HERTFORDSHIRE safeguardingchildren PARTNERSHIP

Report of the Serious Case Review regarding Child J

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19 December 2019

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1.0. INTRODUCTION

1.1. Background to the serious case review and summary of the case

1.1.1. This Serious Case Review (SCR) concerns the death of Child J aged three months whilst in the care of his[1] mother. The death was initially regarded as a sudden unexplained death[2] but the initial post mortem found fractures and healing fractures to the ribs and the right leg around the knee. Expert opinion is that the rib fractures would have required significant force (squeezing the chest) and a pulling and twisting action on the leg. The mother did not seek any medical attention for these recently inflicted injuries. The cause of Child J's death is undetermined but would not have been caused by these injuries.

1.1.2. The mother of Child J had a history of depression, self-harm and attempted suicides. The mother had been diagnosed with Emotionally Unstable Personality Disorder.[3] She also had a history of domestic abuse from her (ex) partner, substance misuse including: alcohol, cannabis and cocaine.

1.1.3. At the time of Child J's death there were a number of agencies involved with the family. Child J was subject to a Child Protection Plan under the category of neglect.

1.1.4. The case was referred to the Hertfordshire Safeguarding Children Board (HSCB) on 18.10.17 and was considered by the Case Review Group Meeting on 22.11.17, which recommended that there should be a Serious Case Review. The chair of HSCB accepted the recommendation to conduct a SCR on the 04.12.17, in line with Chapter 4, Working Together[4].

1.1.5. The case was subject to a Coroner's inquest and the outcome was open - undetermined. Following a Police investigation, no further action was taken.

1.2. TERMS OF REFERENCE

1.2.1. Full details of the review process are included in appendix 2. In summary, an independent lead reviewer worked alongside a review team, composed of senior managers, and facilitated by the chairperson of the Case Review Group. The purpose of the SCR was to review the involvement of the agencies involved with the family to understand how professionals had understood the cause and nature of the family's difficulties, and how effectively professionals had responded. The focus of the review was to learn about how local safeguarding systems are operating and if any changes may be required as a result of the wider lessons from the case.

The SCR considered the work of the following Hertfordshire agencies:

- Health agencies (including Community Mental Health, Perinatal Mental Health service, General Practice services, Health Visiting and Community Midwifery)
- Local Authority Services (including Children's Services (CS), Family Safeguarding Team).
- Housing Services (including borough council and a social housing provider).
- Domestic Violence Services

[1] To protect children's anonymity all the children are referred to using the male pronoun.
[2] Sudden and unexpected death of a baby less than 1 year old in which the cause was not obvious before investigation.
[3] Also known as Borderline Personality Disorder.
[4] Working Together to Safeguard Children, HM Govt 2015.

- Change Grow Live - Spectrum Drug and Alcohol Service
- Hertfordshire Constabulary
- Two Children's Centres in different geographical areas and
- Princess Alexandra Hospital NHS Trust, Harlow Essex

1.2.2. The timeframe for the review was from September 2016 when the mother informed her Recovery Worker for Change Grow Live (CGL) Spectrum that she was: pregnant, drinking six litres of cider each day, smoking £10 worth of cannabis and also £50-£60 worth of cocaine (when she could afford it) up to the death of Child J in early October 2017, when it was reported that the mother was still using cannabis.

1.3. FAMILY COMPOSITION

1.3.1. The family members relevant to this review will be referred to as follows:

Family member	Description used in this report	Age at time of Child J's death	Ethnicity
Subject	Child J	3 months	White British
Mother of Child J	Mother	30	White British
Maternal Grandmother of Child J	Maternal grandmother	59	White British
Ex-partner	Ex-partner	47	White British
Biological father	Biological father	30	White British

1.3.2. **Family involvement.** The involvement of key family members in a review can provide particularly helpful insights in to the experience of receiving or seeking services. Letters were sent to: the mother, maternal grandmother and biological father. There is currently no family involvement with the SCR.

2.0. BRIEF SUMMARY OF THE CASE

2.1. The mother discovered that she was pregnant but not by her (ex) partner who had been violent and abusive to her for the past five years. She had a history of depression, self-harm and attempted suicides. She had been diagnosed with Emotionally Unstable Personality Disorder. During her early adolescence she had been a victim of sexual abuse. She had a history of substance misuse including alcohol, cannabis and cocaine.

2.2. Appropriate referrals were made to Children's Services, which, resulted in the unborn baby (UBB) being made subject to a Child Protection Plan (CPP) under the category of neglect.

2.3. During the antenatal period the mother engaged well with all agencies involved and was determined 'to turn her life around'. She had regular testing for drugs and alcohol and all of the professionals working with the mother told the SCR that they were surprised about how well she did, and were pleased for her; they wanted her to succeed.

2.4. Three weeks after the birth of Child J the third CPC was held. Children's Services was confident that the case could be managed under a Child in Need Plan. However, the multi-agency group felt it was too early and it was agreed the case would be reviewed in October 2017. The mother and maternal grandmother were angry about this decision and the professionals involved told the SCR that the family were not as welcoming as they had been during the mother's pregnancy.

2.5. Child J was reported to be unsettled and that he cried a lot; advice was given on how to manage a baby with colic. There was little exploration about the possible impact of a crying baby on a single mother with a history of substance misuse, depression and attempted suicides. After the mother moved into her new flat with Child J she became isolated.

2.6. The mother attended her GP towards the end of September feeling anxious and depressed. She was prescribed anti-depressants and asked to keep a diary of how she felt over the next two weeks, which would be reviewed at her follow-up appointment. The GP did not share this information with any of the professionals working with the mother and Child J.

2.7. In early October 2017 the mother fed Child J at about 07.30 and then placed him back into the cot on a double folded duvet and covered him with a blanket. At around 10.00 the mother noticed that Child J was not breathing.

2.8. At the time of Child J's death, it was thought to be a case of sudden unexpected infant death, but following a forensic post mortem, injuries were found that were considered to be potential non-accidental injuries (NAI).

3.0. HOW PROFESSIONALS UNDERSTOOD THE CASE AT THE TIME

3.1. The following section is a summary reconstructing how professionals understood the mother and Child J's experience and their situation at the time.

<u>The initial referral to Children's Services following mother's disclosure of pregnancy to her Recovery Worker; November 2016 - January 2017</u>

3.2. On the 02.11.16 the mother called to speak to her Recovery Worker in CGL (who was off sick), as she was pregnant and "scared as hell" and really "wants to stop drinking". She was seen by her GP who prescribed diazepam to support her not to drink. The GP sent a booking referral letter to Princess Alexandra Hospital (PAH), which outlined her history of depression, alcohol dependency and details of her current anti-depressants.

3.3. The following day (03.11.16) mother attended CGL and was seen by her Independent Domestic Violence Advocate (IDVA). The Recovery Worker returned from sickness absence on that morning and when informed that the mother was pregnant asked for the case to be reassigned for personal reasons. The Recovery Worker informed the mother in a face-to-face meeting that there was going to be a change of worker. Initially there was some disappointment from the mother about this but she was happy with her new male worker, as she already knew him.

3.4. Consideration had been given as to whether a male worker was appropriate but due to capacity issues within the service there was no other worker available to take on this piece of work. There was a good and timely face-to-face handover between the two workers. The former Recovery Worker, who had worked with the mother

over a period of some years, told the SCR "the mother sometimes puts a mask on to hide her pain".

3.5. 11 days later a referral was made to CS by the IDVA due to the high level of risk to the mother and the viability of the pregnancy because of her misuse of drugs and alcohol. The referral included: numbers of Multi Agency Risk Assessment Conferences (MARAC), self-harming, alcohol issues and re-iterated the concerns about the level of violence the mother had experienced in her life. It was reported that the mother was unhappy about this referral, as she did not want CS involved; she was afraid that the baby would be removed. However, she did understand that a referral had to be made due to her history and current substance misuse. CS decided that due to the very early stage of the pregnancy the case should be re-referred in eight weeks' time following the 12 week ultra sound scan. This was an appropriate decision.

3.6. Following a booking appointment at PAH at nine weeks gestation a referral was made to CS (the second referral). A Section 17 Child and Family Assessment commenced on the 5.12.16.

3.7. Three days later the mother attended CGL to collect a food voucher. She stated that she had been smoking cannabis with friends and had also had two or three cans of lager. The mother agreed to have an unscheduled test and breathalyser; she tested positive for cocaine but was negative for all other drugs tested for. The mother suggested that she might have smoked a friend's roll up with cocaine in it. A follow-up appointment was made for 13.12.16, which she failed to keep.

3.8. In early January 2017, a strategy telephone discussion took place between the Team Manager in the Children's Services Assessment Team and the Police. Information sharing highlighted serious concern about mother's alcohol use and the non-engagement with police, following an incident in October 2016 when her (ex)-partner was arrested for: high-risk domestic abuse, common assault and theft of mobile phone and keys. There were also concerns raised about the mother's extended family and it was agreed that the case should be escalated to a Section 47[5] Child and Family Assessment, and that the case should proceed to an Initial Child Protection Conference (ICPC).

<u>Initial Child Protection Conference and Core meetings established to activate Child Protection Plan for the Unborn Baby under the category of neglect January 2017 - June 2017</u>

3.9. The ICPC took place on 20.01.17, the mother and maternal grandmother attended. It was reported that the maternal grandmother was hostile and defensive during the meeting. The volatility of the relationship between mother and her mother (maternal grandmother) was discussed. The subject was also raised as to whether the mother would be able to sever all contact with her (ex) partner, the perpetrator of domestic abuse. The (ex) partner was unaware of the pregnancy and the mother is convinced that he is not the biological father of the baby.

3.10. The UBB was made subject to a CPP under the category of neglect. The chair of the conference acknowledged that the mother was starting to make changes in her

[5] s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm

life and that she was very positive about the pregnancy. However, it was not known whether she would be able to sustain the changes that she had started to make. The chair of the conference also put in place a contingency plan that if contact with her (ex) partner continued, a legal planning meeting would be convened. The case was allocated to a social worker (SW) from the Family Safeguarding Team (FST)[6].

3.11. Core group meetings took place on 01.02.17, 01.03.17 and the 31.03.17. The mother and maternal grandmother attended all the meetings. There was no opportunity for professionals to discuss the case without the family present, but the professionals told the SCR that there was good information sharing within the network. The mother continued to test negative for cocaine and alcohol but positive for cannabis, which she openly admitted that she was continuing to use.

3.12. A management move to be re-housed had been agreed and she was awaiting a suitable property to become available. It was also agreed that IDVA would support the mother in her Non-Molestation Order[7] once the move had been completed.

3.13. Three referrals were made to, the Community Mental Health Team (CMHT), Safer Places for Domestic Abuse support [8] and to the outreach team in the newly commissioned Perinatal Service.[9] It was reported that the mother welcomed mental health intervention and saw it as a means of proving her co-operation with CS. There appeared to be a limited emphasis on safeguarding by the Perinatal team as CS were already involved. Safeguarding did not appear to be routinely embedded as part of practitioner supervision and observations saw the mother as compliant and progressing positively as a good enough parent. (The SCR has been told that the threshold for intervention by this service has changed and this case would no longer be accepted.)

3.14. On the 07.04.17 the second CPC took place. It was noted that the mother had received e-mail communication from her (ex) partner stating that he was going to commit suicide, wanted to know what tools to use and that it was all her fault. A letter was also sent that accused her and the maternal grandmother of fire-bombing a neighbour's car. It was felt that gaining a Non-Molestation Order at this point might escalate the situation as her (ex) partner had ignored previous orders obtained.

3.15. The mother was currently first on the housing list for the managed move, but the property would have had to be a like for like swap and that may not have happened before the birth. The mother accepted a new property on 02.05.17 (she did not move until the 20.07.17). The pregnancy continued with reportedly good engagement by the mother with all professionals involved and that she remained negative when tested for alcohol and cocaine.

<u>Birth of Child J and discharge from hospital, end of June 2017 - 07.07.17</u>

[6] Model introduced in Hertfordshire three years ago. Engages families into holistic change using Motivational Interviewing. 8 modules incorporate the framework of the parenting assessment.

[7] Is aimed at preventing your partner or ex-partner from using or threatening violence against you or your child, or intimidating, harassing or pestering you, in **order** to ensure the health, safety and well-being of yourself and your children.

[8] Safer places provide group work and referral to the Triple R programme

[9] The Perinatal Service is a new service that commenced operations on the 20.03.17. Work with women with moderate to severe mental health during pregnancy and up to one year postnatal.

3.16. The mother had a normal delivery after a long labour. Child J had a Finnegan[10] Score of 3, which is low and would indicate there was no sign of drug/substance withdrawal. Mother and baby remained on the post-natal ward for a period of seven days as there was concern about the possibility of sepsis (an infection) and a course of intravenous antibiotics was given.

3.17. A discharge-planning meeting took place on 03.07.17 and it was noted that mother and Child J would be discharged to maternal grandmother's address. The mother was absent from the ward on a number of occasions over the next few days. It was reported that she was asked to inform the staff when she was leaving the baby but did not do so. On the 05.07.17 the mother left the ward on at least four occasions. On one occasion the mother and maternal grandmother were involved in an incident in the hospital grounds whereby security had to be called due to the maternal grandmother becoming verbally abusive. It was reported that the mother sat passively on the bench during the altercation between security and the maternal grandmother.

3.18. The mother continued to leave the ward on a number of occasions and then became upset after the SW had contacted her. The mother reported to the staff on the ward that she felt very emotional, was struggling with lack of sleep and feels let down by family members and friends who have not visited her. The mother also felt that she was constantly being scrutinised and assessed as to how capable she was as a mother; she was reassured that this is done on all mothers. The mother was observed giving lots of cuddles to the baby and the care was appropriate at times but she did not always respond when the baby was crying and had to be woken by staff to attend to Child J.

3.19. Mother and Child J were discharged from PAH NHS Trust to the care of the community midwifery team. Information is shared by telephone from PAH to the Maternity services at the Lister Hospital. The allocated community midwife telephones the Lister hospital to pick up new cases on a daily basis and then allocates the cases to the team. The information shared over the telephone did not include the concern about the mother leaving Child J unattended on the postnatal ward on a number of occasions, or that the baby was subject to a CPP under the category of neglect. The mother was discharged with a letter detailing the birth and postnatal period but the system in operation relies on parents to present this letter to the midwife at the first visit. The midwife who made the two home visits was, however, aware of the family circumstances. The mother was observed handling the baby well and advice was given about safe sleeping and there were no concerns documented.

<u>Supporting mother to care and protect Child J until the death July 2017 - October 2017</u>

3.20. The Health Visitor (HV) carried out the New Birth Visit at 14 days post birth; the midwife was still visiting and had informed the HV that she would continue until at least 28 days[11] (the midwife eventually discharged mother and Child J on 11.08.17). The HV told the SCR that the mother and the maternal grandmother were annoyed by the number of professionals visiting the house and they could make you feel uncomfortable if you were early or late for a planned visit. The HV also felt the

[10] Used to quantify and diagnose neonatal withdrawal or abstinence syndrome. https://www.lkpz.nl/docs/lkpz_pdf_1310485469.pdf

[11] Currently 10% of community midwives caseload have visits up to or over the 28day statutory duty to visit.

mother could get 'wound up' by the maternal grandmother. During the visit the mother was observed jigging the baby up and down in her arms even though the baby was asleep. The HV thought that the mother was agitated and explored how she was coping with the new baby and whether she had experienced any urge to use alcohol or drugs; the mother was reported to say that she had not thought of using. Child J was under Universal Partnership Plus[12] post birth.

3.21. The third CPC took place on the 19.07.17. CS were of the view that the risks could be managed under a CIN Plan whilst the other professionals supported continuation of the CPP as Child J was only three weeks old. The decision was for Child J to continue with a CPP under the category of neglect. The professionals told the SCR that both mother and maternal grandmother were furious that the plan had continued. It was reported that the SW had started some of the parenting assessment sessions but could not start the parenting capacity section before the birth.

3.22. In the middle of July, the (ex) partner contacted the SW and reported that the mother had told him that after the parenting assessment had been completed in July they could be together.

3.23. The mother did not attend her CGL key worker appointment on 11.08.17, contact was eventually made by phone on 29.09.17 and a home visit was arranged for 02.10.17. The CPP did not specify/stipulate the frequency of substance testing following the birth of Child J.

3.24. On the 14.08.17 Safer Places closed the case due to non-engagement by the mother. It was also noted that she had failed to attend the Triple R programme in May but stated that she wanted to go in September. The SW was informed of this decision.

3.25. On 15.08.17 the HV made a planned visit to the mother's new address, it was the HV's first visit of the morning and there was no reply. Child J was six weeks old at this visit. The HV telephoned the mother who advised her that she was at the GP surgery accompanying her mother (maternal grandmother). The HV waited outside the flat for about 25 minutes and whilst waiting she looked through the window and saw ashtrays and bottles of formula milk lying on the floor. When the mother arrived, she appeared to be stressed and flustered. She had run to the door of the flat without Child J who she said was in the car with the maternal grandmother. The mother did not let the HV in and told her to wait outside; the HV told the SCR that she thought the mother might have gone in to the flat in order to hide something. After a few minutes the mother emerged from the flat and collected Child J from the car.

3.26. The HV described the mother as being really angry and uptight. When she asked if the maternal grandmother was well she 'bit her head off' and told her that it was none of her business. This was the first time that the HV had seen the mother behave in this way; the HV did not feel threatened or intimidated and the planned visit continued.

The mother talked about DNA testing to confirm the biological father of the baby. At the end of the visit the HV was shown around the flat and observed six or seven dirty nappies lying on the floor. Following completion of the visit she shared this

[12] Four levels of health visiting intervention: Health Visitor Implementation Plan: A Call to Action (DH.2011)

information with the SW but did not consider that any immediate action was required.

3.27. At the Core Group meeting on the 23.08.17 the mother informed the group that her (ex) partner was paying £50 per week into her bank account and that she had spent £100 before she realised where the money was coming from. The mother was advised to block the payments to her account and pay back the money. The mother reported that she was due to commence the Triple R programme[13] in September (Safer Places had closed the case on 14.08.17). It was also reported that the Perinatal Consultant had discharged her (11.08.17) but she would continue to be supported by the Perinatal Team in the community.

3.28. The eight-week postnatal check and developmental assessment took place on the 25.08.17; no concerns were noted by GP1. The mother had taken Child J the week before with a cough, it was thought to be viral and mother was advised to give paracetamol and return if still worried.

<u>It is believed that the injuries would have occurred in the following timeframe 3-21 days before the death of Child J.</u>

3.29. The HV made a home visit on the 11.9.17 (this was the last time that the HV saw Child J). Child J was reported to be gaining weight, smiling, cooing and reaching developmental milestones. The mother reported that she was anxious about the DNA test that was going to be done later that day and told the HV that she had smoked cannabis on three occasions because she felt stressed. It was reported that maternal grandmother was looking after Child J on these occasions and the SW was aware. The mother also asked about childminders for Child J, the mother stated that she wanted some time to herself and that maternal grandmother was not offering her so much support since she had moved into her new flat. The mother had asked the HV to "cuddle" Child J on this visit; it is very unusual for HVs to hold a baby. This may have been an indication that the mother was finding the constant care of Child J more difficult and was possibly too scared to tell the professionals. It would also appear that the maternal grandmother was not offering as much support since the move into her new flat. (At the CPC, it was reported that the maternal grandmother was planning to visit every day).

3.30. The following day the SW made a statutory home visit as required by the protection plan, and found the mother very upset. She reported that she was anxious that her (ex) partner may be the father of Child J. She reported that she had been having nightmares and described handing over Child J to her (ex) partner and Child J's head fell off. It would appear that there was no further exploration by the SW or discussion with Mental Health support services about this. The DNA test confirmed that her (ex) partner was not the biological father of Child J, and the mother was reported to be very pleased with this outcome. The biological father did not want to be involved with Child J.

3.31. Child J was seen by GP1 on the 12.09.17 as he was reported to have a cough, the mother reassured that it was viral and that no treatment was required. This is the second consultation for a cough. It is unclear whether any of Child J's clothing was removed during this consultation. A referral letter was sent to urology concerning Child J's hypospadias[14] on the 20.09.17.

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[13] Therapy Based Domestic Abuse programme.

[14] A congenital condition in males in which the opening of the urethra is on the underside of the penis.

3.32. On 18.09.17 the support worker from the Children's Centre phoned the mother as she had not attended the baby massage group. The mother stated that she had been awake from 4 am and felt very stressed but would be attending the core group meeting later in the day. (Maternal grandmother looked after Child J).

3.33. The mother disclosed to GP2 on the 25.09.17 that she felt low in mood and that the baby was crying all the time. The mother was commenced on anti-depressants and a follow-up appointment booked for two weeks to review her depression diary, which GP2 told the SCR was standard practice. There was no recording within the mother's notes that there had been any exploration about how the mother was coping with her baby. GP2 did not share this information with the HV or any other professionals working with the family; however, GP2 did put the family on the agenda for the next multi-disciplinary meeting due to take place on the 02.10.17.

3.34. GP1 told the SCR that the practice was unaware that Child J was subject to a CPP under the category of neglect. GP1 told the SCR that the practice only became aware of this fact after Child J had died. It has now been established that the minutes from all three case conferences were received by the practice within the agreed timeframe. The process in place at the time was for the GP (who saw the child the most) to review the conference minutes and then they were filed separately. The SCR found that there was no safeguarding icon/alert, present on Child J's records. The HV told the SCR that she had at least monthly multi-disciplinary meetings at the GP surgery and that this case was routinely discussed (see paragraph 4.3.5).

3.35. On 28.09.17 the support worker from the Children's Centre visited the mother at home to support her in making an application for her maternity grant. The following day she dropped off a food parcel at the house and reported that there was a male in the flat to the SW.

3.36. The Recovery Worker made a planned home visit in early October and contacted the mother ahead of the 10 am visit to tell her that he was on his way; the mother did not answer the phone. Shortly afterwards the mother called the worker back requesting that the appointment be re-arranged as she did not feel well and did not get much sleep last night. The mother was also due to attend the Children's Centre later that morning for the baby massage group but failed to attend.

3.37. On the same morning the mother noticed that Child J was not breathing, an ambulance attended but Child J was unresponsive and was pronounced dead at the hospital. The death was initially thought to be due to 'sudden unexplained death' but the initial post mortem found fractures and healing fractures.

4.0. FINDINGS

4.1. **Introduction** This section of the Review assesses the quality of multi-agency practice at the key points that are considered to provide the most significant learning. In doing so, the Review considers both the contemporary required standards and the information that was known, or could have been known, at the time of the events. Where there is information about why practice may not have met required standards, this is explained. By understanding **why** things happened in the way that they did, rather than simply **what** happened, the SCR is seeking to achieve a greater depth of learning about safeguarding systems within Hertfordshire, and beyond this individual case.

4.1.1. The cause of Child J's death remains undetermined. The post mortem identified that Child J had six fractures and healing fractures. There were three fractures to the ribs (left 6 and 7). All of the rib fractures would have been caused by significant chest compression and squeezing the chest from side to side. A forceful pulling of the limb often with a twisting action would have caused the three fractures to the area around the right knee.

4.1.2. Child J was being seen regularly as part of the CPP. The plan was being implemented. We now believe that the injuries were likely to have been inflicted during the period of 11.09.17 – 02.10.17. Due to Child J's age and the nature of the injuries, he would only have experienced and been in pain for a brief period of time. The five professionals who did see him (HV, SW, two GPs and Children's Centre worker) during this timeframe, had no concerns following their observations and interventions.

4.1.3. The child protection procedures that the HSCB and its member agencies had put in place to implement 'Working Together 2015', had been implemented in the way they had envisaged, throughout the involvement with the family; i.e. early recognition of risk and referral, and, early assessment and planning. With some important exceptions, agencies coordinated their work, shared information and came together to implement the plan. There was a systematic approach to evaluating risks using the Strengthening Hertfordshire Families Approach to conferencing. There was evidence of multi-agency discussion and challenge at the third CPC, resulting in Child J continuing to be subject to a CPP.

4.1.4. Despite robust systems being in place, there were some gaps in practice which need to be considered in order to learn from them. The behaviour and engagement of the mother and maternal grandmother changed subtly following the birth of Child J. Professionals need to be able to interpret subtle nuances in the 'here and now', then think and talk about why they might be happening. The strength of critical thinking through supervision across the professional groups was not evident in this case; indeed, professionals told the SCR that this case was not a case that they were concerned or worried about.

4.2. The parenting assessment was not done in a systematic way and was not prioritised because of the view held by all the professionals that the mother had made significant changes to her lifestyle and was positive about being a parent.

4.2.1. The CS Safeguarding Team employs a structured workbook approach consisting of eight modules and it is recorded in the electronic workbook; in this case, the parenting assessment was not carried out in a systematic way. The records reviewed for this SCR showed a narrative of the contacts and a list of the issues and risks; however, there was limited evidence of timely analysis that demonstrated a good understanding of: the child/ parent story, the volatile relationship between the mother and maternal grandmother, and finally, how the family history may contribute to the likely success of prolonged change of the mother and Child J's lifestyle. The mother's own experience of being parented was not fully explored; the view held was that the mother had made significant changes to her lifestyle and was very positive about being a parent.

4.2.2. The professionals told the SCR that the mother and maternal grandmother had a difficult relationship. This relationship was never fully explored or understood and should have been an important aspect of the parenting assessment, particularly as

the grandmother was believed to be her main (and a positive) source of support. The fragments of information that suggested that this was not the case were not compiled and shared.

4.2.3. The SCR has been told that CS Safeguarding Team had been trained in motivational interviewing prior to the introduction of the new way of working. Each member of the Family Safeguarding Team attended a three-day Motivational Interviewing (MI) course (June to December 2015) with follow up workshops (September 2015 and June 2016). It has a strength-based, solution-focused approach.. Staff are encouraged to listen to parents sympathetically and work with them collaboratively to develop a plan of how they would like to change. The strengths-based approach recognises and attempts to build on the skills that a family already possesses. Although these values resonate with staff, it is a new skill which is complex and difficult to put into practice. Assessing the likelihood of a parent being able to make sufficient changes in their lives to ensure the child's safety and wellbeing is an important part of determining parental capacity.[15] Capacity to change incorporates two elements: the motivation to change and the ability to change.

4.2.4. There is substantial evidence concerning the range of problems that can impair parental capacity to meet the needs of children (Cleaver et al, 2011; Brown and Ward, 2012). They identified a range of factors including: mental illness, problem drug and alcohol use, learning disability and intimate partner violence. There is some evidence that the parenting capacity of individuals, particularly mothers with Borderline Personality Disorder, may be compromised due to a lack of sensitivity to their children (Newman et al, 2007) and "frightened/frightening" behaviour can lead to the development of disorganised attachment (Hobson et al, 2009). Research also indicates that where parents were themselves abused or neglected in childhood there is an increased risk of maltreating their own children (Reder et al, 2003; Dixon et al, 2005). It has been suggested that the more severe the abuse or neglect experienced by parents in childhood, the more difficult it is to resolve early losses and traumas, and the greater risk that parents will maltreat their own children (Howe, 2005).

4.2.5. The mother had historically been diagnosed as having a personality disorder, though this was not put forward as a current diagnosis. 'A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person.'[16] Personality Disorders are conditions where there are a pattern of behaviours and personality traits that develop and can make it challenging for someone to live with themselves or with others. Emotionally Unstable Personality Disorder, (EUPD), also known as Borderline Personality Disorder, is a sub-type of a personality disorder. It often has an association with traumatic childhood experiences for example experiencing childhood abuse (although not all people who have experienced this will go on to develop EUPD). Symptoms include difficulty regulating one's emotions; impulsivity; low self-esteem; feelings of emptiness; oversensitivity in relationships; making relationships quickly but losing them easily and maladaptive coping mechanisms such as self-harm.

4.2.6. Whilst many women with EUPD will make the transition to parenthood without difficulty, for some becoming a mother can be more challenging. They may not have

[15] Department of Health Assessment Framework (2000) to refer to "the ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to adapt to his or her changing needs over time."
[16] https://www.nhs.uk/conditions/personality-disorder/

had a good experience of parenting themselves, so can lack a positive template to model being a parent from. They may struggle to cope with their emotions and managing a newborn's demands maybe harder. They can have difficulty tolerating distress of others, and their own view of themselves can impact on their relationship with their child. Some women have more chaotic lifestyles, or lack support because of their relationship challenges, meaning they have less support around them to manage the new set of challenges.

4.2.7. In this case the mother had a high number of identified risk factors but she was also very determined that the pregnancy offered her the opportunity to "turn her life around." In fact, she did stop drinking and using class A drugs immediately that she knew she was pregnant and only faltered once during the antenatal period. Professionals that had worked with her over a period of years were surprised by this but were also pleased for her. The Consultant Psychiatrist (perinatal mental health) who saw the mother in August discharged her as she felt the mother had made good progress and that she would receive support from the community team with a view to closing the case. There was no evidence that the professionals that were working with and supporting the mother considered the possible impact of EUPD on her ability to parent. The diagnosis / label was part of the mother's history and was seen as something in her past and possibly overlooked. All the professionals working with the mother acknowledged that she had made positive changes to her lifestyle, and engaged proactively with the professionals supporting her.

4.2.8. Initially the mother had been anxious about CS being involved, as she was worried that they would "take the baby away." Given her anxiety about the possibility of her child being taken from her, we now think it may have become increasingly difficult for the mother to admit to the network of professionals that, caring for a baby on her own was more difficult than she had thought and she was unable to tell anyone.

4.2.9. Was the view held by professionals overly optimistic given the mother's past history and substance misuse? The mother had abstained from alcohol and cocaine but this was over a relatively short period of time. Those professionals that had worked with her over a number of years were surprised but pleased that she had seemed to 'turn her life around' and wanted her to succeed.

4.2.10. Following the birth of Child J there were some subtle changes in how the mother engaged with professionals. The skill required by the professionals is to interpret the changes and ask why this is happening. There was also a considerable amount of time taken up by arranging and supporting the mother in obtaining a DNA test to determine the biological father and this was a perceived trigger for the mother's anxiety and her bad dreams. The action to complete the DNA test was prioritised as a key to improve her wellbeing.

4.2.11. An optimistic view is more likely to develop when the difficulties faced by a parent or prospective parent are considered and measured by specific practical steps with professionals not taking an overall view of the challenges faced by someone who has had some extremely bad experiences. Each of the professionals involved judged success by their own case and agency specific criteria rather than the wider picture.

4.2.12. Brandon and colleagues (2008) stress the importance of effective and accessible supervision. This helps staff put into practice the critical thinking required to understand cases holistically, complete analytical assessments, and weigh up interacting risk and protective factors. All the professionals told the SCR that this case was discussed in supervision, but they also told the SCR that this was not a

case that they were worried about.

4.2.13. There was no effective critical voice in the network e.g. the conference chair held back from stepping down the case from a CPP to a CIN, but only in order to provide more time. The focus of the challenge was, 'have we left it for long enough' not, 'are we asking the correct questions'?'

4.2.14. Professionals have to strike a balance between being supportive and positive towards the family in the steps that they have taken, but must maintain "healthy scepticism" and "respectful uncertainty" (Laming 2003). In this case the professionals were reassured about the changes that the mother had made particularly around her drug and alcohol misuse, and her level of engagement albeit over a very short period of time. The depth of the trauma and difficulties that the mother had experienced during her life were listed but the impact of this and her ability to parent successfully was not fully explored or understood.

4.2.15. The professionals involved in this case wanted the mother to succeed, they were pleased it appeared that she had 'somewhat' turned her life around and that she was enjoying being a mother. There was a lack of professional curiosity, the mother had experienced layer upon layer of trauma going back to her adolescence and more recently domestic and sexual violence. The depth of the difficulties that the mother experienced relative to other people was understated. There is a danger that if a change in behaviour is compartmentalized and viewed in isolation (in this case some drug and alcohol misuse improvements) the difficulty in sustaining positive changes may be underestimated and the level of risk may be higher than realised.

4.3. The Child Protection systems in place within General Practice were not followed which meant that all practice staff with appropriate access to the clinical records were unaware that the unborn child and Child J were subject to a Child Protection Plan.

4.3.1. We know that families use the services of GPs in varying ways and that the GP has at times a unique position in being able to assess and monitor the health and wellbeing of the family (and in some cases the extended family). Whilst acknowledging that GPs and practice staff have attended the requisite Safeguarding training, there needs to be more challenge in how they are applying the learning into their everyday practice. The safeguarding system is reliant on GPs and practice staff ensuring that safeguarding information is flagged on the IT system as well as sharing any concerns they may identify with other professionals working with the family.

4.3.2. Considerable work has been done and continues to be done with General Practice in Hertfordshire. Each practice has a Named Safeguarding Lead. Named Doctors and Nurses for Safeguarding, support all practices with advice, training and undertaking audits. The Clinical Commissioning Group have set clear guidelines that children subject to a CPP are identified and 'flagged on the electronic record system in use within the practice. The Care Quality Commission (CQC) has not identified any practices in Hertfordshire with concerns in safeguarding and evidence from CQC suggests that they are measured as 'good'.

4.3.3. In this case the mother had been registered with the practice since 1987, over the last six years there had been episodes where the mother had left the practice for short periods of time. The mother had been registered continuously since July

2015. The lead GP for safeguarding knew both the mother and maternal grandmother well and was aware of their medical and mental health history. The mother always attended the practice on her own, never with the maternal grandmother or (ex) partner.

4.3.4. The mother attended the practice as soon as she realised that she was pregnant and was appropriately prescribed drugs to help her refrain from alcohol; a referral was made to the Princess Alexandra Hospital in Harlow which included all the relevant information.

4.3.5 The GP was invited to all the CPCs but apologies were sent; it is documented that the minutes of all three conferences were sent to the practice. We now know that the practice did receive the conference minutes but no alert was active on the system. The usual practice at this surgery was as follows: the GP who usually saw the family reviews the CP minutes, highlights this with the administration team, who then code the electronic records (EMIS) and put the alert on the IT system. This procedure did not happen and therefore practice staff were unaware that the unborn baby and subsequently Child J were subject to a CPP.

4.3.6. The practice has acknowledged that this was an error and is currently reviewing records over the past year to ensure that all: child protection, children in need and looked after children are correctly identified and an alert is placed on the IT system. Training for clinical and administrative staff in how to correctly code and place a clinical alert has taken place in the surgery. Following completion of this work an audit will be undertaken within the practice to provide assurance that the systems are in place.

4.3.7. The practice has regular multi-disciplinary meetings every six weeks, which, are attended by Doctors, Nurses, Health Visitor, and Practice Manager. The administrative team manages the agenda and professionals raise concerns with the team in order for the concern to be placed on the agenda.

4.3.8. Following presentation by the mother with, 'low mood', at the end of September she was seen by GP2 who prescribed anti-depressants. The mother was asked to keep a depression diary and was to be reviewed in two weeks. There was no exploration by GP2 of how the mother was coping with her baby and what the impact of taking anti-depressants might be on her ability to care particularly with her history. GP2 did not share this information with the health visitor or any of the other professionals, however, she did put the mother on the agenda for the multi-disciplinary meeting scheduled for 02.10.17., the day Child J died. Given the mother's past mental health history, substance misuse and the fact she was saying the baby "cried all the time", it would have been more appropriate to inform the health visitor immediately rather than waiting for the meeting that was scheduled to take place in five days. It is difficult to say that there would have been a different outcome but a visit from the HV may have allowed the mother to talk about how she was or was not coping with Child J.

4.3.9. How to engage GPs and ensure participation in safeguarding is not a new problem. Over the years GPs have struggled to attend key meetings and discussions due in part to work pressures and time constraints. The use of technology to aid communication including nhs.net, and better use of time such as, telephone consultations and use of conference calls and Skype must be further explored to allow the meaningful contribution that GPs can make to the safeguarding system.

4.4. Specific Points of Practice and Learning

4.4.1. All pregnant women can choose where they wish to attend for the delivery of their baby, in this case the mother gave birth at PAH NHS Trust in Harlow Essex. Currently, at the point of discharge a telephone call is made to the Lister Hospital and the community midwives call in on a daily basis to the Lister to be told about new discharges. The danger with this system is that, some significant information may not be passed on at the point of discharge as was evident in this case.

The Clinical Commissioning Groups and PAH have worked to agree a Maternity Information Safeguarding pathway for women who have their babies at PAH, live in Hertfordshire and have antenatal and postnatal care provided by community midwifes from East and North Hertfordshire NHS Trust. An audit should be undertaken to ensure that the new pathway is effective.

4.4.2. It is not known why some babies die suddenly and for no apparent reason from sudden unexplained death, but experts do know that by placing a baby to sleep on its back reduces the risk, and exposing them to cigarette smoke or allowing them to overheat, increases the risk.

Advice is given to all parents about 'safe sleeping'. Health visitors give the HSCB Safe Sleeping leaflet out at the new birth visit and the contents are discussed at the time and again at a follow-up visit between 6-12 weeks. The parents are advised how to avoid the baby becoming too hot (or too cold), these guidelines include: placing the baby on his or her back feet to the foot of the cot, refraining from covering the head and avoiding the use of duvets, quilts, baby nests or pillows. The challenge remains as to how professionals within the network can get the message regarding 'safe sleeping' to all parents but particularly to the most vulnerable and those at the highest risk. Consideration by Public Health as to how this message can be given by all the partner agencies consistently, and reinforced at every contact with families, should be explored.

4.4.3. At the third CPC held for Child J, CS presented the view that needs and any risks to Child J's welfare could be safely managed within a CIN Plan. CS has told the SCR that its approach followed the statutory guidance, *Working Together to Safeguard Children 2015* reserving child protection plans for those children who are likely to suffer significant harm. The local authority believes that this approach has led to a reduction in the number of children who are subject to plans, made possible by the development of better early help services and more robust approaches to plans for children in need. This it is argued is less stigmatising and likely to lead to better family engagement and that if the child in need plan is resourced and overseen effectively children will not be left at risk. However, some other professionals, particularly health agencies, have told the SCR that at the time there were significant differences in their approach to children in need including the prioritisation of resources allocated, approaches to the sharing of information, flagging of children in health agencies, supervision arrangements and management-oversight. Further work needs to be done to ensure that agencies with safeguarding responsibilities have a shared understanding of the function of CIN and CP plans, the interpretation of criteria setting out which child needs to be on which plan and how the plans will operate.

4.4.4. In this case the mother was tested throughout her pregnancy for alcohol and substance misuse. When the unborn baby was made subject to a CPP the testing was done routinely to highlight potential risks to the unborn baby and was not based on the clinical need or presentation. Following the birth of Child J, testing

stopped because the physical wellbeing of the unborn baby was no longer a consideration. However, the risk of the mother relapsing should have been identified and included in the CPP pointing to the need for continuing testing. The learning from this is that professionals must not assume because testing happened during the pregnancy it will necessarily continue going forwards. At each point the need for and value of testing requires active consideration.

5.0. CONCLUSION

5.1. This case has demonstrated that the child protection procedures that HSCB and its member agencies have put in place to implement Working Together 2015 were implemented: early recognition of risk, early referral and assessment and planning. Child J was being seen regularly as part of the child protection plan and the plan was being implemented. On the whole the systems worked and there was multi-agency discussion and challenge at the CPCs.

5.2. The case has also highlighted some areas of practice that require help and support to improve and strengthen the safeguarding and child protection system.
Reviewing how to engage effectively with GPs who are under considerable work pressures (at both a local and national level) in order that safeguarding and child protection is at the forefront of any consultation that they undertake.
To ensure that there is critical thinking within supervision and network meetings and for all professionals who are focused on building on the strengths of families and working with positives, do not overlook the complexity and depth of difficulties that some individuals and families face.

5.3. The FST is a new way of working and to date has demonstrated some excellent outcomes. The way that parenting assessments and parenting capacity are recorded on the electronic workbooks has been a learning process. Further work to demonstrate and provide assurance to HSCB that the assessment is conducted in a systematic way should be explored.

5.4. The engagement by the mother with the professionals involved in the case changed subtly during the postnatal period, this was not picked up in the 'hear and now.' The DNA testing was prioritised because it was felt that it was causing the mother undue stress and that this would improve her sense of wellbeing. However, the attention that was given to this may have served as a distraction to those professionals working with the mother, thereby overlooking the small matter of how she was actually coping with an unsettled crying baby, on her own, or with very little family support.

6.0 RECOMMENDATIONS

Recommendation 1:

The Clinical Commissioning Groups (CCGs) have introduced systems for children in receipt of a Child Protection Plan but must provide assurance to the HSCP that the system is robust and able to identify practices that require improvement.

Recommendation 2:

The CCG through the Named GPs must challenge GP safeguarding practice where necessary, and monitor practices through audit and the use of Key Performance Indicators.

Recommendation 3:

Children's Services must provide assurance to HSCP that the modular parenting assessment undertaken by the Family Safeguarding Team is being carried out in a timely and systematic way; information is provided by the multi-agency network and is highlighted and explored as part of the overall assessment. Assessments should offer an effective understanding of parenting strengths and weaknesses.

Recommendation 4:

HSCP should take an active role in monitoring the understanding that the safeguarding partners (police, health and local authority services) and other member agencies have of agreed approaches to identifying and meeting need at all levels (targeted support, child in need services and child protection plan) and that services provided are proportionate to risk and presenting need. There should be evidence that the understanding is manifest in practice as well as at the level of policy and procedure.

Recommendation 5:

HSCP needs to ensure that key professionals are aware of the significance of a diagnosis of Emotionally Unstable Personality Disorder and the impact that this may have on the parents' ability to parent.

Appendix 1: Acronyms

CCG	Clinical Commissioning Group
CPC	Child Protection Conference
CIN	Child in Need
CPP	Child Protection Plan
CS	Children's Services
CGL	Change Grow Live
EUPD	Emotionally Unstable Personality Disorder
FST	Family Safeguarding Team
GP	General Practitioner/Family Doctor
HV	Health Visitor
HSCB	Hertfordshire Safeguarding Children Board
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advocate
MARAC	Multi Agency Risk Assessment Conference
PAH	Princess Alexandra Hospital
TM	Team Manager
SCR	Serious Case Review
SW	Social Worker
SUID	Sudden Unexplained Infant Death
UBB	Unborn Baby

Appendix 2: Methodology

2.1.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:
Reviews are not ends in themselves. The purpose of these reviews is to identify improvements, which are needed, and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of death, serious injury or harm to children. (Working Together, 2013:66)

2.1.2. The statutory guidance requires reviews to consider: "*what happened in a case, and why, and what action will be taken*". In particular, case reviews should be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children*
- *seeks 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*

2.1.3. In order to meet these requirements, the model adopted in undertaking this review uses a 'systems approach', which draws significantly on the work undertaken by

Professor Munro[17] and SCIE [Social Care Institute for Excellence]. A 'systems approach' to learning recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it is designed to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. The purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

2.1.4. An independent lead reviewer worked alongside a review team (Panel), composed of senior managers, and facilitated by the chairperson of the Case Review Group. The review team met on 4 occasions and considered the following documentation:

- A merged chronology from all the agencies providing care to the mother and Child J
- Rapid Response to Sudden Unexpected Death in Childhood Report
- Copies of Case Conference Minutes
- Copies of Core Group Meetings
- Post Mortem Report / Pathology reports
- Access to Social Work Electronic Records
- CGL Investigation
- Hertfordshire Constabulary management report

A briefing meeting was held for all practitioners involved in the case to explain how the review would be undertaken; 40 people attended.

- Conversations with 20 key professionals.

2.1.5. The author of this SCR, Ann Duncan, was commissioned by HCSB to write the overview report; she was independent of the case and all agencies involved.

2.1.6. The Review Team was comprised of the Independent Lead Reviewer, and the following senior managers/senior professional leads who were independent of the case:

Job Title / Role	Organisation
Independent Chair Case Review Group	Hertfordshire Safeguarding Children Board (HSCB)
Head of 0-25 Together Service	Hertfordshire County Council (HCC)
Head of Housing	Housing Association
Head of Social Work & Safeguarding	HPFT
Designated Nurse Safeguarding/LAC & Care Leavers	East & North Herts Clinical Commissioning Group
Named Nurse Safeguarding Children	Hertfordshire Community Trust
Deputy Service Manager	Change Grow Live - Spectrum
Detective Chief Inspector	Hertfordshire Constabulary
Acting Senior Probation Officer	Probation Services
Service Manager	IDVA service
Business Manager	HSCB
Head of Family Services, Commissioning	HCC
Community Development Manager	Borough Council
Minute Taker	HSCB Business Unit
Ann Duncan	Independent Reviewer

[17] Social Care Institute for Excellence (Fish et al, 2008)

2.1.7. The time frame under consideration for this Review was:
September 2016 – October 2017

The period under review covers the pregnancy and birth of Child J care. Background information has been included to add context. The Review finishes at the time of Child J's death.