Buckinghamshire BSCB Safeguarding Children Board

Serious Case Review

Baby L

Barbara J Firth

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1. Introduction

1.1. On 25th September 2014 at 6.25am an ambulance was called to the family home following a report that Baby L, aged 14 weeks, had died. On arrival it was clear that there were no life saving opportunities. The initial account was that the mother had fallen asleep on the baby. A Rapid Response meeting was arranged and a criminal investigation was begun. The investigation has now concluded and no charges have been brought.

1.2. In accordance with Regulation 5 of the Local Safeguarding Children Board Regulations 2006, Buckinghamshire Safeguarding Children Board instigated a Serious Case Review in line with the criteria set out in Working Together 2015[1].

1.3. In setting out the terms of reference the Case Review Panel identified the following areas to be addressed by the review:

- **Assessments**: what assessments did each agency undertake regarding the parents and/or Baby L. What was the quality of those assessments?
- **Plans**: were any plans identified for the parents and/or Baby L? Were internal agency procedures followed?
- **Risk**: what risk factors were identified either before or after the birth of Baby L?
- **Information sharing**: how effectively did each agency share information about this family with other agencies?
- **Inter-agency working**: did agencies work effectively with one another? Was there co-operation?
- **Working with the family**: were there any factors that enhanced or impeded each agency working effectively with this family?

[1] HM Government (2015) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

1.4. The time frame for this review is from 5th January 2014 until 25th September 2014 when Baby L died.

2. Summary of Circumstances Leading to a Serious Case Review

Family composition

Relationship	*Age/Date of Birth*	*Ethnicity*
Mother	21/08/86	Caucasian
Father	04/06/79	Caucasian
Baby L	15/06/14	Caucasian
Maternal Grandmother	15/03/54	Caucasian

2.1. Within this situation there were issues of maternal substance misuse, maternal ill-health, as she suffered from Crohn's disease, housing problems leading to mother spending a lot of time at the home of the maternal grandmother, missed health appointments, a reluctance to allow some professionals into the family's privately rented accommodation and a baby who was born prematurely out of the area.

2.2. The Mother first reported her pregnancy to her GP on 19th December 2013. Although living in High Wycombe she was registered with a GP in Marlow where the maternal grandmother lived. On 13th January the mother and her partner attended a booking appointment with the Midwife at Wycombe Birth Centre. As she was 13 weeks gestation this was considered a late booking. At this appointment drug issues were discussed, risk factors identified and referrals made to the safeguarding midwife and to the hospital for consultant led care. At this point mother was on an opiate substitute (subutex) and had been accessing SCAS (Specialist Community Addiction Service) for the past year. In February 2014 South Staffordshire and Shropshire NHS Trust won the contract to deliver STAR drug and alcohol services and the mother made the transition to the new service.

2.3. At the end of January the situation was discussed at the monthly liaison meeting between Maternity and Social Care and the Community Midwife was asked to complete a referral to Social Care. This referral was not made until 26th February.

2.4. During February 2014 the mother made contact with the GP to discuss her medication and a prescription for antidepressants was issued; the Community Midwife contacted the Health Visitor to give background information for the targeted Antenatal Universal Plus Health Visiting Service and both parents attended for a 20 week scan and a 21 week midwifery appointment. Throughout her pregnancy the mother missed only one appointment with the Community Midwife at the Birth Centre the reason being she was away. The appointment was rescheduled.

2.5. In March the mother made a new application to Wycombe District Council for housing assistance saying she needed to move on medical grounds, but medical priority was refused. Later in the month the mother revealed she had rent arrears and had been asked to leave the accommodation. She was advised to remain until a court order was obtained and her housing application was suspended.

2.6. At the end of March, beginning of April, the Midwifery Support Worker twice attempted a home visit but was unable to gain access. This information was relayed to Social Care. Eventually at the end of April the MSW successfully gained access to the home where she was able to note the very unsuitable and cramped conditions. The mother was reluctant for the Community Midwife to visit but did allow her to see her at the maternal grandmother's house, which happened on 28th May 2014.

2.7. Meanwhile it was not until the 11th April that a decision was made by Social Care to allocate the case for an assessment. There was then further delay until a new worker was finally allocated on 21st May 2014

and a home visit arranged for 10th June 2014. Before this visit the Social Worker made contact with the Community Midwife and the Midwifery Support Worker.

2.8. During the first two weeks of June 2014 midwifery services and the Health Visitors established contact with the Social Worker who made her first visit to the mother at her own accommodation on 10th June to begin the assessment. This was a lengthy visit and concentrated on referral issues including housing, medical history, drug use, involvement with STARS and relationships. Another visit was planned so that the Social Worker could meet with the father. After the visit the Social Worker spoke with the Health Visitor and it was agreed the latter would attempt a home visit to keep the situation under review.

2.9. On 15th June 2014 Baby L was born prematurely in Bradford Royal Infirmary when the parents were visiting paternal grandparents. She was admitted for observation of neonatal abstinence to the Transitional Baby Care Unit and eventually discharged on 21st June 2014. Shortly after her birth Bradford RI telephoned Stoke Mandeville to ask for details of any social issues and were informed there were no safeguarding concerns.

2.10. During this time midwifery and health visiting were in contact with Social Care to ascertain progress. The Social Worker was away and there was some confusion about the progress of the assessment and whether or not it has been started.

2.11. On 25th June the Community Midwife undertook a Day 10 postnatal home visit at the family's address and on 27th June the Health Visitor saw the baby with both parents at the home of the maternal grandmother. Meanwhile Social Care were considering a discussion with the Family Resilience Service to see if they would take the case on.

2.12. On 29th June after a day 14 postnatal visit by the Midwife, the baby was discharged to health visitor care. Health visiting then transferred the case to the Wycombe team and strongly urged the mother to register with a GP surgery in Wycombe.

2.13. Throughout July there was input from the Health Visitor and the Social Worker. The mother attended the clinic but the Health Visitor found difficulty in accessing the family home and so saw her at the maternal grandmothers house for subsequent appointments, even though this was 'out of the area'. Towards the end of the month there was a missed clinic appointment and the family were not at home on a planned visit. There were also concerns about mother's behaviour as she seemed increasingly anxious and agitated, but there were no concerns about the care of Baby L. Throughout this time the Health Visitor and Social Worker liaised closely and felt that there were ongoing concerns and the situation needed to be monitored. However, the Social Care management decision at the end of July was that the case could be closed as there were no safeguarding concerns.

2.14. However, on the 8th August 2014 an anonymous referral was made to NSPCC at 7am reporting welfare concerns for Baby L and alleging that mother was incoherent as if she had taken drugs. NSPCC was advised by the Out of Hours Service to contact the Police and ask for a welfare check to be undertaken. The Police visited the family at home where they found living conditions not ideal but not sufficiently poor to warrant concern. A referral was made to Social Care.

2.15. The Social Worker then made a further home visit, where both parents were present and liaised with the Health Visitor. Although Baby L continued to be well cared for both were concerned that the situation was deteriorating, that the mother was becoming increasingly agitated and that the 'picture was changing'. As arranged the Health Visitor attempted a home visit whilst the Social Worker was on annual leave, but did not gain access.

2.16. For the rest of the month and into September the mother did attend clinic but the Health Visitor continued to have problems in seeing the family at home. Her final contact was at the maternal grandmother's house on 22nd September 2014 when mother seemed less agitated and was noted to be handling the baby well. Meanwhile the Social Worker had telephone contact with the mother and with STARS.

2.17. Baby L died on 25th September 2014.

3. The Review Process

3.1. This Serious Case Review adopted a systemic approach based on the model developed in Wales[2] for undertaking Child Practice Reviews which have replaced Serious Case Reviews. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.

3.2. A Case Review Panel was convened to steer the process, which was made up of representatives from Health, Police, Children's Services, District Council and the Safeguarding Children Board. It was chaired by a Principal Solicitor from the County Council Legal Department.

3.3. The Panel commissioned summary analysis reports from each agency involved in the situation, produced a chronology of events and began the learning process by identifying significant issues and clarifying questions and areas to explore. They also identified the practitioners to be invited to the learning event, explained the process to them and helped them with preparation. Participants were asked to reflect on their involvement with Baby L and her family thinking specifically about:

[2] Welsh Government (2013) *Protecting Children in Wales: Guidance Arrangements for Multi-Agency Child Practice Reviews*

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of effective practice
- Areas where there could have been some improvements

3.4. At the heart of this review was the Learning Event which was held on 6th May 2015 from 10.00 until 4.00 and which was facilitated by the Reviewer. There were 15 participants:

- GP
- Community Midwife
- Safeguarding Midwife
- Midwifery Support Worker
- 3 Health Visiting representatives
- Social Worker
- 2 Police representatives
- Housing Officer
- Panel Chair
- Thames Valley Police Panel Member
- BSCB Business Manager
- BSCB Administration Officer

3.5. Each participant described their involvement with the family, highlighting the actions they took and the reasons underpinning them as well as their assessments of the situation at the time. This was done as chronologically as possible. After each input there was an opportunity to ask clarifying questions, engage in discussion and begin to identify key issues and learning points. Once everyone had contributed they moved into small groups for further reflection on the emerging learning and to think about some possible actions and recommendations.

3.6. The discussions at the Learning Event were carefully recorded and together with the Panel deliberations and individual agency analysis reports form the basis of this overview report.

3.7. Several attempts have been made to contact the mother and father of Baby L to invite them to contribute to this review and to seek their perspectives on the services and support offered to them. However, there has been no response.

4. Learning Arising from the Review

4.1. **The discrepancy between what is recorded and what actually happened**: if this review had relied solely on written records to understand what happened and to identify key learning then a very different picture would have emerged. Initially some of the single agency analyses reports prepared for this review were based on electronic records only and the themes that emerged were superficial assessments, poor inter-agency communication and collaboration and lack of engagement with the father. When practitioners became part of the review through the Learning Event and in interviews with authors of individual agency reports, this picture changed. As they described what they actually did and the context within which they worked it became apparent that assessment was continuous and individuals understood the risks inherent in this situation. Concerns were shared appropriately with other agencies and professionals and there was some good collaborative work. Far from being a shadowy figure the father was very present and involved and professionals engaged with him.

4.2. There are probably several reasons for this mismatch in perception between what is recorded and what practitioners actually did including how and where practice is recorded; the templates for electronic recording, the volume of work at the time and custom and practice within

each agency and service area. The important point to note is that for real learning to be identified in order to improve practice it is crucial that practitioners are actively engaged in reviews from an early stage so that they can describe and reflect on what they did and why.

4.3. **The effect of organisational context**: in this situation there was delay in allocation to a social worker which led to delay in undertaking a pre-birth assessment, which in turn was not completed because the baby was born prematurely. That is not to say that if a Multi-agency meeting had been held as part of this pre birth assessment the outcome would have been significantly different, but it might have led to more co-ordination and greater communication with, for example STARS, which in turn might have led to a greater understanding of the 'changing picture'. However, at the time, the First Response Team in Social Care was overwhelmed with work and there were staff shortages. Furthermore, once the case was allocated the Social Worker, who worked 3 days per week, had 35 cases in total. This inevitably limited the amount of input she could give to each case. The need for throughput led to the manager closing the case in September when the Social Worker was of the view that more monitoring was needed.

4.4. The General Practice analysis report described the GPs as passive and indeed the practice did seem somewhat out of the loop in terms of communication within the professional network. However, the mother's only surgery appointments during the pregnancy were booked 'on the day appointments' and were not for antenatal care. These clinics are very busy with brief 10 minute appointments for medical concerns which patients feel cannot wait until the next available routine appointment. Other complicating factors included GPs not being informed of Birth Centre appointments; they received only sporadic updates from the drug and alcohol service and although registered with a Marlow surgery the mother's actual address was in High Wycombe. The surgery was also unaware that, because home conditions were so poor, the mother spent a lot of time at the maternal grandmother's address in Marlow.

4.5. **Inter-agency working**: whilst there was some effective inter-agency collaboration (see section 4.17) there were also areas which could have been improved upon; specifically the GP surgery having more contact and communication with the Midwife, the Health Visitor and the Social Worker. Section 4.4 has described the GP as being 'out of the loop' and highlighted some contextual reasons for this. Also initially there was some confusion in midwifery about if the mother was registered with a GP surgery and where. As her home address was in High Wycombe she was seen at the Wycombe Birth Centre by the midwife, but because of poor housing conditions she spent a lot of time at the maternal grandmother's home in Marlow. It was eventually clarified that in fact the mother was registered with the Marlow surgery which the Midwife only visited once a week. After the day 14 visit there was a transfer to the Wycombe health visiting team with an expectation that the mother would re-register with a Wycombe GP.

4.6. If the GP was described as passive it should also be noted other professionals were not proactive in contacting the surgery as part of their assessments.

4.7. The other agency 'out of the loop' was STARS drug and alcohol services. The Midwife did have some contact with them but this was limited. However, midwifery now have a specific worker at STARS who they can email for patient information, which has improved matters. In this situation if there had been more contact with STARS then there might have been greater clarity about the nature of mother's substance misuse. Different agencies had recorded different substances. For instance midwifery notes indicated the mother had told them she had been addicted to heroin, the Police had noted prescription drugs, whereas the drug and alcohol service had recorded cocaine and methadone. The reason for these discrepancies is unclear.

4.8. The quality of interagency working can also be affected by contextual issues. For instance if the Social Worker had had more capacity she might have been able to be more proactive in contacting other relevant professionals and perhaps arranging joint visits.

4.9. Overall inter-agency working was as a result of personal relationships between individual professionals rather than something facilitated by strategic structures for working with children in need. It was about individual commitment rather than organisational processes.

4.10. **Recording systems** across health services are not integrated, there are different systems for different services which 'do not to speak to one another', plus handheld notes for the patient. Whilst practitioners are very aware of the need to find ways of working around this it does have an impact on communication and the effective flow of information between agencies and practitioners.

4.11. **The impact of housing issues**: in this situation the family were living in privately rented, shared accommodation which was unsanitary, unsuitable and cramped. Cupboards were hanging off the wall in the shared kitchen, other communal areas were dirty and smoky and there were times when the water supply was cut off. The small bedroom had only just room for a moses basket for the baby as well as a bed for the parents. As the mother then spent time away from the accommodation it led to some confusion about when and where she was seen and some delay in professionals being able to properly assess home conditions. It also had an adverse impact on the parents' relationship.

4.12. Changes in policy in 2014 meant that the Housing Department could not take a Baby into consideration when assessing an application until after that baby had been born. Previously it had been possible to plan ahead from the 28th week of pregnancy thus allowing more time to search for alternative property. Realistically, therefore, it would have been unlikely for this family to have moved into appropriate

accommodation for several years. If this baby had lived, how would they have managed to parent a toddler in such a cramped and unsuitable space?

4.13. **The limits of professional authority**: professionals can strongly suggest but they cannot force someone to do something. In this situation Health Visitors repeatedly advised the mother to register with a GP in High Wycombe, the location of her 'official' address, but she failed to do this. Nevertheless, the Wycombe Health Visitors, aware of the identified risks, continued to offer a service.

4.14. **The role of the Out of Hours Service**: NSPCC contacted Out of Hours Emergency Social Work Team (OOESWT) after they had received a detailed anonymous referral expressing concern about the condition of Baby L and the behaviour of her mother. OOESWT then requested a welfare check by the Police. There is contradictory information in the individual agency reports about the sequence of communication between OOESWT and the Thames Valley Police and whether or not OOESWT had access to the ICS system, the electronic recording system for Children's Social Care, but what is clear is that the police undertook a welfare visit without any background information on the family. OOESWT did pass on information about the situation to day time services but this was a Friday, a day that the allocated Social Worker, who was part-time, did not work and when the manager was also not there. The consequence of this was the information was not seen by anyone until Monday morning.

4.15. **The importance of reflective supervision**: the Health visitor and the Social Worker were becoming increasingly concerned about this family. They felt that the 'picture was changing' especially after the anonymous referral, but it was difficult to evidence the concerns and to be clear about what was happening within the family. The Health Visitor was going to take this case to safeguarding supervision but unfortunately Baby L died before this could happen.

4.16. For the Social Worker, who had already held on to this case for far longer than is expected in First Response, there had been several changes of Manager which impacted on the regularity of supervision. When it did happen, because of the sheer volume of work, the emphasis was on throughput and identifying which cases could be closed or signposted elsewhere, thus it was that the Social Worker wanted the case to be transferred to a Child in Need Unit whilst the Manager deemed it could be closed. Reflective supervision would have helped define the concerns, identify the risk factors and aid coherent planning

Good Practice

As well as the issues and difficulties identified it was also recognised that there were examples of good practice in this situation.

4.17. **Inter-agency working**: despite systems, processes and pressures there was communication and co-operation between the professionals, especially between midwifery and health visiting and then, once the case was allocated, between the Social Worker and the Health Visitor.

4.18. **Flexibility in service delivery**: although the mother did not register with a Wycombe GP as requested, the Wycombe Health Visitor continued to offer a service and visited both at the Wycombe address and at the maternal grandmother's address in Marlow.

4.19. **Engagement with the father**: the father was present and proactive in caring for the baby when the Midwife and the Health Visitors made home visits and they included him in their discussions and assessments. The Social Worker made a point of arranging a second home visit specifically to meet with the father and he was certainly present at her third visit after the anonymous referral.

4.20. **The tenacity of the professionals**: this family were sometimes difficult to track down as they moved between their address and that of the maternal grandmother. However, all the services made great efforts to

see the family and to assess home conditions. They also followed up missed appointments to check what was happening and to reschedule.

4.21. **The police welfare check**: despite not have any significant background information, the police welfare check following the anonymous referral was thorough.

Personal Learning Points

4.22. At the end of the Learning Event participants were asked to identify personal learning points and these were some of the responses:

- When someone is living between two addresses it can hide the complete picture and therefore the importance of both recognising this but also ensuring both properties are visited.
- Make sure that all agencies involved in a situation speak to one another.
- Checking that we have information from all the professionals.
- If Midwives have any concerns regarding a mother it is important to try to speak to the GP and to get information about that mother from the system.
- It would be beneficial to have the opportunity for multi-agency reflection as soon as possible after the death of a child.

5. Conclusions

5.1. This review has considered assessments, planning, information sharing and inter-agency collaboration in the work with Baby L and her family. It is clear that risk factors including maternal ill health, maternal substance misuse and poor housing conditions were identified at an early stage and appropriate referrals made. However, a family sometimes difficult to make contact with as they spent a lot of time away from their home or were reluctant to allow access because of the poor conditions required persistence and flexibility on the part of

professionals. It also sometimes led to confusion about who needed to know what as well as a lack of knowledge about who was involved with the family

5.2. Organisational context also had an impact with, amongst other things, volume of work affecting professional capacity. However, everyone involved was clear that, despite the risk factors, Baby L was well cared for.

5.3. Inter-agency working was good on the whole, although the drug and alcohol service and the GP could and should have been more integral to information sharing and assessments. However, what is evident is that what facilitated good practice and collaborative working was relationships within and between professional networks rather than systems and processes.

5.4. A final observation focuses on the fragmented recording systems across health services. Previous Serious Case Reviews as well as this one have drawn attention to the deleterious effect separate systems can have on the flow of information and inter-professional collaboration. Obviously this is a national issue which cannot be solved at a local level, but it is to be hoped that the work currently being undertaken to consider this will result in greater integration which, in turn, will facilitate and enhance professional practice.

5.5. Although some improvements in practice have been identified there is no suggestion that these would have affected the outcome for Baby L.

6. Recommendations

6.1. Liaison meetings between Midwives and GPs are an important mechanism to highlight and discuss situations where there are concerns and identified risk factors. Whilst this does happen in some places, it is a

somewhat patchy picture and therefore it is recommended that all surgeries and midwifery services are reminded of the importance of setting up such regular meetings.

6.2. When there are concerns about a family it is important that professionals ensure that their engagement and involvement with fathers is clearly recorded.

6.3. In the month before Baby L's death the Social Worker and the Health Visitor were becoming increasingly concerned that the situation was deteriorating. Although they had access to their own internal management and support systems, it would have been helpful if they could have had the opportunity to reflect on this together in a structured and facilitated environment. It is recommended, therefore, that consideration be given to setting up a system whereby professionals have access to inter-disciplinary supervision when they have serious concerns about a situation. This would require the identification of suitably skilled and qualified supervisors as well as a clear protocol.

6.4. It has been noted that interagency collaboration and communication was about individual commitment rather than organisational processes. It is recommended, therefore, that greater scrutiny of inter-agency working is built in at a child in need level.

6.5. It is recommended that information from OOESWT to the day time service should also go to a central mailbox as well as to specific workers, so it is noted irrespective of whether or not the Social Worker or Team Manager is in the office and in order that there is a timely response.

6.6. Furthermore it is also recommended that OOESWT review and clarify their standard operating procedures and policy statement to specify when they will go out on a visit.

6.7. It is recommended that the process for reporting private landlords when accommodation is substandard is publicised so that all relevant professionals are clear about the procedure.

6.8. As part of the Serious Case Review process it is recommended that frontline practitioners see IMR/Analyses reports before they are submitted to the Review Panel to ensure that they depict a comprehensive picture of professional input.