Serious Case Review

Child U

REVIEW REPORT

CONTENTS

1 Introduction to the case and summary of the learning from this review

1.1 This Serious Case Review (SCR) is in respect of a three month old child to be known as Child U. He died after reportedly falling from his parent's bed onto the floor. A skull fracture was evident that had occurred around three to seven days prior to Child U's death. A police investigation was undertaken that concluded that no further action should be taken. An inquest will be held in order to confirm the cause of Child U's death.

1.2 Child U lived with his mother and father, along with a one year old sibling, a school age sibling, and a number of older adult siblings. Other extended family members were also resident on occasion.

1.3 Prior to his death there were no safeguarding concerns about Child U or his siblings. Mother had a long-term dependency on a prescribed pain killer. No other known predisposing risks were identified.

1.4 Learning has been identified in the following areas:

- Impact of prescription and some over the counter drugs.
- Lack of wide professional awareness of the above, including the impact of withdrawal.
- Importance of information sharing.
- The need for timely communication and challenge when there is uncertainty in a child protection case.

2 Process

2.1 The WSSCB agreed that this Serious Case Review (SCR) would be undertaken using the SILP methodology[1], which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time[2].

2.2 It was agreed that the review would consider in detail the period from **27.1.17 – 11.7.17**, which was the date that professionals were informed of Mother's pregnancy with Child U, to the date of the Initial Child Protection Conference held on the siblings following Child U's

[1] The Chair of the WSSCB agreed the SCR, the lead reviewer was appointed, the terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in July and September 2018. The lead reviewer is **Nicki Pettitt**, an independent social work manager and safeguarding consultant. She is an experienced chair and author of SCRs and a SILP associate reviewer. She is independent of WSSCB and its partner agencies.

[2] Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the learning from the case within their agency. Then a large number of practitioners, managers and agency safeguarding leads come together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the event. The same group then comes together again to study and debate the first draft of the SCR report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review and analysed; and makes use of relevant research and case evidence to inform the findings. This review has achieved these objectives.

death. Relevant information prior to these dates was also considered as required, particularly any significant and relevant agency involvement with the parents or older siblings of Child U.

2.3 Early family engagement is required as part of the SILP model of review. The lead reviewer and a representative of the WSSCB met with Mother during the review, and will speak with Mother and Father prior to publication to ensure that they are aware of the conclusions of the review.

2.4 Statutory Guidance expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some case detail will not be disclosed in this report, which is written in the anticipation that it will be published. The report contains the information that is relevant to the learning established during this review.

3 Family structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Child U
Mother of Child U	Mother
Father of Child U	Father
Sibling age 1 at the time	Sibling 1
School age sibling	Sibling 2
Older adult siblings	Older sibling/s

3.2 Any other relevant family members will be referred to by their relationship to Child U.

4 The background prior to the scoped period

4.1 There had been no concerns about the care or parenting of any of the older children in the family prior to Child U's death. The only historical information of note was that Mother had been arrested for shoplifting in the presence of sibling 2 in 2013.

4.2 Mother was known by her GP to have had a dependence on Tramadol[3], which she had been prescribed for headaches for around 12 years prior to the birth of Child U. Those involved during the pregnancy with Sibling 1 had been aware, but this information had not been shared among professionals involved during the pregnancy with Child U. Mother had refused a referral to drug support agencies. Father and other family members were unaware of this dependency.

4.3 There were no safeguarding concerns for Sibling 1 who was receiving a universal health visiting service, or for Sibling 2, who was at school.

5 Key episodes

5.1 The time under review has been divided into four 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family. They are key from a practice perspective rather than to the history of the child. They do not form a complete history of the case but summarise the relevant activities

[3] Tramadol is a narcotic-like pain reliever prescribed to treat moderate to severe pain. It can be addictive. It is not recommended during pregnancy due to the unborn baby becoming dependent in-utero and suffering withdrawal at birth.

that occurred, and include the information that is thought to be most helpful in informing the review.

Key episodes
1. Information sharing regarding Mother's pregnancy
2. Birth of Child U
3. Immediate response to the serious event
4. Investigation and actions following Child U's death

Key episode 1: (Information sharing regarding Mother's pregnancy)

5.2 Mother self-referred late for her pregnancy with Child U. She had requested a termination and was referred on by the GP, but it was too late for this to take place.

5.3 There is evidence that Mother later contacted her GP surgery asking for a repeat Tramadol prescription stating she had gone ahead with the termination, although Mother continues to deny this. Tramadol was refused as the GP wanted to see her face to face before prescribing. A letter was received and filed around a week later stating that Mother had not had a termination. Mother was next seen by the GP around a week later, but this issue was not discussed.

5.4 The GP provided information about Mother's Tramadol use when referring her to the hospital for a scan, but this was not seen by those providing maternity care to Mother in the community or when Child U was born.

5.5 Mother was seen at 32 weeks gestation by a midwife and was asked questions, including about prescribed medication and drug use. Mother stated that she was not using any medication and did not use drugs. Following the process for Mothers who book late[4], the midwife who first saw Mother for her antenatal care made a referral to the MASH[5]. They were also aware from records that Mother had disclosed domestic abuse from a previous partner.

5.6 The case history provided by the midwife was reviewed by a Group Manager in CYPS and the decision was taken not to progress the referral as there were no known concerns. A re-referral from the same midwife was received a week later and it was agreed that no further action should be taken based on the previous decision making by the Group Manager[6].

5.7 In the meantime a health visitor liaison meeting was held at the GP surgery and the case was on the agenda due to the notification of the MASH referral about the late booking. The health visitor was made aware of Mother's Tramadol use during this meeting. She knew the family, knew that Sibling 1 was on a universal health visiting caseload and there were no known concerns. Mother was offered an antenatal health visiting visit but she declined. The GP and the health visitor assumed that the midwives were aware of the Tramadol use as the information had been forwarded by the GP.

5.8 Mother was referred to and saw a midwife counsellor during her pregnancy, as it was acknowledged that she had requested a termination. There is no record of Father's views being sought.

Key episode 2: (Birth of Child U)

[4] https://www.westsussex.gov.uk/media/3700/cs48_concealed_pregnancy.pdf
[5] Multi-Agency Safeguarding Hub.
[6] Group Managers review decisions at the request of the practice manager.

5.9 Child U's hospital birth was straightforward and he was discharged the same day. Five days after his birth Child U was seen by the midwife to be unsettled, restless, with loose stools and elevated temperature. He was sent to the hospital and was seen for an assessment on the paediatric rapid assessment unit by a paediatrician and appeared clinically well. His presenting symptoms were attributed to possible 'milk intolerance or sepsis'[7].

5.10 The health visitor saw Child U when he was 20 days old, following three previous appointments that were missed by the family. There were no concerns. Child U was also seen at home by the health visitor for his 6 week check, and was weighed in clinic. When asked, Mother told the health visitor she had stopped taking Tramadol during the pregnancy, and the GP records confirm that no more prescriptions were issued. She did not share that she was taking over the counter medication[8] daily, or that Father was unaware of this.

Key episode 3: (Immediate response to the serious event)

5.11 Parents called an ambulance on a Thursday evening reporting that their three-month-old child was seriously unwell. Mother reported that Child U had been left on the bed between two pillows while she was in another room, and that Father had returned home and found Child U lying face down and unresponsive on the floor. The ambulance service contacted the police, and A&E contacted CYPS.

5.12 At hospital the seriousness of Child U's condition was established[9], and police and EDT[10] held an initial strategy meeting including the paediatrician who had examined Child U and was responsible for his care. It was acknowledged that non-accidental injury was a possible cause of the serious brain injury, although there were no bruises or signs of neglect. A second strategy meeting was held during the day on the Friday, and was attended by Child U's health visitor who shared information about Mother's previous dependence on Tramadol. Following the meeting it was stated that Child U (who had been transferred to a regional hospital for specialist care) had a skull fracture with an opinion shared later that this had occurred between three and seven days prior to him coming into hospital.

5.13 Consideration was given to ensuring that Child U was safeguarded in hospital, while allowing the parents to be present. Mother told the review that staff at the hospital handled this situation with sensitivity and compassion. Medical examinations were carried out on both child siblings and no concerns of neglect or abuse were identified. Both EDT and CYPS social workers arranged for the children to initially be cared for by their oldest sibling and then by Maternal Grandmother and made the appropriate checks for an emergency situation. Child U died the following day.

Key episode 4: (Investigation and actions following Child U's death)

5.15 Both the criminal investigation and consideration of the need to safeguard the siblings continued after the death of Child U. There was some confusion regarding the presence of a skull fracture, which is considered in the analysis below.

5.16 An Initial Child Protection Conference (ICPC) was held on Siblings 1 and 2 and they were made the subject of child protection plans. Care proceedings in respect of Sibling 1 commenced around 2 months after the conference.

6 Analysis by theme and learning

[7] As recorded at the time.

[8] Solphadeine Plus. A brand name analgesic medication with paracetamol, codeine and caffeine. This drug should not be taken during pregnancy unless considered essential by a doctor. This can cause withdrawal symptoms in a baby after birth.

[9] Hypoxic (lack of oxygen) ischemic injury to his head

[10] Emergency Duty Team who provide an out-of-hours social work service.

6.1 From the information gained from the agency reports, from the discussions at the learning events, and from the meeting with the family, several key themes have emerged. The following are judged to be most significant and enable us to identify learning for the WSSCB and its partner agencies:

Themes
1. Prescription drug dependence
2. Information sharing
3. Protection and care planning when there is uncertainty

6.2 Each theme identifies learning, and each learning point is linked to a recommendation in either this report or within the agency reports. It will be stated if the learning is being addressed elsewhere.

Prescription drug dependence[11]

6.3 Tramadol was first prescribed to Mother for headaches. Within a year of taking the drug Mother contacted her GP for additional prescriptions on a number of occasions, stating her medication had been lost, had been stolen and had been left on holiday. Tramadol is known to be highly addictive, withdrawal is difficult[12], and there is a high risk of overdose. Although it is only available on prescription, it can also be bought illegally, including on-line. Tramadol is known to impair judgment and slow down reactions. Advice is given against driving, operating heavy machinery, or doing anything that requires the taker to be alert.

6.4 Mother was able to keep her Tramadol dependence from everyone except the GPs at the surgery, and it appears that they did not entirely agree about how much of an issue it was. Her primary care medical notes had two references in their coding system, Suspected Drug Abuse in 2014 and Drug Dependence in 2016. From 2012 GP's were discussing with Mother her dependence and recommending she reduce her prescriptions. In 2014 she was formally diagnosed with an addiction. Mother then had conflicting advice and support from the GPs depending on who she saw. Two of the GPs worked towards a clear plan for support and reduction, and another GP issued further prescriptions of Tramadol with no clear evidence that this was being managed as an addiction. The only occasion where concerns were identified for the children was in 2016 when Mother contacted the out of hours GP and was described as very distressed because her Tramadol had been stolen. Sibling 1 was a baby at the time and the GP recorded their concern for the child. There is no evidence that this concern was shared or followed up, and no consideration was given to whether Father should be made aware of the concern.

6.5 The GP practice often relied on Locum GPs to deal with demand for appointments at this time, and this appears to have led to continuity issues with each appointment either being undertaken in isolation or with differing views on the need for Mother to come off or reduce Tramadol. There was a degree of professional collusion with Mother's Tramadol use which allowed her to play the system and continue to receive prescriptions. However, a clear reduction plan was implemented when Mother was pregnant with Child U. This did not consider whether Mother would then compensate by misusing over the counter medication instead.

[11] Prescription drug abuse is defined as self-treatment of a medical condition using prescription medication that was not prescribed to the user, or as the use of prescription medication to achieve the feeling it provides.

[12] Withdrawal includes both psychological and physical symptoms of withdrawal, such as: depression, severe mood swings, anxiety, nervousness, aggressiveness, insomnia, nightmares, electric shock sensations, restlessness, muscle pain, stomach cramps, sneezing, sweating, palpitations, tremors, headache, nausea, diarrhea. The symptoms of withdrawal are more noticeable if use of Tramadol is stopped abruptly.

6.6 Mother's use of Tramadol was shared with professionals when she was pregnant with Sibling 1 in 2015 as it was recorded in the written antenatal referral that included Tramadol as a listed prescription and in the summary where 'Suspected Drug Abuse' was listed. Those involved were aware of her use of the drug, but at the time they may not have recognised the level of dependence and no reduction was attempted. Sibling 1 was kept in hospital on the post natal ward for observations following their birth, but there is no evidence that they suffered from withdrawal. It does not appear that Father was aware of the reason for the observations, and no conversation was had with Mother about Father's awareness of her Tramadol use and the possible impact on Sibling post-birth.

6.7 Mother approached her GP in December 2017 asking for a termination. She was referred to BPAS[13]. She also requested Tramadol, which was refused due to the pregnancy. Mother was recorded to be very unhappy with this refusal. There is no evidence that consideration was given to the potential risks if Mother had withdrawal symptoms.

6.8 Prior to the GP receiving a letter from BPAS stating that the pregnancy was beyond the gestational age at which they can legally provide an abortion and requesting a referral for antenatal care, there is evidence that Mother telephoned the GP requesting Tramadol claiming to have had the abortion. This was clearly untrue and provides evidence of Mother's dependence and willingness to be dishonest to gain access to Tramadol, although it is acknowledged that Mother denies this happened. The next consultation where Mother was seen by her GP around a month later, when she attended due to concerns that the baby was not moving, would have been the ideal opportunity to discuss her claim to have had a termination in order to get a prescription for Tramadol. There was no discussion about this. This is probably because the GP who saw Mother would have been concentrating on the concern about the baby, and likely because they had not read the record of the telephone call with Mother a month before. This was within the context of a busy practice, with limited appointment times, the system used for filing letters, and locum GPs who do not always know the patients or their history.

6.9 The midwives who were seeing Mother both before and after the birth of Child U were unaware of Mother's long-term use of Tramadol. The GP had shared this by letter when Mother was referred for a scan, but this was not seen by the midwives. There was limited time for the midwives to check records due to the late booking, there were no known concerns during the pregnancy with Sibling 1 (although those involved at the time were aware of the Tramadol use) and Mother always appeared very plausible. No plan was put in place for Mother's care to be managed to limit the impact on the baby of her drug misuse.

6.10 In West Sussex there is a system where a mother can book in for her pregnancy on-line. This leads to an automatic summary being sent to the midwives without the GP seeing the pregnant woman face to face. It also means that decisions to refer to a consultant is not considered by the GP, but is left to the midwives. In this case there may have been an assumption by the GP therefore that the midwives would refer Mother for consultant care. The agency report regarding the GP states that once a woman is receiving antenatal care, it is assumed that any additional support or services will be requested by the midwifery team. Without the midwives being aware of the Tramadol use (as they did not see the GP information and because Mother did not disclose her use) this did not happen.

6.11 There is the possibility that the symptoms shown by Child U five days after his birth, were due to withdrawal from Tramadol or over the counter medication. He was stated to be unsettled, restless, with loose stools and elevated temperature. Mother's previous use of Tramadol and

[13] British Pregnancy Advisory Service who provide the service in the area.

on-going use of over the counter medication during her pregnancy was not considered by the hospital paediatrician, as they were not aware of it. Child U's symptoms were thought to be due to 'milk intolerance or sepsis'[14] but they are also common symptoms of withdrawal.

6.12 It was not until the strategy meeting held in Key Episode 3, that the health visitor shared the information that Mother had previously used Tramadol for 12 years. She had believed Mother when she stated that she was no longer using the drug, but did not gain details of how she had detoxified, how she was managing without it after such a long period of dependence, and whether she was instead taking over the counter medication. There is no evidence that it was established if Mother was receiving prescriptions for Tramadol following Child U's birth, whether the ease of accessing the drug illegally was known or considered, or whether Mother was self-medicating with over the counter medication. There was also no discussion about what Father knew and what support he could potentially provide.

6.13 Only recently has prescription and over the counter medication addiction been identified as an emerging and potentially significant issue for individuals, for public health, and as a child safeguarding issue. Prescription drugs are thought to be misused and abused more often than any other drug except cannabis and alcohol. This growth is likely to be fueled by misperceptions about prescription drug safety, and increasing availability. It is also noted that the user themselves and health practitioners don't necessarily recognise someone who is addicted to prescription or over the counter medications as a substance abuser/misuser, as they would with someone who misuses alcohol or non-prescription drugs. The Government has commissioned a review of 'dependence and discontinuation syndrome' from medicines that are prescribed[15] to treat anxiety, insomnia, chronic (non-cancer) pain and depression[16]. The findings are expected in early 2019.

6.14 There is limited research into the impact on parenting and child safeguarding of the misuse of prescription medications such as Tramadol. Dependence on or abuse of prescribed or over the counter medication is not included in safeguarding training in West Sussex, which will mean that the issue is not always identified and acknowledged. Whilst there was evidence that the GP recognised that there were children in the home, this appeared to be related to the potential risk to children from the medication directly (i.e. if they found the tablets). There is no evidence to suggest that the GP felt that there was any increased risk to the children. They also did not consider the difficulties in Mother coming off Tramadol without help and support when a prescription was denied, and the impact this might have on her parenting.

6.15 Another impact of the lack of awareness and insight into the impact of prescription and over the counter drug abuse is that there is limited availability of specialist services or support to help misusers. Mother was offered support from existing drug agencies to help her stop using Tramadol, but she refused. This is not an unusual situation with abusers of prescription or over the counter drugs, as services are seen as more relevant to users of illegal drugs such as heroin. Mother confirmed to the review that this was the case.

Learning:

- Many prescription and some over the counter drugs are highly addictive and may have an impact on parenting. This is not widely acknowledged and understood.

[14] As recorded at the time
[15] It will not include over the counter medications.
[16] benzodiazepines, Z-drugs, GABA-ergic medicines, opioid pain medications, antidepressants.

- Professionals need to ask detailed questions about the use of prescribed or over the counter medication and consider the impact of any dependence on parenting. This includes the impact of withdrawal. This questioning should also consider the other parent, in this case Father.
- Current support and treatment services for substance misuse do not meet the needs of those misusing prescription or over the counter medications.

Information sharing

6.16 A number of issues with communication and information sharing in this case have been identified. They include:

- The information about Mother's Tramadol misuse was not seen by the midwives caring for her during her pregnancy, both in the community and in the hospital.
- GPs did not identify the information in their own records that Mother had lied about having a termination to get Tramadol, and this was not addressed with her.
- As it was the midwives who decide to make referrals for additional care during pregnancy, they did not do so for Mother.
- Midwives were not able to share the information about the Tramadol use with CYPS when they referred the case due to Mother's late booking, as it had not been identified.
- The health visitor visited 4 times to ensure she saw Child U after his birth, she accepted Mother's report that she no longer used Tramadol without checking with the GP.
- The paediatrician who saw Child U in hospital when he was 5 days old was not aware of Mother's Tramadol use during her pregnancy.
- No questions were asked about what Father knew about Mother's drug misuse.
- The children's GP was not informed of the concerns about Child U's death and when they became aware the child protection concerns were not recorded onto the GP records of Sibling 1 and 2.
- The children's GP was not invited to the ICPC. Two Doctors were listed on the invitation list. They were both hospital-based doctors.
- The police did not attend the ICPC. This was due to a long-standing agreement within Sussex Police that they do not attend ICPC's if they get less than five days' notice. In a case such as this, where there has been a serious incident but medical opinions are not entirely clear, it is likely the conference will need to be held in a timely way as soon as some certainty is received and the decision is made. It is also noted that Working Together states that ICPCs should be held within 15 days of a strategy meeting. In West Sussex the rejection of the invitation is made by the civilian staff employed to prepare for and attend ICPC's without enquiry into the case. This issue has been noted by Sussex Police and changes are being considered.
- The safety plan for the siblings was not shared with early help or the GP following the ICPC.

6.17 There were also examples of positive information sharing in the case, particularly following the incident, where there was excellent information sharing across almost all agencies.

6.18 Serious case reviews often highlight the importance of information sharing and communication, and this review is no exception. Information sharing between professionals is

integral to improving safeguarding. In 2017 a DfE review of 25 serious case reviews involving the Centre of Excellence for Information Sharing[17], found that 'not knowing the bigger picture about vulnerable children and families was cited as a reason that information was not shared' and that 'professionals often struggle to understand the purpose for sharing crucial pieces of information that may help protect children without the full context of a family's history. Without this holistic view, the most appropriate early help and safeguarding interventions may not take place.' In this case there was information that was not adequately shared. This was partly due to a lack of awareness of the potential impact on parenting of long term Tramadol misuse, partly due to structural administrative issues, partly due to Mother's late booking and misrepresentation of her use, and the lack of any previous concerns about the older children.

Learning:

- Information sharing about a parent's misuse of prescribed drugs is as important as with any other drug dependence. Don't assume other professionals (or family members) will be aware or that a parent will disclose the information. This learning should be included in WSSCB substance misuse training.

Protection and care planning when there is uncertainty

6.19 If a child has a life-threatening illness or injury and it is not certain what the cause is, child abuse may be one of the possibilities being considered. Working in these circumstances is very challenging for all professionals. Despite the on-going uncertainty, the response when Child U was transported to and admitted to hospital had been to consider a differential diagnosis which included non-accidental injury. This ensured that the child's health needs took precedence, but that their protection and that of their siblings, and the potential need for a criminal investigation, were also considered.

6.20 Those present at the learning events explained that the weekend of the incident was exceptionally busy for partner agencies in regards to child protection work. There had been two child deaths and a suspicious fracture to consider in West Sussex. This case was also unusual, as while the skull fracture was diagnosed following the initial investigations, it was not identified during the postmortem and this created some uncertainty. It is accepted that it can be very hard to diagnose some skull fractures, and be difficult to distinguish an accidental from a non-accidental cause. In this case the position of the fracture in such a young child would raise suspicion of a non-accidental injury. A number of doctors got involved to consider the images taken of Child U's skull both at the time and in the weeks following the child's death, and it was eventually agreed that a skull fracture was present.

6.21 After Child U's admission to hospital, a skull fracture was identified. When a child presents with such an injury, further investigations should be undertaken, both medical and of the wider family circumstances. In this case it became clear that the explanation provided by the parents that Child U had fallen from the bed immediately prior to hospital admission did not fit with the dating of the fracture. The circumstances of Child U's medical condition on admission and the fracture were considered by the police investigation, a S47 investigation, at a child protection conference and when legal advice was sought in respect of the child siblings.

6.22 Legal advice was sought on the first day by CSC. An application for an Emergency Protection Order was drafted, but this was not necessary as the family cooperated with the

[17] Information Sharing to Protect Vulnerable Children and Families. DfE and The Centre of Excellence for Information Sharing 2017

requests of the police and CSC. Further legal advice was sought and advice was given that care proceedings should be commenced in respect of Sibling 1, due to inconsistent accounts by Mother in respect of the injuries to Child U, and the requirement for the parents not to live in the family home with the children. CSC did not apply for an order at this stage, mostly due to the case being further complicated in respect of differing and contradictory medical opinions being received about the skull fracture.

6.23 The ambiguity about the cause of death, and uncertainty about the existence of the fracture following the post-mortem (based on a verbal update from the police officer who attended) continued throughout the next few weeks, with the involvement of a number of experts. Sussex Police have reminded the individual officer of the need to seek absolute clarity regarding what medical professionals are saying prior to sharing that information with other professionals, in order to avoid confusion. Best practice is for the officer to take written notes at the time, and confirm them with the medical practitioner with a signature.

6.24 This uncertainty led to a request from West Sussex County Council Legal Services for a professionals meeting to include the medical professionals involved and to gain clarity about the existence of a skull fracture, due to there appearing to be a number of differing opinions being expressed in respect of the injuries. No meeting was held, but it was agreed that care proceedings should be initiated. This took place in September 2017, around three months after the incident.

6.25 With hindsight it has been agreed that the initial diagnosis should have been enough evidence for the legal process to commence in respect of the siblings. It is not unusual to fail to reach a conclusion on the cause of death in spite of multiple investigations and agencies need to work with this. In this case the uncertainty about the fracture side-tracked the focus from the incident which led to the death of Child U. However, it did not delay the plan to protect the surviving children in the short term. There was a delay in starting care proceedings which appears to be due to the continuing uncertainty regarding the existence of a skull fracture. An earlier legal planning meeting would have been of benefit.

Learning

- If there is a lack of certainty in a child protection case, consideration should be given to convening a timely high-level meeting of professionals from the three main agencies. This could be facilitated by using teleconference technology. The outcome of the meeting should be communicated effectively to those making decisions and considering the safeguarding of children, and if possible to the family.

7 Conclusion

7.1 Prior to his death, there had been no safeguarding concerns identified for Child U or his siblings. The parents received support from extended family, and were not identified as having any additional needs that required professional involvement. Mother, however, had been concealing her dependence on prescription medication for over a decade from her partner, her family and from professionals, with the exception of her GP, and very recently Child U's health visitor, who was told by Mother that she no longer used Tramadol, but did not disclose that she was then using over the counter medications daily. Despite this dependence, no concerns emerged about the care of any of the children until the night that Child U was taken to hospital and died shortly afterwards.

7.2 The review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner

behaviour" (Woods et al[18]). It has identified the learning that is relevant both to this case and to the wider system. Individual agency learning has also been identified and the WSSCB has ensured that a robust consideration of the concerns identified has been undertaken by each agency involved in this matter.

7.4 It is important to also learn from the good practice identified during the course of this review. Good practice across a number of agencies has been acknowledged throughout the report, and includes the following:

- Positive information sharing between the GP surgery and health visitor during their regular multi-agency meetings.
- The provision of a midwife counsellor following Mother being unable to have a termination.
- The timely notifications of the incident from the ambulance service.
- Two well attended strategy meetings despite them being held over the weekend. This included the health visitor who provided the information about Mother's Tramadol misuse.
- Challenge and debate over the weekend between the police and CYPS manager to find a way forward.
- A pragmatic and sensitive approach was taken to where Sibling 2 should stay immediately following the incident.
- Commitment by professionals over the weekend to keep the siblings safe.
- Sensitive supervision of contact with Child U in hospital.
- The early involvement of a Home Office pathologist to consider the fracture.
- Information sharing from CSC and from the regional children's hospital to community health professionals following the incident.
- Medical examinations were carried out on Siblings 1 and 2. (No concerns were identified.)
- The long-term support provided by legal services.
- Legal services sought advice from a senior advocate.

7.5 There has been a high degree of cooperation and engagement from agencies with the SCR process, which has been important in identifying the learning.

8 Recommendations

8.1 Child U died while in the care of his Mother, who had not been open with professionals or her family about her long-term misuse of Tramadol. It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning, and that changes have been made which will be outlined in the WSSCB's response to this SCR.

8.3 The agency reports have made recommendations which have largely been completed by the conclusion of the SCR. Some of the learning identified within this report will have been addressed by the single agency actions plans. For example, the Primary Care agency report makes a recommendation that awareness of prescription medication addiction as a potential risk factor for safeguarding children is now included in Level 3 training sessions and shared via email learning bulletins.

8.4 Other changes have been made. This includes the improved response to ICPC initiations by Sussex Police, Midwives covering West Sussex having laptops and mobile access so they can read GP records and a vulnerable pregnancy pathway has been developed. The purpose

[18] David D Woods et al. Behind Human Error. 2010.

of providing additional recommendations is to ensure that the WSSCB and its partner agencies are confident that any areas identified as being of particular concern, and not included in the single agency plan, or which require an interagency or Board action, are addressed.

8.6 The learning regarding information sharing is being considered by the Improving Practice Group of the WSCB who are undertaking a piece of work on improving information sharing, which will address the issues indentified in this case. No further recommendation is therefore required.

Recommendation 1:

Due to the delay in a conclusion being reached in the criminal investigation of this case, the WSSCB should give consideration to how the learning from this review is shared in a timely way.

Recommendation 2:

The WSSCB substance misuse training should be reviewed to ensure that the risks from prescription and over-the-counter drugs are included, along with the need to share information. The Board should then undertake quality assurance activity to ensure that this has an impact on practice.

Recommendation 3:

The WSSCB should consider the Government's review of prescription drugs to be published in 2019 (see 6.13 above) to determine if the findings can be used to further strengthen safeguarding practice in West Sussex[19].

[19] https://www.gov.uk/government/publications/prescribed-medicines-review-report