



Serious Case Review
Executive Summary
In respect of Baby M

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INTRODUCTION

CIRCUMSTANCES OF CHILD M'S DEATH

1. Baby M was born in August 2007, the second child of B (mother) and the first of C (father). In late January 2008 an emergency ambulance was called to the family home and Baby M was found to be in cardiac arrest. Baby M was transferred to hospital where Baby M was pronounced dead.
2. The pathologist's report of the subsequent post mortem examination concluded that on the balance of probability, the cause of death was pneumonia. At the inquest, held in December 2008, the Coroner's verdict confirmed this, and was at pains to assure the parents that they could not have known that their child was suffering from pneumonia and thus could not have done anything about it.
3. Baby M and older half-sibling, Child D were the subjects of a child protection plan at the time of Baby M's death. Baby M and family were receiving multi-agency support due to increasing concerns about the children's welfare since the early months of D's life.

ARRANGEMENTS MADE FOR THE SERIOUS CASE REVIEW

4. Following the death of Baby M, the Serious Case Review Committee of the Blackburn with Darwen Local Safeguarding Children Board met in March 2008 and recommended that a serious case review be held in respect of child M in line with government policy ("Working Together to Safeguard Children" DfES 2006.) The recommendation was subsequently endorsed by the LSCB chair and an Overview Panel was set up in May 2008 to undertake the review.
5. Internal management reviews were undertaken by relevant agencies that had involvement with the family. Agencies contributing to the review were:
 - Blackburn with Darwen Primary Care Trust – a combined report from all the Health agencies involved in the case
 - Police
 - Children's Services
 - Early Years Service
 - Supported Housing Provider
 - Sexual Health Advisory Service

6. The serious case review covered a three year period starting in April 2005 when Baby M's mother became pregnant with D and ending at the point of Baby M's death in January 2008.
7. The overview panel met five times between June and August 2008. The deadline for submission of the report to OFSTED was extended to 31.12.08 by agreement with Government Office North West to allow for the completion of the Coroner's inquest.
8. Both of Baby M's parents took the opportunity to contribute to the serious case review process by giving views about the services provided by agencies to support them in the care of their children. Having lost their child, this was a distressing process for them and the effort they put into this difficult process is very much appreciated.
9. Ofsted evaluated the serious case review as 'inadequate' in April 2009, and following a meeting with Ofsted in July 2009, BwD LSCB agreed that a re-consideration of the serious case review would address the inadequacies. The serious case review Panel met again in August 2009 chaired independently and a re-consideration report submitted to Ofsted in October 2009.
10. In February 2010 Ofsted wrote back to the LSCB having evaluated the re-consideration report as satisfactorily addressing the inadequacies identified in their April 2009 evaluation.
11. This executive summary reflects all the information presented to the LSCB from the original review and the re-consideration process.

SUMMARY OF EVENTS DETAILED IN THE OVERVIEW REPORT

12. Baby M's mother, B, was known to local authority Social Services during her childhood due to concerns about her welfare including child protection concerns which resulted in two periods of registration on the child protection register. She left home at sixteen and went to live in supported accommodation. She subsequently moved out, but returned during her pregnancy with Child D, to a section of the unit specifically for young mothers and their babies.
13. As a vulnerable young person who had experienced difficulties and personal tragedy during her childhood, she received support from staff within the supported accommodation unit and from health services in relation to her pregnancy, including early introduction to health visiting services before the birth of Child D.
14. Whilst B attended most ante-natal appointments, concerns began to be expressed about her preparation for the birth of her baby and her potential ability to cope with the demands of a child.
15. B had a difficult birth with D and found it hard to cope with the demands of a young baby. She also became depressed in the weeks after the birth and continued to suffer from low mood and withdrawn behaviour throughout the period covered by this review, although she had some periods when her mood lifted.
16. B's difficulties in coping with the demands of Child D continued and concerns also arose about neglect, as a result of which B was offered family support from the Early Years service.
17. Within a few months, new concerns emerged in relation to alcohol consumption and possible domestic violence. B was still suffering from depression and issues of neglect continued to arise. Additionally, Child D's development was becoming a cause for concern.
18. In September 2006 B decided that Child D should live with a member of the extended family for a short period until she felt able to care for Child D again. Child D spent several months with a relative, returning to mother's care in April 2007, following a failed application by the relative for a residence order.
19. During the separation, B had maintained some contact with her child, but had at times expressed some uncertainty about whether or not she wanted to have the child back to live with her. Child D returned home with a package of services for mother and child, including Early Years family support, a nursery place, support from a worker from Children's Social Care and health visiting services.

20. B became pregnant with Baby M in December 2006, and moved out of the supported accommodation shortly before Child D returned to her care. Her boyfriend, C, (baby M's father) subsequently moved in with her. She received regular ante-natal care.
21. B had a normal pregnancy with Baby M, but there were further concerns about her care of Child D, inappropriate levels of drinking in relation to both B and in particular C, and suspected domestic violence. B found it difficult to engage with the services offered to her, although she kept most of her specific ante-natal appointments.
22. B gave birth to Baby M in August 2007.
23. Following the birth, all the same problems continued and B missed more appointments with the services available to her. A further specialist family support service was offered to B and C, but after a positive start, the couple stopped attending appointments and the service was withdrawn. Despite the serious nature of the family difficulties, Baby M's general development was normal, although weight gain was not satisfactory.
24. At the end of November 2007 a decision was made to convene a Child Protection Conference. There was a delay in this being arranged and it took place in January 2008. Both Child D and Baby M were made subject to a child protection plan on the grounds of neglect, and the first core group meeting of agencies involved with the family and the parents took place mid January 2008.
25. Baby M died towards the end of January 2008.

SUMMARY OF AGENCY INVOLVEMENT

26. Health services, in the form of ante-natal care, were involved with B from the beginning of her pregnancy with Child D, and there was early involvement of the health visiting service from the late stages of B's first pregnancy and throughout the rest of the period of this review. B also saw her GP in connection with her pregnancies, her children, and her depression, and a referral was made by the GP to the Community Mental Health Team in relation to her depression.
27. There was a high level of visiting by the health visitor, including extra visits connected to B's depression throughout the review period. During Baby M's short life, however, B did not keep a significant number of these appointments.

28. Given B's young age, vulnerability and physical state, the level of midwifery support in the aftermath of D's difficult birth was insufficient. Following the birth of Baby M, a number of midwifery appointments were not kept by B.
29. B visited her GP in relation to her depression and was referred to the Community Mental Health team. The referral was not accepted by the team who suggested that the Sexual Health Advisory Service might be an appropriate service (the provider also delivers emotional health and wellbeing services). B therefore received no thorough assessment of her mental health needs, although she did receive medication from her GP and increased visiting by her health visitor. Given the longstanding nature of her depression, a mental health assessment should have been undertaken.
30. Services in the form of parenting support and nursery provision were provided by the Early Years Service from the early months of Child D's life onwards and were increased as the family difficulties became more complex. This required a lot of contact with B and Child D in particular, but B found it difficult to recognise that she needed these services and difficult to engage with them.
31. Children's Social Care undertook three initial assessments of B and Child D's situation. The first two assessments concluded that ongoing involvement from this service was not required as there was sufficient support in place for B and Child D from other services. The third assessment was interrupted by Child D going to live with a relative, but a worker from Children's Social Care was nevertheless allocated to support B from the end of August 2006 onwards and had significant contact with her, which B found helpful. This worker was however not a qualified social worker, and did not have the skills and knowledge of child protection issues, needed to address the increasingly complex needs of the family. The assessments undertaken when B was referred to Children's Social Care should have included a Core Assessment that would have looked at B's history and parenting ability in more detail.
32. In October 2007 a request by the health visitor for a child protection conference was turned down by Children's Social Care in favour of the involvement of a specialist family support service. The particular nature of this service meant that it was unlikely to be successful and given the level and number of concerns about the risks to the children from the parents' problems, the decision not to convene a conference was inappropriate. When a child protection conference was agreed at the end of November 2007, there was a delay in arranging it which should not have occurred.
33. From September 2006 onwards, a number of multi-agency planning meetings took place to consider the welfare of Child D and later both

Child D and Baby M. This was good practice and should have enhanced good multi-agency communication in this case. However, whilst information was shared at these meetings and plans reviewed, there is little evidence that all the relevant information available within the professional network was brought together, analysed and new plans made in the light of the meaning of that information for the children's welfare and safeguarding needs. Despite significant evidence that B did not engage well with the services provided and that the services were not therefore improving her parenting abilities or impacting on the neglect issues, the same services became part of the reviewed plans at every meeting. Nor were the issues of domestic violence and alcohol consumption properly addressed within these meetings and agencies did not actively seek to engage with C (Baby M's father), or properly consider the impact of his presence in the family and on the children. When the child protection conference met, much of the content of the previous plans, in terms of services offered, was again included in the child protection plan.

34. In terms of resources, the family received a high level of service from the agencies. There were frequent visits by the health visitor, the Children's Social Care worker and also significant contacts with Early Years workers, including nursery provision which increased in the later stages of the period covered by this review.
35. Although there were justified significant concerns on the part of professionals about the children's safety and welfare, the Coroner was clear in his verdict that Baby M died of natural causes from pneumonia, and told the parents that they could not have known at the time that Baby M was suffering from pneumonia.
36. In relation to the conduct of the agencies in this case, there are lessons to be learned about multi-agency working and communication, recognition of risk to children, the way that services were provided, and some decision making. However, there is no evidence to suggest that Baby M's death could have been predicted or prevented.

LESSONS TO BE LEARNED

37. Several opportunities to undertake a core assessment of the child(ren) and family were missed in this case. When a case is initially categorised as a child in need case requiring family support services, the situation needs to be regularly reviewed and any emerging concerns fully assessed and analysed by the multi agency partnership to facilitate a comprehensive understanding of the child and family's developing needs through time.
38. Recording of agency involvement with children and families is still held on different systems within agencies, resulting in service responses that do not assess all available information and histories.
39. Where a non-social work qualified member of Children's Social Care staff is allocated to support a family, the line manager should, through the supervisory process, regularly review whether or not the changing family circumstances reflect a need for the skills and knowledge of a qualified social worker to be applied to the case.
40. Where there is evidence to suggest that post-natal depression may be a factor for the mother, a thorough assessment of mental health needs should be undertaken by a suitably qualified professional.
41. Where a paediatric developmental assessment is requested, this should be actioned in a timely manner.
42. Reviews concerning services provided to families need to take full account of the response of family members to these services and in particular the possible reasons for lack of engagement with services. The professional network needs to be open to adjusting services and other interventions to facilitate the family's full engagement and to promote the welfare and safety of the child(ren).
43. All agencies working with children should follow their respective policies and procedures to undertake assessments and analysis of concerns they have about risk to children, and should accordingly make a decision about the need for referral to statutory children's services, irrespective of whether or not another agency professional holds a different view.
44. Information about and an understanding of parental histories are often crucial to a full understanding of the family's strengths and difficulties, and central to planning and delivery of appropriate services and interventions.

45. The planning and delivery of services and other interventions should always take account of the emotional needs of parents. The potential impact of the parents' emotional state on the ability to form satisfactory relationships with professionals, as well as healthy attachments to their children needs to be given thorough consideration.
46. Where domestic violence and/or alcohol misuse are known or suspected as issues within a family, they should be taken very seriously and steps should be taken by the appropriate professionals, to explore and gain an understanding of the scale and dynamics of the problem, so that appropriate safety planning can be included in the overall services, and other appropriate support and interventions provided to the family.
47. Strenuous attempts should be made to engage with fathers present in families receiving agency support, particularly where significant concerns about children's safety and welfare are emerging. Assessments of the family should always include the father /mother's partner.
48. The quality of multi-agency communication is an issue which arises repeatedly in Serious Case Review reports. Whilst there was a clear commitment to good and effective multi-agency communication in this case, there were instances when this did not happen, and it can only be re-stated that high quality communication is essential in all work with children and families in order to have the best chance of securing good outcomes for children.

RECOMMENDATIONS

CHILDREN'S SERVICES SOCIAL CARE

- 1) Core Assessments should be triggered automatically if a third initial assessment is triggered on any family member within 12 months of the first initial assessment.
- 2) Consideration of the need for a core assessment should be undertaken by the team manager if a third initial assessment on any member of the family is triggered within 2 years of the first initial assessment.
- 3) A case tracking system to be introduced throughout the social work service which ensures management review of child in need/family support cases.
- 4) Core Assessments will include a social history of both parents wherever practicable and possible and include the father/male partner in the assessment and subsequent planning process.
- 5) All social workers are provided ongoing professional development by way of education in respect of the implications of neglect, poor attachment, alcohol abuse and domestic violence on children.
- 6) Where consistency of the quality of parenting is a concern, there should be systematic, objective and regular assessment of the quality of parenting experienced by children that should then inform service provision and care planning. This should be through the use of an objective assessment tool.
- 7) Assessments (Initial and Core) and reports for court proceedings are undertaken by qualified social work staff only.
- 8) The social work capacity of the Referral and Assessment Service is so that there is sufficient suitably qualified and experienced staff and their workloads are consistent with providing optimal and safe service.
- 9) Measures are taken to ensure there is appropriate expertise within the service to support social workers undertaking assessment of families where domestic violence is a feature.
- 10) Protocols are further developed to support the process by which professional differences of opinions are resolved.

POLICE

- 1) Initial actions of attending officer(s) to record every deployment to a Domestic Violence related incident on a Sleuth DV Referral Form.
- 2) The officer's supervisor is to ensure that a thorough quality assurance process is undertaken and recorded on the Police Incident Log to ensure all appropriate action is taken and rationalised.
- 3) Following the placing of a marker upon vulnerable addresses, referrals should be made to the Public Protection Unit.
- 4) Communications staff to be reminded of their obligation to identify warning markers.
- 5) Recognition of harm factors for safeguarding children also needs to be reinforced through the Lancashire Constabulary Training Plan.
- 6) To consider the creation of a contingency plan and/or multi agency problem profile.

SUPPORTED HOUSING PROVIDER

- 1) Where residents are receiving multi-agency involvement, joint risk assessments to be completed prior to accommodation being offered.
- 2) Consideration should be given to the attachment of a children's social worker to the Unit to provide a closer and effective working relationship.
- 3) To improve management support to the Unit's practitioners, a senior member of staff should be available at all times for advice and consultation for staff working on complex cases.

CHILDREN'S SERVICES EARLY YEARS

- 1) The responsibility of the role of early year's worker needs to be standardised across both key functions referred to in this case (family support and childcare /nursery) which will see uniformity in training and development and will affect the best level of support for the children and families.
- 2) All recording functions (file recording) for children's centres to be reviewed.

- 3) The service continues to move to adopt 'a dads and men friendly organization' (DMFO) approach which positively encourages dads, fathers and male carers to engage in service delivery.
- 4) Additional work to be undertaken with partner agencies to improve information sharing practice. Work to be undertaken to better understand the need to share information about children's centres.
- 5) A protocol to be developed that will encourage parents to report absences from nursery/centre activities/groups and their attendance /availability for planned visits.
- 6) Encompass safeguarding as part of the supervision protocol.
- 7) Awareness raising with regard to 'safe sleeping' and bed sharing as detailed in the healthy child programme to be developed and rolled out across the Borough. This will link with partner agencies that will share the responsibility and make explicit a joined up approach to address issues and concerns.
- 8) The implementation of an electronic database to record initial children's centre registrations via the UF1 Form.
- 9) Ensure that the Working Together (2006) is understood and translated in to practice and that any recent supplements to this document are incorporated into Early Years Policies and Procedures.

HEALTH

- 1) Hospitals NHS Trust midwifery services to review care pathways offered to high risk / mothers and their infants.
- 2) Hospital's NHS Trust and the PCT's assessments of families should be conducted using the holistic framework 'The framework for assessment of children in need and their families'(DoH 1999). This should be used alongside an assessment of risk.
- 3) Hospital's NHS Trust and the PCT to stress the importance of including the father figure / mother's partner in any assessments of family functioning.
- 4) Review effectiveness of post natal depression (PND) care pathway and the inclusion of Community Mental Health Team (CMHT).
- 5) Hospital's NHS Trust and the PCT to have systems in place to respond to mother's suffering domestic abuse and / or abusing alcohol.

- 6) Hospital's NHS Trust and the PCT to raise awareness of the significance of compromised maternal / infant attachment and the negative impact it has on the infant's emotional and physical development.
- 7) Hospital's NHS Trust and the PCT provider to review effectiveness of growth assessment policy and its application to high risk infants/children.
- 8) Hospital's NHS Trust and the PCT to develop guidance for health staff when they have 'no access visits' to children.
- 9) NHS direct to develop systems to highlight children not living with their parents and who are in alternative caring.

SEXUAL HEALTH ADVISORY SERVICE

- 1) Closer liaison to be developed between the counselling and clinical departments and sharing of information.
- 2) Improve the referral process within the organisation to the Outreach Nurse Service.
- 3) The local service's experience of the serious case review process will be reported to the national office and recommended for cascading across the organisation's network.

MULTI-AGENCY RECOMMENDATIONS

- 1) Agencies involved in multi-agency planning meetings for common Assessment Framework (Team Around the Child), Child in Need and Children subject to Protection Plans to have clear processes to review regularly the effectiveness of, and accessibility to services, adjusting plans to meet additional and new needs of families.
- 2) Where professional differences occur as to whether thresholds are met for CAF, CIN and CPP intervention, a clear process should be developed to resolve such differences.
- 3) Multi-agency referral pathways for families experiencing compromised parenting due to alcohol misuse, drug misuse and domestic violence to be made clear in LSCB policies and procedures.