternal was not captured).

Indication of mother's anxiety

2.3.5 On one occasion (07.01.16) mother phoned and spoke with West Middlesex Hospital night staff. She asked to speak to a doctor and reported that she could not cope with having baby S at home because of the demands of her other children. No record has been located of the response by staff, either at the time or at the following week's 'psychosocial meeting'.

Comment: *the hospital has confirmed that the nurse should have spoken with the consultant paediatrician and mother's anxiety addressed at the discharge planning meeting; this was a significant missed opportunity to derive and share with others an improved understanding of mother's affect / competence and wider family support needs.*

2.3.6 On 08.01.16 a request was put to mother that it would help her and her baby if she could visit more frequently and for longer periods. Father and grandparents (whether maternal or paternal was not recorded) visited on 10.01.16 but a further 4 days elapsed before mother visited again. On that occasion, she was informed of the plan to discharge baby S home on oxygen and in turn reminded staff of the imminent family move to Buckinghamshire.

[2] 'Rooming-in' is a practice where parents and other caregivers provide total care for their baby in a home-like environment while in the hospital; this provides the caregiver with the opportunity to care for their infant with the availability of assistance from healthcare professionals.

2.3.7 The planned transfer to the more local Stoke Mandeville Hospital was postponed whilst a bed was awaited. It was completed on 27.01.16 by which time baby S was 15 weeks old. West Middlesex Hospital's 'safeguarding midwife' briefed her counterpart at Stoke Mandeville by phone, on the concerns previously expressed to her about the apparently limited commitment to baby S of her parents.

Comment: *the sensitivity of staff in discerning and responding to the infrequent visiting was commendable, albeit the opportunity at West Middlesex Hospital to explore mother's single acknowledgment of struggling to cope had been missed.*

2.3.8 Written material passed over to Stoke Mandeville Hospital identified no other social issues except that of infrequent visiting. During a phone conversation between an unnamed Stoke Mandeville nurse and another from West Middlesex Hospital, the latter suggested that the frequency of parental visiting had increased once the issue had been raised with parents. This is not apparent from the calculation completed in the course of this review and may (assuming records are complete) reflect some optimism on the part of the individual.

2.3.9 On 02.02.16 the nursing sister from Stoke Mandeville Hospital's Neonatal Unit (NNU) sought a further briefing and informed her counterpart at West Middlesex Hospital that the family was now visiting often.

Training & preparation for home-administered oxygen

2.3.10 Routine arrangements were made for the delivery and parental use of oxygen at home. Records indicate no recognition of difficulty on the part of either parent to understand the advice given. A 'pre-discharge visit' by the Outreach Team of the Neonatal Unit (NNU) was completed on 02.02.16. Safe sleeping, use of oxygen and resuscitation methodology were discussed. A 'discharge checklist' was reportedly completed (though cannot be located) and confirmation of GP registration obtained.

Comment: *thus, neither Unit staff nor the Outreach Team noticed any indication that either parent found it difficult to comprehend advice given, nor that there existed any indication that their respective mood states or relationship was of concern*.

SUPPORT IN THE COMMUNITY

GP registration & domiciliary follow-up from hospital

2.3.11 Prior to the family completing its move to Aylesbury, baby S had been registered at a local GP Practice, where the administrator (commendably) drew the attention of the GP to the complex medical needs of the child [3]. Other family members were registered a week or so later.

2.3.12 The NNU Team undertook a home visit within an hour of the discharge of baby S on 03.02.16. Father and mother were seen to handle the oxygen equipment competently. In accordance with established procedures, further visits were arranged for the following 2 days. The formal discharge letter from Stoke Mandeville Hospital is reported to have indicated that there were 'no social concerns'.

2.3.13 The parents were informed that, because their child was in receipt of oxygen at home, they could be assured of rapid access to paediatric advice or, if need be, re-admission of baby S.

2.3.14 At the visit next day a different nurse demonstrated use of the equipment and noted no concerns about either parent's understanding. She liaised with the allocated health visitor and they agreed a pattern of home visits. Further home visits by the NNU Team were completed and identified no concerns about the parents or their accommodation.

2.3.15 The relevant GP Practice operates a useful routine health visitor / GP liaison forum. At its meeting held on 09.02.16, the vulnerability of baby S was acknowledged and a home visit by a health visitor promised 'soon'.

Initial health visiting contacts

2.3.16 Records supplied to the SCR suggest that the planned visit was made on the same day and that the health visitor met both parents, and all the children. Her observations of home (kitchen and living room) and family were positive. The parents reportedly said that the baby had yet to be registered with a GP. This must reflect some miscommunication because baby S (though not her siblings or parents), had already been registered on 02.02.16.

2.3.17 Presumably because such notification is generally triggered by GP registration and notification of 'Child Health', the health visitor who visited on 09.02.16 reports being unaware of the existence of the other children or the family's recent move to the area; nor, until mother mentioned it, of historical concerns about the older children's diet, growth and ongoing monitoring of development. The parents' registration with a local GP would trigger such notification.

[3] The details of baby S's health-related needs do not need to be spelled out in this report beyond reporting that they were extensive, complex but not life-threatening.

2.3.18 In recognition of the health-related challenges faced by the family, health visiting was to be provided at 'Universal Plus' level[4]. Because of the extended stay in hospital, core health visiting services (new birth visits and 6-8 week review) had not occurred. 'Routine confidential enquiries' about domestic abuse were not made (as per Department of Health expectations) because of the presence of the children's father and children aged over 2. A further visit by the health visitor was planned for 24.02.16.

2.3.19 On the day after the home visit by the health visitor, a report of a 'new infant paediatric examination' (NIPE) of baby S was received by the health visiting team. The date of the examination was missing so its account of a 735 grams weight gain could not be evaluated. A planned NNU visit on 12.02.16 was unsuccessful because the family was out. There is no record of any attempt by the outreach nurse to contact the family by phone.

2.3.20 On 15.02.16 father and older siblings were registered at the GP Practice.

Immunisations administered to baby S

2.3.21 On 17.02.16 the NNU Team visited and recorded no concerns. A reduction in relative weight to the 2nd centile was noted but not regarded as significant. On the same date, having obtained the consent of a person understood to have parental responsibility, the GP practice nurse gave baby S her routine immunisations in accordance with the recommended schedule.

Comment: *records do not (though should) note which parent consented; given later doubts about mother's level of cognitive functioning the need to be clear about such matters is self-evident.*

2.3.22 Having completed a home visit, at which mother was asked to repeat advice given about changing the level of oxygen, the paediatric nurse made contact with a paediatric consultant on 18.02.16 to discuss weaning baby S off oxygen. They agreed on gradually increasing periods of dependence on air.

Comment: *asking mother to repeat back the instructions given was a sensible precautionary means of confirming the parent's understanding.*

Mother's GP registration & ongoing provision of community health services

2.3.23 On 18.02.16 mother registered at the GP Practice. Information that emerged during the immediate agency responses to baby S's death, i.e. was *not* available at the time of mother's registration, indicate a 'diagnosis' [sic] of 'mild learning difficulties' in 1999 and that mother had attended a special school. It has not been possible to confirm the accuracy of that information.

[4] 'Universal Plus' offers rapid response from the local health visiting team if specific expert or additional help is needed e.g. a medically vulnerable or sleepless baby.

2.3.24 At a further home visit by the health visitor on 24.02.16, she met mother and all the children. The home was noted to be clean, tidy and have age-appropriate toys. Baby S, who slept through most of the visit, was noted to have been positioned and covered in accordance with the medical advice provided on safe sleeping. Mother's care of her children and new baby was noted to be caring and her responses to the children to be calm. The health visitor read the parent-held 'red book' and learned that the community paediatric nurse was expecting her to weigh baby S. She had not been alerted to this and was not carrying scales. She arranged instead to complete the required weighing next day.

Comment: *this was a minor individual failure of communication.*

2.3.25 The health visitor discerned the possibility that mother might have a 'learning difficulty'. At the consultation event, this highly experienced professional was able to reflect on the underlying reasons for her suspicion which lay in the manner of mother's responses and perhaps an undue readiness to acquiesce. The health visitor saw no evidence that mother's cognitive ability might impact adversely on parenting. Mother confirmed that she was aware of and able to access local sources of support though would naturally be more free to do so once baby S no longer required administration of oxygen. The notes of mother's presentation referred to her being calm and taking things in her stride. She acknowledged her own chronic medical condition for which she was receiving medication and which left her feeling tired. She was encouraged and agreed to raise this with her GP.

2.3.26 Routine confidential enquiries (about potential domestic abuse) were achieved using paper so as to circumvent the impact of baby S's siblings being aware. Mother indicated that she knew what was being asked and that she had a good relationship with her husband who was supportive of her and the children. The health visitor subsequently initiated contact with a community staff nurse and a nursery nurse and sought their involvement.

Comment: *the health visitor's sensitivity to the possibility of mother's additional needs and her response to it were commendable; what might be described as informed intuition had discerned what had not been apparent to previously involved professionals.*

2.3.27 A further home visit was undertaken next day (25.02.16) by a community staff nurse. Baby S's weight had increased by 120 grams since the last time she was weighed by a NNU nurse. Mother expressed no concerns and baby S 'looked well'**.** A neonatal physiotherapy session was planned for 03.03.16**.**

2.3.28 Father brought baby S to the GP Practice on 29.02.16 and consulted a doctor for what was thought to be oral thrush (a common complaint in young babies). The need for completion of an overdue hospital follow-up was recognised and an urgent referral was agreed as required (and completed next day). At the same visit, the GP agreed to refer sib.1 to a dietician and discussed sib.2 (about whom there had existed 'ear / nose / throat' (ENT) concerns).

2.3.29 Though an insufficiency of records renders it impossible to be certain on which dates conversations occurred, the health visitor liaised with the community staff nurse and nursery nurse so as to put in place support with respect to the growth and diet-related needs of the siblings of baby S. At the postponed weighing of baby S on 25.02.16 she had gained weight and the NNU nurse was duly informed.

2.3.30 A further visit was completed by the NNU Team on 02.03.16 when the weight of baby S had returned to the 9th centile (it *may* already have done so when weighed on 25.02.16). A physiotherapy appointment for 03.03.16 was cancelled by the parents though no reason was captured. A further cancellation (of a health visitor appointment) occurred on 14.03.16 reportedly because of a family bereavement. Records did not capture which relative had died.

2.3.31 Mother raised a question on 09.03.16 about an overdue ophthalmology appointment which was anticipated in the period 6-8 weeks post discharge. A re-referral was initiated.

Comment: *mother's initiative might reasonably be interpreted as an example of organisation and commitment to her baby's health.*

2.3.32 Baby S had reverted to the 2nd centile at the time of the next NNU visit on 22.03.16. The parents were informed that their baby was severely deaf in both ears and would require implants. Observed 'tongue pushing / thrusting'[5] prompted a later discussion with the paediatric consultant. Baby S was not brought to a physiotherapy appointment next day (records offer no reported reason) and the appointment was re-booked for April.

2.3.33 The community paediatric nurse liaised with the health visitor next day and (given that there would be a 2 week interval before the next scheduled NNU weight check visit) suggested the need for a supportive visit by the health visitor.

2.3.34 At a visit by the NNU team on 24.03.16 a possible fault in the monitoring equipment led to a new monitor being provided. A completed sleep study was (for un-recorded reasons) considered invalid and was later repeated successively. The health visitor spoke by phone on 30.03.16 to the father of baby S. He explained how shocked they had been to learn of his daughter's hearing loss. The focus had previously been on her eyesight. A 2nd set of routine immunisation was completed when father presented baby S to the GP Practice on 30.03.16.

Comment: *capturing in records which parent presented a child to appointments is basic good practice but often not achieved.*

[5] A natural reflex in very young babies; if tongue pushing / thrusting persists it can be associated with dental difficulties and lisping.

2.4 TRIGGER EVENT & AGENCY RESPONSES

2.4.1 A call was made by the South Central Ambulance Service (SCAS) to Police at 16.30 on 03.04.16 advising of a 6 month old baby [sic] having experienced a cardiac arrest. The parents had called 999 and sought an ambulance and father was being instructed by 'Ambulance Control' to administer cardio-pulmonary resuscitation (CPR). Baby S accompanied by her father, was transported to Stoke Mandeville Hospital where attempts to resuscitate her ceased at 17.12 and life was pronounced extinct.

2.4.2 The Health Visiting Team, safeguarding children administrator, Child Health Information Service and GP practice were informed of the death on 03.04.16. The allocated health visitor was also given the news in a phone call.

2.4.3 On 04.04.16 the senior nurse in the NNU was informed. Arrangements to collect oxygen equipment were postponed on the news that the incident was being investigated.

2.4.4 A routine 'rapid response meeting' was convened on 05.04.16. On the basis of available information, there was a unanimous conclusion that there were no safeguarding concerns. Parents were to be signposted toward relevant sources of support. The health visitor phoned mother on 11.04.16 to offer condolences. Mother described the circumstances on the day of the death of baby S and updated the health visitor in terms of the initial uncertainty as to its cause. An apparent absence of distress was acknowledged in the notes kept by the health visitor as being one of many ways in which a person responds to the death of a family member.

2.4.5 As outlined in the introduction to this report, the possibility that this was a suspicious death emerged *only* at a post-mortem initiated on 13.04.16.

2.4.6 As reported in section 1, mother was, in July 2017, assessed as lacking sufficient mental capacity to participate in the ongoing Care Proceedings. However, a subsequent assessment of vulnerability, i.e. any need for mother to be offered services potentially available from the local authority Adult Services, identified no such need.

3 RESPONSES TO THE TERMS OF REFERENCE

3.1 INTRODUCTION

3.1.1 This SCR is unusual in that:

- Prior to the birth of baby S, the family had been known to and involved with universal services *only* and extensive further research during the course of the review has not identified evidence of unrecognised need that might reasonably have predicted any difficulty in providing safe and good enough parenting
- Following the premature birth of baby S, the additional needs of a very vulnerable baby appear to have been effectively communicated to her parents and a wealth of medical advice and support provided
- The parents responses were predominantly unremarkable and they had in consequence, remained relatively 'invisible'
- The result of the prolonged criminal investigation remains unknown at the time of the completion of this review

3.1.2 Comments about generally minor opportunities for improved practice have been provided in italicised paragraphs throughout section 2. The remainder of section 3 offers a fairly brief response to the issues raised by the terms of reference defined by the Safeguarding Children Board when it established this review.

3.2 BABY S'S PREMATURITY & ADDITIONAL NEEDS – WAS THE LEVEL OF SUPPORT PROVIDED SUFFICIENT?

3.2.1 Material submitted by the involved hospitals offers solid evidence of a very high level of resource, skills and commitment in meeting the acute medical needs (ante-natally and in the post-natal period) of a highly vulnerable baby S.

3.2.2 That the family was provided with support by staff in all hospital settings (and later in the community) is not in doubt. An evaluation of the *sufficiency* of that support is rendered more difficult because:

- Of the regrettable absence of any social dimension in the ante-natal records supplied by West Middlesex University Hospital
- An absence of any record of the frequency of family contact or family dynamics in the case of Chelsea and Westminster Hospital
- Very limited acknowledgement in records of exploration of either sources of stress within the family, or of any wider issues associated with ethnicity or cultural norms
- The family has elected not to contribute to the SCR, thus leaving their views of service provision unknown

3.2.3 A research document recently published by the NSPCC[6] summarises learning from a series of SCRs completed last year on children aged less than 2. That summary points out that premature babies in particular may be born with disabilities or chronic health conditions which can be challenging for parents and carers to manage, and that children with disabilities *are generally* more vulnerable to abuse and neglect (a fact previously well established).

3.2.4 The NSPCC suggest that professionals are not always aware of signs that a parent is struggling to meet their premature baby's needs and interestingly, cite as an example, parents not regularly visiting the baby in hospital or bringing the baby to medical appointments.

3.2.5 While it is not possible to conclude that the infrequency of hospital visiting to baby S reflected any lack of parental commitment (e.g. it has been estimated that a visit by non-driver mother, from her then address to West Middlesex University Hospital would have required a 2 hour public transport journey each way), that *possibility* should be borne in mind by involved professionals.

3.2.6 Records provided by West Middlesex University Hospital show that upon the return from Chelsea and Westminster Hospital of baby S, the issue of the frequency and duration of parental visits was indeed recognised and prompted:

- Consultation with the safeguarding midwife
- Discussion with the parents

3.2.7 The single most obvious 'missed opportunity' was in early January 2016 when mother made an understandable reference to anxiety about coping with the care of such a vulnerable baby as well as the baby's other very young siblings.

3.2.8 Had mother's expression of anxiety been followed up, it might have offered a better understanding of the family's support needs. It is to be hoped that the recorded suggestion next day that mother visit more often was not directly linked to her acknowledged self-doubt.

[6] Infants: learning from case reviews: summary of risk factors and learning for improved practice for child and adolescent mental health services NSPCC 12.03.18

3.3 WAS PARENTAL LEARNING DIFFICULTY / DISABILITY IDENTIFIED?

RECOGNITION OF MOTHER'S COGNITIVE FUNCTIONING

3.3.1 Assuming that the conclusions of the assessment of mother's mental capacity during Care Proceedings were accurate and of relevance to everyday functioning such as parenting, potential opportunities for recognising a learning difficulty or disability[7] may have arisen:

- During her schooling
- In unknown consultations that she may have had with GPs

3.3.2 Mother's denial of access to her medical records coupled with an inability to access school records have rendered it impractical to access either of the above sources.

3.3.3 Within the period under formal review, the potential opportunities for recognition by professionals of mother's learning disability were:

- At the initiation of ante-natal care (*if* the midwife had been able to access what has been reported to exist in historical GP medical records)
- On the numerous occasions that doctors and nurses in all involved hospitals and the NNU Outreach Team, conversed with her and confirmed her understanding of various parentally-administered medical procedures
- When mother was engaged with community services such as GP and health visiting

3.3.4 It seems probable that the reference to a learning difficulty that emerged during the statutory 'Rapid Response Process' was not immediately visible to the midwife assessing mother's ante-natal needs. The consultation event reinforced that there had been no indication whatever to any of the health professionals with whom the parents co-operated in 3 hospitals that mother had any difficulty in understanding and following advice / instruction.

3.3.5 The possibility of a form of cognitive difficulty was discerned by the health visitor's professional curiosity about mother's demeanour and communication. Her response to the possibility was sensitive, cautious and entirely appropriate.

[7] A learning disability is a reduced intellectual ability and difficulty with everyday activities with onset in childhood; it may be 'mild', 'moderate', 'severe' or 'profound' [mother fell within the former category in the view of the assessing psychologist]; a general learning disability differs from a specific learning difficulty when a person has a difficulty in a specific area such as reading, writing or understanding but none in other areas.

RECOGNITION IN THE WIDER POPULATION

3.3.6 Limited desk-top research about the subject identified some relevant epidemiological research summarised for use by health professionals.[8] It indicates a prevalence of about 2% for intellectual disability and [as at 2013] an estimated 1.1 million people (900,000 adults) with learning disabilities in England.

3.3.7 Of the estimated 300,000 *female* adults who have a learning disability, only 23% were known to their registered GP. Records of the 'Rapid Response Meeting' that followed the death of baby S indicated a single reference to mother's condition though nothing of its origin, any detail or implication for day to day living.

3.3.8 Insofar as the above collation of research shows that 86% of children with 'mild learning disability' (IQ 50-70) are anyway educated in mainstream schools, it remains uncertain whether education records (had they been traced) would have offered any further clarification about the anticipated implications of mother's cognitive ability.

3.3.9 Only about 15% of those adults with a learning disability were [according to the 2013 research] in receipt of services from Social Care indicating that the greater majority function sufficiently well without such support. A post event assessment of mother's needs failed to identify any need for such local authority service provision.

3.4 DID MOVING ACROSS AUTHORITIES IMPACT UPON THE LEVEL OF SUPPORT OR ANY TRANSFER OF INFORMATION?

3.4.1 Insofar as the journey by public transport from home in Hayes to West Middlesex University Hospital was a lengthy one, visiting baby S was rendered easier when the family moved and she was transferred to Stoke Mandeville Hospital. The absence of a parental contribution renders it hard to be sure, but it is a fact that for the brief period baby S spent at that hospital, there was no concern about the level of contact

3.4.2 Because the issue had not been identified in either of the previously involved hospitals, the handover notes received by Stoke Mandeville contained no reference to learning disability or difficulty (nor any other description of family dynamics or relevant cultural issues). The *only* family-related issues in those notes referred to the level of visiting whilst baby S had been in the West Middlesex University Hospital.

[8] https://patient.info/doctor/general-learning-disability offers information and guidance for health professionals

3.4.3 During the course of the staff consultation event, it was learned that a reference to mother having been a 'nursery nurse' had been included in the material passed over to Stoke Mandeville Hospital (and in turn across to the health visitor). Whilst that information (the accuracy of which remains unknown) was not *decisive* in professionals forming a view about mother's ability to understand relevant issues, they acknowledged that it served to influence their thinking. This could be regarded as an example of what has been described as a 'halo effect' [9].

3.4.4 Because the SCR has been denied access to her records, it remains unclear whether, at the point of mother registering with a local GP, any information (in particular about cognitive functioning) was immediately visible. If it had been, one would hope that a GP might initiate liaison with the relevant health visitor.

3.5 LEARNING

3.5.1 It seems as though mother's level of cognitive ability and its potential impact on her ability to safely parent had either not been recognised or anyway had not prompted any specific professional response prior to the period under review. During the review period, in spite of the active involvement of many health professionals, *only* the health visitor discerned the possibility that mother might have some learning difficulties.

3.5.2 Insofar as the mother's presentation (in the opinion of the psychologist who assessed her during the Care Proceedings) belied her actual level of understanding, the collective inability over time to detect mother's additional needs may not be as surprising as it first appears.

3.5.3 What *was* more readily discernible than any 'learning needs' were the pressures outlined in the following section; 3 children (all born prematurely) within 3 years, a house move away from supportive parents and the challenge for a mother who was herself less than 100% fit, to re-build a supportive network following the move to Aylesbury.

3.5.4 A more 'enquiring' approach to the familial (not just medical) circumstances into which baby S was to be born and raised, might have highlighted a variety of additional needs (potentially including needs relating to cognitive functioning, parental relationship and any cultural issues) and better informed agency responses. Professional curiosity is required and justified in *all*, not just troubling, situations.

[9] The 'halo effect' can be seen as the behaviour (usually unconscious) of using evaluations based on things unrelated, to make judgments about something or someone i.e. in this instance, a 'nursery nurse' would be competent and not have a learning disability.

4 CONCLUSIONS & RECOMMENDATIONS

4.1 CONCLUSIONS

4.1.1 In the ante-natal and post-natal period the quantity and quality of health-related advice and support was of a high standard.

4.1.2 Missed opportunities (ranked in order of significance) have been identified as follows:

- Mother's admission of her anxiety to Middlesex Hospital Midwifery in early January 2016, should have prompted a more informed and sympathetic response than is apparent from records
- As a result of baby S's extended stays in hospitals and latterly Stoke Mandeville's NNU, the Health Visiting Service in Aylesbury was denied the opportunity to complete a new birth visit or a 6-8 week review, and remained unaware (until the health visitor made a home visit) of baby S's siblings
- A preoccupation with the (undoubtedly substantial) medical needs of baby S with the consequence of insufficient curiosity about the wider familial context into which the child was to be living
- Hospital records captured even less about father than they did about mother, thus reducing and rendering less visible, his potential as a source of understanding of the family and its strengths and areas of need

4.1.3 Setting aside mother's undetected cognitive deficits, the medical needs of baby S distracted attention from some more apparent stressors:

- The birth of 3 children (all born prematurely) within 3 years
- A house move that removed the advantage of living with supportive parents
- The need to re-build a social network following the family's move to Aylesbury

4.1.4 Though the above sources of stress were known to the involved hospitals, the potential implications of their combined effect could usefully have been addressed and evaluated.

4.1.5 No single missed opportunity would necessarily have changed the focus of support being offered, and none could have prevented the unexpected death of baby S. Based upon the very few findings of sub-optimal systems or individual practice, the scope for recommending systemic improvements is *very* limited.

4.2 RECOMMENDATIONS

NHS AYLESBURY VALE CLINICAL COMMISSIONING GROUP (CCG)

4.2.1 GP Practices should be reminded of the need to capture in records which adult presents a child and to ensure that immunisations or other medical interventions are legitimised by lawful fully informed consent, from a parent or other person who has parental responsibility.

WEST MIDDLESEX UNIVERSITY NHS FOUNDATION TRUST & CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

4.2.2 Both Trusts should issue a reminder to relevant staff that effective record keeping requires, in addition to the capture of technical / medical information, evaluated observations of a child's familial circumstances, (including issues relating to ethnicity, religion and wider cultural norms), behaviours of its members and (when relevant) any additional support needs.

5 OUTCOME OF CRIMINAL PROCEEDINGS

5.1 Mother stood trial at Reading Crown Court between 2nd and 24th October 2019, charged with the manslaughter of her daughter, baby S, in Aylesbury in April 2016. Mother accepted that she had shaken baby S and the court accepted that the injuries caused by the shaking were the cause of death, however Mother's defense was that she shook baby S as a resuscitative action after finding her unresponsive. The question for the jury was whether Mother had the necessary intent to cause harm or was reckless in her actions in the circumstances. The trial relied heavily on complex medical evidence and a number of medical experts accepted that a sudden collapse or Apparent Life Threatening Event (ALTE) could not be precluded. After just over 4 hours of deliberations the jury unanimously found mother not guilty of manslaughter and she was duly acquitted.