West Sussex Safeguarding Children Board

Serious Case Review

Baby O

Report Author

Jane Wonnacott

MSc MPhil CQSW AASW

Director, Jane Wonnacott Safeguarding Consultancy Ltd

20th November 2017

CONTENTS

1 INTRODUCTION 3

2 REVIEW PROCESS 3

3 FAMILY BACKGROUND AND CASE SUMMARY 4

4 INVOLVEMENT WITH SERVICES IN WEST SUSSEX 5

5 FINDINGS AND RECOMMENDATIONS 7

6 CONCLUSION 11

1 INTRODUCTION

1.1 This serious case review was commissioned by West Sussex Safeguarding Children Board following the death of a new born baby, known throughout this review as Baby O. The pregnancy had been concealed from both professionals and Mother's partner. Mother admitted that she killed her infant, was subsequently found guilty of infanticide[1] and was sentenced to a two year community order with a rehabilitation requirement.

1.2 Statutory guidance[2] requires Local Safeguarding Children Boards to carry out a serious case review when a child has died and abuse and neglect are known or suspected. In this case on 03/05/2016 the Chair of West Sussex Safeguarding Children Board agreed with the recommendation of the case review group that the death of Baby O met the criteria for a serious case review and commissioned this review.

1.3 Baby O had a four year old half sibling (referred to in this report as Child 1) who was at home at the time of the baby's death. Apart from attending for immunisations, Child 1 had not been seen by any early years' practitioners since the three month developmental check and it was therefore agreed that the review would consider service provision in respect of both Baby O and Child 1.

2 REVIEW PROCESS

2.1 An independent lead reviewer was appointed and the first phase of the review started before criminal proceedings were completed. The lead reviewer worked with a panel of senior professionals within West Sussex and produced a draft report. Due to unforeseen circumstances, it was necessary to appoint a new lead reviewer and the second phase of the review started after the criminal proceedings concluded in January 2017.

2.2 The lead reviewer and author of this report is Jane Wonnacott who is independent of all organisations in West Sussex and has over twenty years' experience of completing serious case reviews.

2.3 The serious case review panel comprised:

- Head of Safeguarding for Children, West Sussex County Council (chair)
- Lead Reviewer
- Strategic Lead for High Risk Adolescents, West Sussex children's social care.
- Early Years Outcomes Leader, Integrated Prevention and Earliest Help Service
- Safeguarding in Education Manager, Education and Skills West Sussex County Council
- Child Protection and Safeguarding Manager, Sussex Police
- Designated Nurse for Safeguarding Children, NHS Coastal West Sussex CCG.

2.4 The primary questions agreed for the review were:

---

[1] The Infanticide Act 1938 refers to infanticide as being when Mother kills her child within a year of birth *'but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child' she shall be guilty of infanticide rather than murder.*

[2] Working Together to Safeguard Children 2015

- What do we know about what prevents parents from engaging with services designed to provide support and care during pregnancy and labour? What is the interagency response when professionals identify that families haven't engaged with services?
- What do we know about how a pre-school child became invisible to universal services?

2.5 The lead reviewer considered all the material gathered for the first phase of the review including individual management review reports from:

- Western Sussex Hospitals NHS Trust (provision of midwives within the acute trust)
- General Practitioner provision
- Early Childhood Service
- Education and Skills Service
- Sussex Community NHS Foundation Trust (health visiting services)
- South East Coast Ambulance NHS Trust

2.6 Further reports were obtained from:

- The nursery attended by Child 1 after the death of Baby O in order to clarify the extent of any developmental delay
- The probation officer responsible for the pre-sentence report in respect of Mother.

2.7 The lead reviewer and the designated nurse met with the midwives and health visitor who had contact with Mother. The purpose of these discussions was to understand what factors might have been influencing service provision and professional responses at that time.

2.8 A focus group of professionals involved in delivering early childhood, health and social care services met with the lead reviewer to consider the strengths and weaknesses of the current safeguarding system in relation to the review questions. The review panel are very grateful to these professionals for giving up their time to assist the review.

2.9 The father of Child 1, Mother, and the father of Baby O were offered the opportunity to contribute to the review. Mother and Baby's O's father did not wish to do so but the lead reviewer did meet with Child 1's father and the review panel are grateful for his contribution. In order to preserve anonymity this report does not include all aspects of this discussion but information from the meeting has been used to clarify the sequence of events and inform the final findings and recommendations.

3 FAMILY BACKGROUND AND CASE SUMMARY

3.1 Mother, who is Lithuanian and has no family in England, met the father of Child 1 at work. Child 1's father is English and owned a property in West Sussex which Mother moved in to when she discovered that she was pregnant. Child 1's father also had limited family support in the area; his parents were separated, his mother did not live in the immediate vicinity and his father died within a month of Child 1's birth.

3.2 Neither parent had any previous experience of children and it was not until Mother was 28 weeks pregnant with Child 1 that contact was made with midwifery services. After Child 1's

birth, both parents continued to work alternate shifts meaning that Child 1 was cared for at home by one or other parent.

3.3 As a result of a relationship with a fellow Lithuanian, Mother became pregnant. She concealed this from colleagues at work as well as the father of Child 1, who had suspicions about the relationship but no idea that Mother was pregnant.

3.4 In April 2016, Mother was found by Child 1's father having lost a lot of blood and he became aware at this point that she had been pregnant. She told father she had "done something terrible" and he assumed she had aborted the baby. Although Mother was reluctant for an ambulance to be called Child 1's father did so as he was concerned about the seriousness of her condition. Following arrival at hospital and full medical examination it became clear that Mother had given birth to a full term baby and Police, ambulance and midwife were dispatched to the address. Baby O was found deceased wrapped in wet clothes in a baby bath with a ligature around the neck.

3.5 Practitioners who subsequently visited the home noted a poor physical environment and were concerned about the level of care being given to Child 1, who had not attended any pre-school provision and had not been registered for school as would have been expected at his age. Subsequent assessments at nursery school revealed significant developmental delay.

4 INVOLVEMENT WITH SERVICES IN WEST SUSSEX

4.1 The first involvement with West Sussex services was during Mother's pregnancy with Child 1. Child 1's father has told the review that Mother did not like going to the doctors. When she found she was pregnant he did take her to a Lithuanian doctor in London who advised that she should contact local services. Father subsequently contacted the West Sussex midwifery services via their e-mail system. At this stage Mother was not registered with a GP.

4.2 The usual practice is that a mother would be seen by a midwife attached to her GP surgery but this was not possible in this case as she had not registered. The first task of the midwife (who saw Mother at home) was therefore to assist Mother in obtaining an NHS number and making sure she was registered with a GP. At this visit the midwife estimated that Mother was around 28 weeks pregnant and eight days later Mother was formally "booked" by the same midwife at the surgery. The documentation used within the Acute Health Trust does ask relevant questions about the father of the baby including their date of birth, whether they have had previous children and any previous contact with children's social care. This is very good practice. It is also usual practice to ask a woman at this stage whether she has any concerns about domestic violence but as Child 1's father was present this was not asked.

4.3 The midwifery notes show that a paper ante-natal summary was completed which included information about the late booking and the need for an interpreter. Usual practice would have been for this summary to be left in the health visitor's tray as well as the pregnancy being discussed at the regular health visitor/midwife meetings. In this case, no trace of the summary could be found within the health visitor records and there is no record or recollection of a discussion between midwives and the health visitor. The use of paper summaries has now been superseded by a system whereby the booking is entered on a computer and this generates an electronic letter to the GP and health visitor. This should maximise the likelihood that the health visitor receives relevant information alongside

information received at the regular meetings that continue to be held at the GP surgery where all pending births are discussed.

4.4 There are two key issues at this stage and these are explored further in Findings one and two.

1. Mother's first language was Lithuanian and it was good practice that the midwife recognised the need to use language line, a telephone interpreting service. Some practitioners query whether this was sufficient to cover the complexity and nuances of a conversation regarding a range of medical and social issues although others view this as a positive and accessible service.
2. Mother had booked very late for this pregnancy and the review was informed that it was a situation not uncommon at the time in that area of West Sussex[3]. The midwife does not recall any concerns being raised from her meeting with Mother and no further worries emerged since Mother attended regularly for further ante natal appointments.

4.5 Mother gave birth by planned caesarean section and returned home two days later. Mothers in this area of West Sussex receive a good level of maternity care with a total of three home visits and, in the case of Child 1, an additional visit from a maternity support worker for support with bathing and feeding. No concerns were noted by any of the practitioners regarding the home conditions or care of Child 1. The midwifery discharge summary was completed and passed to the health visitor; this summary did not contain information about the late presentation of pregnancy as this had been included in the ante natal documentation.

4.6 Usual practice in the area is for a health visitor to carry out a pre-birth home visit in line with the Healthy Child Programme[4] and at that visit to ask whether the family would like to be registered with their local children and families centre. In this case, this visit did not take place as, due to staff shortages, only targeted ante natal visits were being undertaken. The new birth visit was therefore the first contact that the health visitor had with the family and since the health visitor had not seen the ante natal summary completed by the midwife, she was unaware of Mother's late presentation when she carried out the new birth visit to the home.

4.7 The health visitor completed a Family Health and Wellbeing Assessment and no concerns were noted. Similarly Child 1 was developing within expected norms at the six week check carried out at the GP surgery. At the follow up health visitor visit three months later, Child 1's development was within the normal range and home conditions were noted to be clean and tidy. At the three month review Child 1's father did express a worry that Mother was depressed and the health visitor, who was unaware of the need for an interpreter, explored this with her using "google translate". With hindsight it would have been more appropriate to have carried out the visit using an interpreting service as is recommended practice within the Community Health Trust. Mother reported no low mood and said that she was coping. Current practice would be to ask standardised questions[5] as recommended by national

[3] This information came verbally from midwives and also from data collected by the Eastern European Family Public Health Outcomes Working Group.
[4] Department of Health (2009) *Healthy Child Programme: pregnancy and the first five years of life.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
[5] https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789

guidance and this, combined with the use of an interpreter, may have given a more accurate picture of Mother's emotional state.

4.8 From this point the only contact that the family had with professionals was when Child 1 was taken to the GP surgery for immunisations. Child 1's father explained that appointment letters were sent and he responded to these. Community Health Trust policy regarding developmental checks is to invite parents via letter to make an appointment and if no reply is received follow up reminders are sent. In this case there is no evidence on the health visitor file that the letters were sent as it was not common practice to keep copies. Whether they were received and the family did not respond or whether they were not sent is impossible to determine, although Child1's father has no recollection of receiving them and there is evidence that he did respond appropriately in other circumstances, for example when asked to take Child 1 for immunisations.

4.9 Mother's only contact with the GP was one appointment for routine screening and Child 1's last contact with a professional prior to death of Baby O was for an immunisation around the same time at the age of five months.

5 FINDINGS AND RECOMMENDATIONS

Finding One

There is a lack of clarity regarding the nature and type of assessment needed when a woman presents late in pregnancy since child protection procedures do not differentiate sufficiently clearly between late booking and concealed pregnancy.

5.1 In this case there are two different issues relating to Mother's pregnancies. In her first pregnancy Mother booked late but thereafter attended regularly for ante natal care. Mother was in a relationship with the father of the baby and had the opportunity to live with him and form a family unit. The second pregnancy was concealed until Baby O was born and even at that stage Mother took steps to hide the birth from her partner and professionals. This pregnancy was as a result of an external relationship and surrounded by a great deal of uncertainty regarding how her partner would respond and what future arrangements might be for both herself and Child 1. The review was informed by midwifery colleagues that in these circumstances it was likely that the mother could successfully conceal her pregnancy from those around her.

5.2 At the time of Mother's first pregnancy there was an opportunity to understand the reason for the late presentation and any underlying concerns. At this time three sets of procedures existed relating to late presentation and concealed pregnancy.

1. LSCB guidance on concealed pregnancy and birth was found by the report author via an internet search. This would have been available to professionals at the time.
2. The LSCB guidance had been superseded by the Pan Sussex on line child protection and safeguarding procedures (section 8.10 concealed pregnancy)[6].

[6] The previous LSCB version has now been archived.

3. Local Acute Health Trust procedures “Management of Women who Fail to attend for Maternity Care”; it was these procedures that health staff said they would always refer to in the first instance.

5.3 There are inconsistencies between the procedures where a late booking is defined in the Acute Trust policy as after 20 weeks whereas within the Pan Sussex procedures it is defined as after 24 weeks. The Acute Trust procedures differentiate between action needed in relation to late presentation and concealed pregnancy but the Pan Sussex procedures concentrate on risks associated with concealment.

5.4 Reasons for late presentation may be many and varied and the current situation might have the unintended consequence of health professionals informing children's social care of all bookings after 20 weeks without information that would help to differentiate between those where there is a reasonable explanation and those where other factors indicate potential risk. Both the Acute Trust procedures and the Pan Sussex procedures would benefit from outlining questions that should be asked to inform professional judgement at this stage. This would be consistent with the children's social care pre-birth assessment guidance and process (2016) which notes that where a mother has presented late or has concealed her pregnancy a pre-birth assessment would not always be indicated unless there are other risk factors present.

5.5 Procedures alone will not change practice and the Safeguarding Children Board will need to evaluate the impact of procedure change on day to day work with late presentation and concealed pregnancies.

Recommendation One

West Sussex Safeguarding Children Board should work with relevant local organisations and the Pan Sussex Procedures group in order to rationalise procedures and produce a consistent approach to late booking and concealed pregnancies which includes a risk assessment to determine whether a referral to children's social care is required.

Recommendation Two

West Sussex Safeguarding Children Board should seek assurance that procedures in relation to late presentation of pregnancy are effective in influencing practice.

Finding Two

Despite considerable efforts by agencies in West Sussex to engage Eastern European families in health and early help services, this case illustrates that there are continuing challenges involved in making it easier for the community to access services.

5.6 Mother was Lithuanian and although it has not been possible to talk directly to her, other work within West Sussex has indicated that that there are challenges associated in making sure that people from Eastern European communities access health care provision.

5.7 There is good evidence that organisations in West Sussex are working hard to understand any barriers to accessing early childhood, health and social care within the Eastern European community with two key published reports[7] [8] supplemented by further focus group activity and the formation of Eastern European Families Public Health Outcomes Working Group. This group has commissioned an analysis of data which indicates that Eastern European women in the area of West Sussex where Child 1 was born, are significantly more likely to book with midwives later than the target of 11 weeks 4 days. This is within the context of an Acute Health Trust with a very high rate for booking women within the desired timescales.

5.8 It is known via police records that Mother visited a Lithuanian doctor when she was first pregnant with Child 1 and was told that she needed to access health care locally. This is entirely consistent with the findings of the research and focus groups within West Sussex which shows that many women from Eastern Europe expect doctor led care rather than care from a midwife. Midwives are generally viewed as having less expertise and more akin to a health care assistant. Mother had not registered with a GP and discussions with the community have also found that people from Eastern European countries may not see GPs as having the same status as a hospital doctor. These factors may have therefore contributed to Mother's lack of GP registration and late booking with a midwife.

5.9 Once Mother had made contact with a midwife it is positive that the Acute Trust has language line freely available and that this was used rather than expecting her partner to help with translation. The use of google translate by the health visitor was less helpful and it will be important for all health services to make sure that all staff have full access to more appropriate interpreting services.

5.10 Mother has spoken to professionals since her arrest about feeling lonely and of difficulties in integrating with other Eastern European communities in the area. This serves as a reminder about the importance of understanding cultural differences between the different cultural groups paying particular attention to those who are in a minority. The Healthwatch survey did not include any Lithuanian respondents and they were in a minority in the Early Years Needs Assessment.

5.11 It is likely (although speculative) that Mother's concealment of the second pregnancy was influenced by factors other than access to healthcare. She was registered with the same GP that she had been registered with during the first pregnancy and would have known how to access midwifery services. At this stage there was a reason why she did not want her partner to know and the emotional impact of an unplanned pregnancy and uncertainty about the future are both factors likely to have contributed to the concealment. Support needs are discussed further in Finding Three.

Recommendation Three

West Sussex Safeguarding Children Board should ask all organisations providing health care to review arrangements for interpreting services in order to ensure that practitioners have timely access to the appropriate service in the range of languages required and know how to use it.

[7] West Sussex Early Years Needs Assessment (2016)
[8] Healthwatch West Sussex (2016) West Sussex: A home for all. Listening to Migrant voices.

Recommendation Four

West Sussex Safeguarding Children Board should work with the Eastern European Families Public Health Outcomes Working Group in order to share the findings of this review and develop a joint approach to the dissemination of good practice.

Finding Three

A number of factors came together in this particular case which resulted in the parents of Child 1 not accessing those services which could have provided support and recognised developmental delay.

5.12 Child 1 came to the attention of statutory authorities because of the sad events surrounding the death of Baby O. Concerns for Child 1 at this stage extended beyond the emotional and psychological impact of Mother's actions, to issues regarding Child 1's overall care and development. Child 1 had very limited contact with other children, was found to be developmentally delayed and parents had not planned for Child 1 to be registered for a school place at the appropriate time. It seems that neither parent fully understood Child 1's developmental needs or how to meet them. The potential impact of Mother's unfamiliarity with English systems is one possible factor and there were also aspects of the system (outlined below) which did not work well in this case.

5.13 Child 1's father did respond to letters giving Child 1 appointments for immunisations but there is no evidence that similar letters sent regarding developmental checks. Letters that should have been sent asking Child 1's parents to make an appointment were not received and there was no means of tracking those parents who did not take their children to developmental checks offered under the Healthy Child Programme. This should be understood within the context of parent's right to choose whether to take up the offer of a check and for some parents who may not choose to take up the offer without any detrimental impact on their child. For example some parents who may have had several previous children or are very familiar with expected milestones may not feel it necessary to use this service. For this reason a universal tracking system would not be viable or appropriate. In fact the Community Health Trust providing health visiting services in the area of West Sussex where Child 1 lived has a very good record for completing checks compared to other providers in the County. For example from January through to March 2017 87.6% of one year checks were completed and 82.1% of 2-2.5 year checks[9]. It would therefore not be appropriate to make overarching recommendations focused on developmental checks on the basis of this case alone.

5.14 Although not all parents may use the services on offer, the aim is to identify and support those families who may have particular needs that increase their children's vulnerability. Within West Sussex, children and families centres play an important role in relation to this and health visitors are charged with asking parents at ante natal and pre-birth visits whether they would like to be registered with their local centre and assisting them with registration.

[9] Performance data provided by Sussex Community NHS Trust to West Sussex Public Health.

The take up rate for this service is 85%.[10] Once registered the centre is proactive in sending parents information via e-mail and where information from the Department of Work and Pensions shows that a family is eligible for free nursery funding a member of centre staff will visit the home if this has not been taken up[11].

5.15 In this case there is no evidence that the health visitor asked the family whether they would like to be registered with the children and families centre. The system at the time meant that individual health visitors had to gather together all relevant documents to take on a visit and it is likely that this form was overlooked. This is less likely now since all the necessary documentation is computer generated for each visit. It is possible that Child 1's father at least would have taken up the offer as he told the review he was open to receiving help and did respond to an invitation from a local church to an activity day. He also explained that both he and Mother were inexperienced parents and they did ask for additional help with bathing which was provided by the midwifery service.

5.16 Although Child 1's father was open to receiving help it is less clear whether services would have felt positive and relevant to Mother. There is one initiative being piloted in part of West Sussex that may have made a difference in this case although it should be noted that in its current form it is provided in English and the initial contact is with the mother. Family Assist is an online communication and information tool and has the potential to deliver public health messages to women and families from pregnancy to 19 years. Women and nominated others can sign up at booking with a midwife and from then the system generates e-mail communication relevant to the age of the child. It is possible to see whether e-mails have been opened and to target information as needed. The system includes a live chat function which enables families to ask for advice before difficulties escalate. In this case it may be that such a system would have provided additional advice and assisted the take up of developmental checks, access to free nursery provision and school registration. The Safeguarding Children Board and Public Health will need to work together to review the outcome of the pilot on safeguarding children in hard to reach families.

Recommendation Five

West Sussex Safeguarding Children Board should work with partner agencies to scrutinise how early help services are engaging with families from communities that are currently underrepresented or hard to reach.

6 CONCLUSION

6.1 It is hard to see how any professional or organisation could have prevented the death of Baby O. This second pregnancy had been concealed from even those close to Mother and there were no opportunities to support her in managing her relationships and decisions at this time.

6.2 In this case, the issues surrounding each pregnancy were different. In the first pregnancy there was a delay in the family accessing midwifery services whereas the second pregnancy was deliberately concealed from her partner, colleagues and medical professionals. In the

[10] West Sussex Child and Families Centres Management Report 2017
[11] In this case it is likely that the family would not have been eligible so this visit would not have taken place.

first pregnancy there were some opportunities to identify additional support needs through greater understanding of the impact of Mother's ethnicity on the take up of services, more consistent use of interpreters and assessment of the reasons for the late presentation. The review has also identified a need to review and rationalise the procedures relating to late booking and concealed pregnancies. These need to stress the importance of a thorough assessment of each late presentation by midwifery services in order to determine whether a referral to children's social care is needed.

6.3 Although no direct link can be made with the death of Baby O, the family would have been less isolated from professional help if Child 1 had been accessing services. The review has found that there were instances where the system that is in place could have worked better with parents being asked if they wished to register with the children's centre and letters being sent inviting Child 1 to make a developmental check appointment. The systems within West Sussex are proactive in trying to engage with families but ultimately it is parental choice whether such services are taken up. It is therefore hard to differentiate between those children whose needs will be fully met within their family and community and those who may not receive the services they need. It will be important to monitor the progress of the on line Family Assist pilot to understand whether it can help in this regard.