South Gloucestershire Children's Partnership

Serious Case Review

TOBY

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1. Introduction

1.1 Why was this case chosen to be reviewed?

In May 2018 South Gloucestershire Safeguarding Children Board (SGSCB) decided to conduct a Serious Case Review (SCR) because the circumstances of this case met the following criteria:

(a) abuse or neglect is known or suspected: and

(b)(i) the child has died.[1]

1.2 Succinct summary of case

At about 10am on Sunday 14th January 2018 the parents of five week old Toby found him very pale and icy cold in his cot. An ambulance arrived soon after this and pronounced him dead. His father had last seen him alive at around midnight the night before. The family was spending the weekend at paternal grandmother's house where father lived.

Toby and his mother were known only to maternity services, GP and health visitor. No concerns had been raised about Toby or his parents prior to his death.

The paediatrician who undertook the Rapid Child Death Response[2] visit to the house on the day Toby died initially assumed Toby was a victim of Sudden Infant Death Syndrome (SIDS). The baby's bedding and sleeping arrangement did not comply with safe sleeping guidance. Both parents presented as having limited understanding of a five week old baby's needs and were unable to give a clear history of his care in the hours leading up to his death. After Toby died it was found that his father had a diagnosed learning disability and his mother presented as having some level of learning difficulty.

The subsequent post mortem found Toby had a total of 74 rib fractures some occurring within a range of between four and 48 hours prior to his death, some occurring days prior and some up to two weeks prior to death. There was also evidence of traumatic head injury likely to be consistent with a non-accidental event.

[1] Working Together to Safeguard Children 2015

[2] https://www.proceduresonline.com/swcpp/bristol/p_rapid_response.html If a child has died at home or in the community, the lead police investigator and Lead Paediatrician or Health Responder should decide whether there should be a visit to the place where the child died, how soon (ideally within 24 hours) and who should attend. This should almost always take place for cases of sudden infant death.

1.3 Family Composition

Toby Date of birth 05.12.2017
Mother 25 years old
Mother and Toby were living with his maternal grandmother and maternal grandfather and her two adult siblings

Father was 28 years old, he lived with Toby's paternal grandmother and he worked as a delivery driver.

1.4 Scope of the review

The period of time chosen for this review is from September 2017 when Toby's mother had a positive pregnancy test and was found to be 28 weeks pregnant until Toby's death on 14th January 2018.

1.5 Organisational learning and improvement

This case presented as having no identified preceding risk factors and minimal agency involvement. The SGSCB identified that it could shed light on particular areas of practice including addressing the following questions:

- How well the multi-agency safeguarding system (in particular maternity and Health Visiting services) identifies risk and supports vulnerable parents of new born babies
- How effectively agencies assess, engage and support new fathers
- How risk is assessed and identified prior to and following birth

1.6 Circumstances of the review

This Serious Case Review commenced in June 2018. Shortly afterwards the Police informed SGSCB that they were undertaking a criminal investigation into Toby's death and that family members could not take part in the review. The Senior Investigating Officer asked that the review not proceed with interviews of the health professionals involved as they would need to be interviewed as part of the investigation and may become key witnesses. As a result SGSCB secured the agreement of the National Child Safeguarding Practice Review Panel[3] to put the review on hold on the basis that there would be insufficient data with which to meaningfully undertake an SCR.

The Police investigation did not progress to a prosecution due to a lack of agreement between the Police and the Crown Prosecution Service (CPS). To

[3] https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

date there have been no criminal charges in relation to Toby's death. The Police are appealing to the CPS for a further review of the decision not to pursue a prosecution and the case has been referred to the Coroners Court. This will not take place until a final decision has been reached about criminal prosecution.

The serious case review resumed in July 2019, 18 months after Toby died.

This review commenced before the publication of the 2018 edition of Working Together to Safeguard Children and therefore it has been conducted according to the guidance set out for serious case reviews in Working Together 2015.

1.7 Methodology

Statutory guidance requires SCRs to be conducted in such a way which:

- "recognises the complex circumstances in which professionals work together to safeguard children;
- seek 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.' (WT 2015 4:11)

In order to comply with these requirements this review has used a systems approach drawn from the Social Care Institute of Excellence[4] (SCIE) Learning Together Systems model. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families, and make it more or less likely that the quality of practice will be good or poor.

The lead reviewer was Lucy Young, an independent Safeguarding Consultant with an extensive children's social care and safeguarding background. She is experienced in undertaking serious case reviews and is an accredited SCIE Learning Together reviewer.

The lead reviewers worked closely with a review panel comprised of the following:

Agency	**Role**
Independent Safeguarding Consultant	Lucy Young SCR Author and Lead Reviewer
North Bristol NHS Trust	Lead Midwife for Safeguarding

[4] https://www.scie.org.uk/children/learningtogether/

Sirona Care and Health	Head of Health Visiting
Sirona Care and Health	Named Nurse for Safeguarding
South Gloucestershire Clinical Commissioning Group	Consultant Paediatrician and Designted Doctor for Safeguarding Children

1.8 Data collection: practitioners and records

Understanding practice in context requires reviewers to engage those people who were directly involved in the case in a collaborative process of dialogue, as well as drawing on the formal documentation as a source of data.

In this case by the time the review resumed the health visitor had retired and did not wish to take part. A number of maternity service professionals came into contact with Toby's mother through the course of her pregnancy and it was not possible to identify or meet with each of these. Therefore the review was limited to discussions with one community midwife and Toby's GP who saw him on one occasion. A health visitor who was not involved with Toby provided general information about the service and working conditions.

The review had access to the record of a detailed root cause analysis style interview with Toby's health visitor. In addition GP, obstetric, antenatal and postnatal hospital and community midwifery records were made available.

1.9 Involvement of the family

Both parents and the maternal grandmother were invited to take part in the review to give their views but declined to do so.

2. Summary of events

Date	Event
05.09.17	Toby's mother visits her GP who confirms she is pregnant. She is booked in for a midwife appointment and an ultra sound scan to determine the due date.
07.09.17	Toby's mother (with maternal grandmother) attends a booking in appointment with Community Midwife 1 at Cossham, Midwife 1 thinks she might be 20 weeks pregnant.
07.09.17	Community Midwife 1 sends the 'Booking In' form to the Health Visiting Team and it is mistakenly manually filed as EDD in March 2018. The case is therefore not flagged for a 28 weeks antenatal visit by the health visitor.
12.09.17	An ultra sound scan confirms that Toby's mother is 28 weeks pregnant.

26.09.17	Toby's mother (with maternal grandmother) attends an appointment with Community Midwife 2 at her local Health Centre. Midwife 2 recognises a need for extra support regarding her possible anxiety around the pregnancy and birth. Maternal grandmother says that the family does not want any services involved as they have had a lot of involvement with other services in connection with Toby's mother's disabled brother. Midwife 2 thinks that maternal grandmother seems to always speak for her daughter who says very little.
27.09.17	Toby's mother (with maternal grandmother) attends an antenatal clinic at Southmead Hospital because her gestational diabetes needs to be monitored by the Obstetrician. The SHO writes to Toby's mother's GP and copies in Midwife 2 describing Toby's mother's initial anxiety about her pregnancy and that although Toby's mother reports she feels fine the SHO highlights potential concerns about her having low mood and anxiety that may be exacerbated after the birth.
03.10.17 19.10.17 22.10.17	Toby's mother attends further antenatal clinic appointments (always with maternal grandmother) at Southmead Hospital. These appointments focus on monitoring her gestational diabetes and there are no social issues or concerns noted.
24.10.17	Toby's mother and maternal grandmother attend an antenatal appointment with Community midwife 2. There are no concerns noted. Toby's mother does not want to attend antenatal classes and says she is planning to bottle-feed.
07.11.17 09.11.17	Toby's mother and maternal grandmother attend further antenatal appointments at Southmead Hospital there are no concerns noted.
22.10.17	Toby's mother and maternal grandmother see Community Midwife 2 at theHealth Centre for her 34 week antenatal check. Toby's mother says she is looking forward to the birth, things are going ok with her boyfriend and he and her mother are likely to be her birthing partners.
05.12.17	Toby is born by normal vaginal delivery at Southmead Hospital. There are no concerns noted. Toby's father is present at the birth and there is no information recorded about him.
05.12.17 to 08.12.17	Toby's mother remains in hospital with Toby, her emotional wellbeing and attachment to the baby are noted as normal. Toby returns home to live at his grandparent's house with his mother.
09.12.17	Community Midwife 3 does the first postnatal home visit. Records note that she discusses bathing, feeding and making up bottles, safe sleeping, and risks of bed sharing. There is no note of who else was present at this home visit. She does not record any concerns and notes Toby's mother's emotional well-being and attachment to the baby as normal.
11.12.17	A Maternity Care Assistant does a second postnatal home visit. She undertakes routine neonatal screening tests and does not note any concerns. There is no note of who else is present.

16.12.17	Community Midwife 2 does the final postnatal discharge home visit. That Saturday Midwife 2 has 8 home visits to do, this means she has a maximum of 15 minutes per visit and her focus is very much on the baby's health and standard checks that need to be undertaken. Toby's mother, father and maternal grandparents are present. Father stays in the background playing on the computer, she does not observe him interacting with the baby. Midwife 2 has no concerns and completes the Transfer Form to send to the Health Visiting team.
19.12.17	The Health Visitor visits the home to complete the Family Health Needs Assessment[5]. Toby's mother and grandmother are present. The health visitor observes that Toby's mother handles the baby appropriately and has no concerns about her care of him. She describes the house as cluttered, very grubby, the carpet is sticky and the paintwork is grey. The Health Visitor assesses that Toby's mother's support from her parents and her appropriate handling of the baby are both positives. However she has some concerns about mother's presentation as 'monosyllabic' and about the state of the house. She does not make a decision about the level of health visiting service[6] at this stage and leaves that section of the form blank. She decides to visit again on 4th January 2019 to continue her assessment to decide on the health visiting weighting. Later that day the health visitor speaks to Midwife 2 who tells her she thinks Toby's mother may have a learning difficulty.
27.12.17	Toby's grandmother attends the GP surgery with Toby, she does not have an appointment. She tells the GP that Toby has been unsettled and vomiting after feeding. She has not brought Toby's Red Book so the GP cannot plot his weight. She says that Toby's mother is upset about the vomiting and a little tearful and too upset to come to the doctors. She also tells the GP that Toby's dad is "very loud with him".
28.12.17	The GP leaves a phone message for the health visitor about the GP visit and what Toby's grandmother has said about Toby's mother and father.
04.01.18	The health visitor does her pre-arranged follow up visit. Toby's mother is present with her parents and the baby. Toby's mother says that she feels anxious in social situations but does not want any help with this, Toby's father lives with his mother but she hopes to move in with him sometime this year, she says they have been in a relationship for two years. The health visitor does not explore the issues raised by the GP because she does not know if the GP has told Toby's grandmother that he was going to tell the health visitor what she had said. She does not know if she can discuss Toby's grandmother's visit to the GP because of information sharing policy. She asks Toby's mother why she had not gone to the GP with the baby and Toby's mother says that she was scared and worried about the baby. The health visitor thinks that she has social anxiety and possibly a learning difficulty.

[5] Healthy Child Programme: Pregnancy and the first 5 years of life. DoH 2009

[6] See above ref p.31The HCP Schedule

14.01.18	At approximately 10.15am an ambulance is called to Toby's paternal grandmother's house where Toby's parents are staying with Toby. The ambulance crew pronounces Toby dead at the scene, he is already cold with rigor mortis.

3. The Findings

3.1 Structure of the report

This section contains four priority findings that have emerged from the SCR. The findings explain why professional practice was not more effective in identifying vulnerability, complex needs and risk and engaging and assessing Toby's father and mother. Each finding also lays out the evidence identified by the Review Panel that indicates these are not one off issues. Evidence is provided to show how each finding creates risks to other children in future cases, because they undermine the reliability with which professionals can do their job.

The appraisal of practice provides an overview of 'what' happened in this case, looking at professional response and systems learning. It sets out the view of the review team of how effective maternity and health visiting services were in their contact with Toby and his parents. It aims to outline what got in the way of professionals being as effective as they wanted to be. Where possible it provides explanations for practice, or indicates where this is discussed more fully in the detailed findings that have immerged from this SCR.

3.2 Appraisal of professional practice

Toby died as a result of non-accidental injuries but it is not known how these occurred. The health professionals who came into contact with Toby and his family during the antenatal and postnatal period were devastated to learn of his tragic death. None of them saw any early signs that he may have been at risk of such catastrophic non-accidental injuries and there was nothing unusual about the pregnancy, birth or immediate postnatal period. There were no identified preceding risk factors.

At the heart of this case lies the difficulty for professionals of working in a fragmented maternal and child health system that has limited capacity to provide the opportunity to assess and understand parental mental capacity or to involve or even get to know fathers. Different elements of information tend to be seen in isolation rather than being collated to form part of a jigsaw that might lead to a holistic assessment and analysis of parenting capacity and need.

3.2.1 Late booking of pregnancy

Toby's mother's explanation for the late booking, that she had not wanted to be pregnant in the first place, was not probed further, analysed or shared throughout the antenatal and postnatal period. There is no "Late Booking" policy or practice guidance for staff in NBT and the late booking did not contribute later to the sum of information known about mother or influence the approach to her antenatal care.

The care provided to Toby's mother was fragmented despite a recommendation from the booking in midwife based on her acutely shy presentation, that she required continuity of care. This is further explored in Finding 3.

One hour and 15 minutes is set aside for each booking in appointment when the midwife is required to complete a medical history and undertake all routine observations as well as writing it up on handheld notes. The appointment is very medically focussed and midwives do not have the capacity to attend to the social side in any depth at this stage. Although there can be the flexibility to book a double appointment that was not done in this case. There is no information recorded about mother's literacy skills or levels of understanding and capacity to take on board information leaving a question over how much she understood of what she was being told. See Finding 1.

3.2.2 Antenatal care

Antenatal appointments with the community midwife are generally 15 minutes long and the main focus is on the expectant mother's health and any medical issues. The risk of domestic abuse is higher during pregnancy and immediately after the birth and midwives are expected to ask mothers if they are experiencing domestic abuse at home. In this case the question was not asked because maternal grandmother was always present and the midwives felt that mother may not be able to answer the question with her mother there. There appears to have been no attempts to enable a conversation with mother on her own that may have led to finding out more about her relationships at home and possible vulnerabilities. It was not possible to determine whether or not mother had any learning difficulties or needs with grandmother usually speaking for her. Maternal grandmother was seen as a strength in the support that she was providing. Although this may well have been the case alternative scenarios were not explored.

The 'booking in' form designed by maternity services tells the health visitors what the midwifery service assume the health visitor needs to know. It is a single sheet of information that the midwife sends to the GP and the Health Visiting team to inform them about the pregnancy. The review found that it was inadequate in the level of information provided. For example the expected delivery date (EDD) was left as unknown so there was no flag that this was a late booking. There was no reference to mother's acute shyness or social anxiety or her not wanting to be pregnant.

Under the Healthy Child Programme[7] health visitors are expected to undertake an antenatal home visit when a mother is 28-34 weeks pregnant. This is the first opportunity to assess family strengths, needs and risks to future outcomes, identify families that may need additional support and start talking about the transition to parenthood. Fathers should be encouraged to attend. In this case the Health Visiting Team's manual filing system was poorly managed and this form was filed with an incorrect EDD so it would not have come to the notice of the health visiting team for an antenatal visit.

In any event in 2017 Sirona was not undertaking routine antenatal visits and as few as 20% were being done. There was an expectation that health visitors decided on priorities and these were known as targeted visits with no clear criteria as to which ones came into this category. Standards and priorities set out in the Healthy Child Programme were not clearly understood in South Gloucestershire at the time and teams were left to decide their own priorities. There was no information on the (wrongly filed) booking form to indicate the need for a targeted visit. The review team heard that there has been significant progress with this and that practice has improved since the events in this review. Therefore there is no finding relating to this issue however the review recommends that these improvements are further tested and evidenced to ensure they are embedded and are improving outcomes for children.

Continuity of care during the antenatal and post partum period means seeing the same community midwife at appointments if at all possible and this was highlighted as a particular priority for this mother given her acute shyness and social anxiety. In this case mother's medical complication of gestational diabetes meant that she was seen for six antenatal appointments at Southmead Hospital where the focus was understandably on her medical care.

Concerns about Toby's mother's social anxiety could have resulted in attempts at meaningful conversations with mother and possibly some scaling of her mood and anxiety. The Review Panel questioned whether staff feel sufficiently skilled to undertake a more in depth assessment of a mother's presentation. This is explored further in Finding 1.

Toby's mother was asked if she would like to attend antenatal classes but, unsurprisingly, she refused. There was no alternative to offer her such as a one to one session or a more tailored group situation.

3.2.3 Toby's birth

Toby's birth and the 48 hour postpartum period she spent in hospital was the only time professionals may have observed mother and father together and caring for the baby. There is no reference to father in any of the delivery and postnatal hospital notes although it is known that he was present at the birth and was in the hospital after the birth. The notes focus entirely on mother's

[7] Healthy Child Programme: Pregnancy and the first 5 years of life. DoH 2009

and baby's health and mother's bonding with and care of the baby. The observations recording mother's handling and attachment to Toby are positive. There is a lack of evidence in the hospital notes from this period that delivery and ward staff are expected to assess both parents holistically and consider father's bonding and care of the baby. From reading the hospital notes reviewers could not assume that hospital staff did not notice anything about father's care of the baby but no information either positive or negative is noted.

3.2.4 Postnatal home visits by midwife

The postnatal home visits were the first time professionals visited the home. They were undertaken by two different community midwives and a midwifery assistant, despite the specific recommendation that this mother have continuity of care. North Bristol Health Trust is contractually funded for three postnatal visits and this is usually two by a midwife and one by a maternity care assistant. Usually one of these three postnatal contacts takes place at the Health Centre but in recognition of mother's anxiety they were all done at home.

The visits are usually up to 15 minutes long and focus on the baby's weight, feeding, mother's health and covering information on baby care with mother. Father was recorded as being present at the final midwife visit but he did not take part in the meeting. Notes are succinct and there is no expectation on recording who was present apart from mother and baby and to note the condition of the home or issues about mother's presentation. The limited time for home visits mean that midwives carry out set tasks and complete forms without the time to observe or engage parents.

3.2.5 Transfer of care to health visitor and Family Health Needs Assessment

This was the first time that a professional expressed some immerging concerns about mother's presentation and the home condition.

The Transfer of Care form sent to the health visitor by the midwife is a mainly tick box single sheet that does not allow for any narrative about any aspects of concern or otherwise. It is quite usual for the health visitor to receive the form after her first visit to the family. This form appears to meet the needs of the midwifery team (transfer care) rather than those of the family (share significant information that promotes wellbeing and reduces risk in a timely way). The form has been developed by the maternity service with no consultation with the health visitors. The form does not include any information about mother having never been seen alone, grandmother's refusal of additional support for mother with her shyness and anxiety, the condition of the home, lack of any involvement with father, mothers mental capacity**.**

There was no evidence that professionals were skilled in understanding how to assess a mother's mental capacity or level of understanding. Boxes on

forms were ticked when a baby care topic was discussed with the mother but there was no information as to how mother had understood this.

The health visitor was experienced and was able to assess and analyse the balance of support mother was getting from the grandmother and her generally appropriate care of Toby with the poor condition of the family home (mentioned for the first time in any notes) and mother's social presentation. She did not have the benefit any information from a 28 week antenatal visit or from maternity services and the health visitor appropriately decided she needed to visit again to continue her assessment. The lack of any previous collation of concerns and observations meant that low level concerns were only now immerging and being recorded and analysed.

There were no clear pathways for midwives and health visitors for responding to low level concerns about parents who may have a mild learning difficulty that do not reach the threshold for child protection or child in need. Professionals have few resources to offer parents who struggle to understand and communicate with professionals but do not reach the threshold for, or refuse, referral to early help services. In this case the grandmother refused an offer of referral to Toby's mother with her anxiety.

3.2.6 Grandmother takes Toby to the doctor and follow up home visits by health visitor

It was good practice by the GP to fully undress Toby and examine him when he weighed him. Although there were no safeguarding concerns from this visit he appropriately shared information with the health visitor about the fact the grandmother said mother was too upset to bring Toby herself and that grandmother told him that father very was loud with baby Toby. There is an ambiguity in this information that would have benefited from some professional curiosity by the GP to understand more about the nature and context of father's 'loudness'. This is further explored in Finding 4.

The review panel was concerned about the limited understanding of information sharing policies and guidance and considered this to be an over cautious and counter productive response to the GP's information. According to government advice there is a lawful basis for sharing advice when 'safety may be at risk'.[8] The health visitor concluded that she would visit again for Toby's 6-8 week review.

3.3 Findings in detail

3.3.1 Finding 1

Maternity services in South Gloucestershire are task centred and narrowly focused on maternal and baby health (to the exclusion of fathers and extended family members), which has led to a system where

[8] Information sharing advice for practitioners providing safeguarding services DfE 2015

midwives lack the skills and tools to take a holistic view which would enable them to identify underlying vulnerabilities or potential concerns.

(i) How did the issue manifest in this case?

The Review Panel found that forms and recording systems do not allow for lower level signs of vulnerability to be recorded and shared. Because the notes are handheld by mothers midwives feel limited in what they can write as they are reluctant to write anything that may place a mother at risk or may offend her. In this case there was a lack of analysis of the possible significance that late booking may be a sign of vulnerabilities and the information was not recorded in a way that it formed part of a holistic picture of her needs and vulnerabilities. Evidence from Serious Case Reviews[9] has found that a woman might present for antenatal care at a late point in pregnancy for a number of reasons some of which may make her and her baby vulnerable. These include: learning difficulties, drug or alcohol misuse, mental illness or fear that revealing the pregnancy may provoke or worsen domestic abuse or violence.

Information recorded by the hospital antenatal clinic and maternity ward focussed only on the medical needs and there was no reference to the impact of any social aspects, for example mothers social presentation.

Apart from Toby's father's name and occupation there is no record of any other information about him or that any maternity health care professionals met him or discussed his role as a new father. There was a lack of professional curiosity about father and his ability to care for a baby. The focus was entirely on mothers health needs. As a maternal and child health service there is no expectation or requirement that fathers needs or role form part of the information gathering or assessment of baby care.

Midwives do not record low level concerns. In this case the health visitor contacted the midwife after her first home visit and the midwife told her that she thought the mother might have a degree of learning disability. The midwife was not clear what to do with this information apart from to tell the health visitor, she was reluctant to label mother through a supposition and she had not been able to make further assessment by spending time with Toby's mother on her own. This is the first time that mother possibly having learning difficulties is mentioned and there is no written record of it within the maternity notes.

Midwives were over reliant on grandmother to speak for mother and did not make meaningful attempts to speak to mother on her own they were, therefore unable to make an assessment of her capacity to understand. After Toby died professionals who visited them at home and spoke to both parents immediately gained an impression that both had a limited understanding of the baby's needs. The information that father has a diagnosed learning difficulty was not known throughout the pregnancy or postnatal period.

[9] NSPCC Knowledge and Information Service Learning from SCRs 2015

(ii) How do we know it is an underlying issue and not unique to this case?

In South Gloucestershire, unlike in some other areas, midwives do not have their own caseloads and consequently midwives tend to be task orientated rather than person focussed. This means that the system is less geared to midwives being able to build a gradual holistic picture of a mother's strengths, needs and vulnerabilities.

The review team heard that there is an anxiety amongst professionals about how to describe learning difficulties or low learning levels for those parents who do not have a formally diagnosed learning disability. They do not have access to practice tools that may help them to analyse issues such as this.

Midwives can discuss safeguarding concerns with the lead midwife for safeguarding and record them on the Family Life Events sheet which is a paper recording system held in the community team. They also record medical information on the electronic database (Euroking). None of these recording systems are designed for recording low-level issues such as mother's social presentation. In this case although the midwife told the health visitor that she thought the mother might have some level of learning difficulties she did not record it anywhere.

(iii) Why does it matter? What are the implications for the reliability of the maternity system?

By completing tasks such as filling in forms and undertaking all necessary maternal health checks midwives could satisfy themselves that they were doing their job as well as could be expected. However this did not enable them to spot potential vulnerabilities by exercising professional curiosity about parents and enquiring further.

Working Together (2018) states: "Local organisations and agencies should have in place effective ways to identify emerging problems and potential unmet needs of individual children and families. Local authorities should work with organisations and agencies to develop joined-up early help services based on a clear understanding of local needs. This requires all practitioners, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other practitioners to support early identification and assessment."[10]

For maternity services mother's and babys' medical vulnerabilities and physical health are their primary focus with specific targets and poor or fatal outcomes if medical issues are not monitored and treated. This results in a form of 'trade off' with other priorities. For example in this case getting to know mother, attempting to see mother on her own and assess her capacity, meeting father. Under pressure people can narrow down their focus, this can result in 'tunnel vision' whereby practitioners tend to make the task

[10] Working Together to Safeguard Children 2018 p.13

manageable by seeing an increasingly narrow portion of their work environment. This has the benefit of allowing them to stay well focused on one thread in the case but has the weakness of making them slow to notice issues arising outside that focus.[11]

3.3.2 Finding 2

Health visitors, community midwives and hospital maternity professionals do not work collaboratively which results in poor information sharing and parent's and children's vulnerabilities and wellbeing not being properly understood or responded to.

(i) How did the issue manifest in this case?

The review found that information sharing between midwives and health visitors is, at best, ad hoc.

The forms used to share information were inadequate and have not been designed collaboratively to achieve effective information sharing. For example the 'booking in' form designed by maternity services tells the health visitors what they think they need to know and is based on information on maternal and baby health that is essential to maternity services. The review found that it was inadequate in the level of information provided.

The midwives were not aware that the health visitors had failed to undertake the 28 week antenatal visit.

Information from the maternity hospital to the community midwife team is done through the 'Baby Transfer of Care' form which is a computer generated mainly tick box form focusing on mother and baby's medical needs. There is no space on this form for reference to family interaction, social issues, low level concerns or father's care of and attachment to the baby. The Review Panel considered this form to be inadequate in terms of the quality of information passed to the community team. The lack of an electronic shared database at that time contributed to shortfalls in information sharing.

(ii) How do we know it is an underlying issue and not unique to this case?

The Review Panel confirmed that there is no pathway formally agreed by North Bristol Trust and South Gloucestershire health visiting service to support communication between health visitors and midwives. This means that the level and effectiveness of communicate are variable across the service.

There is evidence of a lack of collaboration throughout the system in South Gloucestershire, which would need to be evident at the strategic commissioning level in order to improve the interface between midwifery and health visiting at the operational level.

[11] Dekker S. (2002) The Field Guide to Human Error Investigation

(iii) Why does it matter? What are the implications for the reliability of the system?

Many serious case reviews flag the issue of inadequate information sharing and ineffective work with colleagues and other agencies as an issue contributing to system failure. In South Gloucestershire there was a similar finding in the SCR Baby E and Baby F (June 2019) that there was a need for more effective information sharing between midwives and health visitors.

The maternity and child health systems tend to be task centred with a focus on ticking boxes to demonstrate that tasks have been completed or topics have been discussed with parents. The key point as to whether or not a parent has actually understood and processed the information has become irrelevant. For example filling in a short form and ticking boxes that focus on specific tasks can feel more efficient that spending time getting to know a parent.

Pressure within each organisation to deliver contracts with diminishing resources leads to a blame culture. Systems tend to focus on the needs of the organisation to deliver the contract over the specific needs of each individual.

3.3.3 Finding 3

The maternity service is not able to provide continuity of care to the most vulnerable mothers particularly if they have an additional health need which results in no one in the service building up a relationship with them and understanding their vulnerabilities

(i) How did the issue manifest in this case?

Toby's mothers care was fragmented, she saw a number of different maternity professionals at three different locations. Despite an identified need for her to have continuity of care it was not possible to offer this. Her acute shyness and social anxiety meant that professionals became over reliant on the grandmother during appointments and no one really understood Toby's mothers individual needs.

(ii) How do we know it is an underlying issue and not unique to this case?

There is a shortage of midwives, particularly experienced ones, both locally and nationally. The workforce is predominantly female and the system allows for flexible working arrangements with many midwives working part time.

In South Gloucestershire midwives do not have caseloads, the system is under pressure and the focus is on fulfilling the contractual requirement. Midwives tend to carry out the specific tasks required at each shift, anything outstanding is left for the another midwife on another shift.

(iii) Why does it matter? What are the implications for the reliability of the system?

The inability within the system to provide continuity of care to Toby's mother meant that professionals did not have the opportunity to build a picture over time. It might have been the case that Toby's mother would have felt more at ease and able to talk more freely to a known and trusted professional. If that had been the case it's probable that vulnerabilities and capacity may have become more apparent.

Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.

In December 2017,the Maternity Transformation Programme published Implementing Better Births: Continuity of Carer**,** to help Local Maternity Systems (LMS) plan and deploy continuity of carer models in their services.

3.3.4 Finding 4

In South Gloucestershire there is a tendency for information sharing within health agencies to be ineffectual due to a lack of clarity about why information is being shared, what to do with it and whether the information could be followed up

(i) How did the issue manifest in this case?

It was good practice that an SHO at Southmead Hospital thought it important to write to Mother's GP and the community midwife with concerns about mother's acute shyness, social anxiety and social presentation and highlighting it as a possible flag for postnatal concerns. However this letter appears to have been filed by the GP and midwife without the information influencing mother's future care. There is a tendency for medical practitioners to share information without being clear about why they are doing so and what they think needs to be done. As a result information sharing can be ineffectual and does not influence outcomes.

Another occasion when a doctor shared information about low level concerns was after the GP saw Toby with his grandmother after Christmas. He did not suggest to the health visitor how he expected her to act on the information. In this case the doctor thought he was sharing information that may be significant in the context of other information the health visitor might have. This is an example to a professional understanding the need to collate all levels of information as part of a potential jigsaw of concerns.

The health visitor did not understand the information sharing policy in this context and, apart from Toby's health, she did not feel she was able to discuss the GP's information with the family as she did not know whether he had told grandmother he was going to tell her. She did not want to exacerbate Toby's mothers social anxiety and possibly alienate her.

(ii) How do we know it is an underlying issue and not unique to this case?

The review panel and the other professionals involved in the review confirmed that there is a lot of information shared between professionals in the health system but a lack of clarity about the purpose of the sharing. They confirmed a tendency for information to be placed on records without being collated or analysed as part of the whole patient picture.

(iii) Why does it matter? What are the implications for the reliability of the system?

There is a risk of information overload which can result in professionals being so overloaded with information that they do not have the capacity to absorb, analyse and act on it. An additional barrier to effective information sharing can be an overcautious interpretation of the information sharing policies.

Learning from SCRs [12] found that 'the knowledge held by an individual practitioner or agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern. Practical barriers to information sharing include using different and incompatible IT or paper systems and diverse interpretation of policy, procedure and protocol'.

4. Recommendations

This section outlines an overall approach to how the response to this serious case review will be managed and monitored. There are then separate recommendations for each finding. The response to the SCR should not be limited to the recommendations suggested below and health agencies are encouraged to work with their managers and staff to develop the most appropriate response to the findings.

Managing the response to this serious case review

1. These findings should be considered in conjunction with the findings from the Baby E and Baby F serious case review

[12] Learning from Serious Case reviews NSPCC 2015

2. The findings and recommendations should be considered collaboratively by the relevant health commissioners and providers who will develop an action plan and report to the Children's Partner Executive

3. The Children's Partnership Executive will monitor the progress of the SCR action plan

Finding 1
Maternity services in South Gloucestershire are task centred and narrowly focused on maternal and baby health (to the exclusion of fathers and extended family members), which has led to a system where midwives lack the skills and tools to take a holistic view which would enable them to identify underlying vulnerabilities or potential concerns.
Recommendations
1. Develop a 'late booking' policy, practice tool or guidance for midwives, health visitors and doctors that highlights any potential vulnerabilities or safeguarding risks, includes information sharing pathways and is included in mandatory training. 2. Offer training, development and processes for midwives and health visitors in supporting parents who have a learning difficulty or need that does not reach the threshold for referral to learning difficulty services 3. Develop systems and tools to enable midwives to facilitate the reporting of low level concerns such as maternal presentation (e.g. shyness, anxiety, possible learning difficulties). These should be in electronic format to enable them to be seen in real time by the wider maternity team. 4. Notes and forms that currently rely on information in the form of tick box answers should have scope for social narrative. 5. Observations about father's presence and interaction with baby and professionals and their role in parenting should be just as routine as mothers. Notes should have scope for recording information about fathers including any needs they may have in relation to learning difficulties. 6. Develop opportunities (time and tools) to enable midwifery staff to factor in assessment of parent's learning needs and capacity to

understand information and to create reasonable adjustments especially around lower levels of disability or other areas of need.

7. Make available one to one tailored parent craft classes to parents with learning difficulties or other vulnerabilities and needs.

Finding 2

Health visitors, community midwives and hospital maternity professionals do not work collaboratively which results in poor information sharing and parent's and children's vulnerabilities and wellbeing not being properly understood or responded to.

Recommendations

1. Commissioners and providers of maternity services and public health nursing should work together to provide strategic direction to enable services to work together collaboratively to improve the quality and quantity of relevant information sharing so that parents vulnerability is better understood and responded to within and between services.

2. Increase opportunities for joint training and development by maternity services and health visitors

3. Improve pathways for information sharing and handover between midwives and health visitors (e.g. collaborative development of transfer of care forms, sharing of assessments etc.)

4. CCG and Sirona review the improvements reported to have taken place in the delivery of health visitor services including the reported improvement in 28 week ante natal visits

Finding 3

The maternity service is not able to provide continuity of care to the most vulnerable mothers particularly if they have an additional health need which results in no one in the service building up a relationship with them and understanding their vulnerabilities

Recommendations

1. Improve the capacity for midwives to work in a continuity of care model, especially where additional needs are known or suspected

Finding 4
In South Gloucestershire information sharing within health agencies can be ineffective due to a lack of clarity about why information is being shared, what to do with it and whether the information could be followed up
Recommendations
1. Review the information sharing advice that is given to staff to ensure that when information is shared it is collated with other information held, there is an analysis of the risk to individuals and the information is shared when necessary to keep the individual or their child safe 2. Improve systems for information sharing, especially with health visitors and at post natal transfer of care from hospital to community midwives. This includes addressing the quality of the information that is shared and a move away from paper forms with tick boxes to electronic information that includes a social narrative.