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Executive Summary of
SERIOUS CASE REVIEW
Concerning 'M' d.o.b.15.05.2004

Report commissioned by
SWINDON LOCAL SAFEGUARDING CHILDREN BOARD

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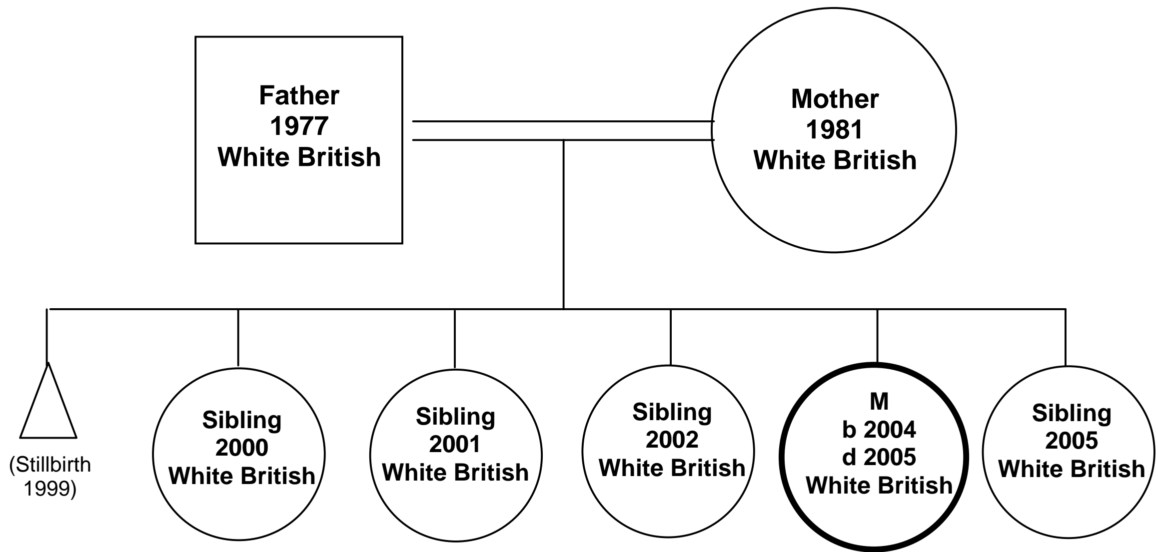
Executive Summary approved and signed off by Swindon LSCB April 2007
Extracted from the Overview Report approved by Swindon LSCB 11 April 2006

Genogram



1. Introduction

1.1. M was born in Swindon on 15.05.04 and lived with both her natural parents and siblings in a local authority property until her death on 26.04.2005. M was the youngest child born to both parents and at the time of her death her mother was pregnant with her sixth child, the first pregnancy resulting in a still birth in 1999.

1.2. M was born by an emergency caesarian section weighing 3.010 kgs. Following her birth she was transferred to the Special Care Baby Unit having developed a temperature soon after delivery. Her mother was advised of the need to remain in hospital in view of her own medical history but she discharged herself against medical advice three days after M's birth in 2004.

1.3. M remained in hospital alone; she was visited by both parents until the 22nd May when she was discharged from the special care baby unit and returned to her parents' care. Throughout May, although there are a number of no access visits recorded by health professionals, when M is seen she is feeding well and appears an alert baby.

1.4. There was frequent contact by health professionals to the family home during June and July 2004 where they were able to gain access on all but one occasion. M was making excellent weight gain and feeding well. However, she was not taken for her first triple immunisations and the rescheduled appointment in August was also not kept.

1.5. In August 2004 M continued to gain weight, and had begun to look around and Mother reported that she was smiling.

1.6. During a visit from health professionals early in September 2004 the family were reminded of the importance of M having her 6-week check and immunisations and the Health professionals stressed the need to attend the clinic. The family also failed to attend Paediatric Out Patients on the 7th September and, as there were no concerns on discharge from the Special Care Baby Unit, M was discharged from outpatient clinic.

1.7. The last date that M was seen by any professional prior to events leading to her death was on the 22.09.2004 for her 6-week check and first triple immunisations at the GP surgery. No concerns were expressed by Health Professionals regarding M's development. She was taking formula, weaning had been commenced and M was generally sleeping well. She was described as vocalising, reaching, grasping, alert and responsive.

1.8. Health Professionals continued to visit the family home from this point up to the time of M's death, leaving messages on numerous occasions and seeing other family members but not M.

1.9. 'M' was found dead on the 26.04.2005 at the family home in Swindon where she lived with her parents and siblings. An emergency call was received at 05.15:54 and an ambulance dispatched to the family home where a clinical assessment and brief attempt at resuscitation of M were undertaken. M was brought in dead to the Great Western Hospital. The post mortem established that M had died of starvation and neglect. Medical examination upon her death revealed she looked emaciated. Her approximate weight was that of a 3-4 month old baby; she was aged 11 months when she died. **Recommendations 9.2.1., 9.2.2**.

2. Criteria for undertaking a Serious Case Review

2.1. "Working Together" and Protocol 1 from the Swindon and Wiltshire Multi-Agency Child Protection Procedures identify a number of factors which should be taken into account when deciding whether a Serious Case Review should be undertaken. The Swindon Local Safeguarding Children's Board (LSCB), formerly the Area Child Protection Committee (ACPC), has the responsibility for commissioning Serious Case Reviews. The factors relevant to this case are:

2.1.1. Swindon is the responsible authority – and is not aware of any other ACPC/LSCB involvement.

2.1.2. A case review should always be undertaken when a child dies and abuse or neglect is known or suspected to be a factor in a child's death.

2.1.3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.

2.1.4. To identify clearly what the lessons are, how they will be acted upon and what is expected to change as a result.

2.1.5. To improve inter-agency working to better safeguard children.

3. Scope of Reference for the Review

3.1. It was agreed that the case should be subject to a full Serious Case Review in order that a comprehensive picture of the practice in this case across all agencies be available.

3.2. That as a minimum the review should cover the period from the birth of the couple's first surviving child born in 2000.

3.3. That subject to legal advice, the Panel recommend that the medical notes for both parents should be reviewed from the time of the first pregnancy (resulting in a still birth).

3.4. Agency Representation on the Overview Panel

The purpose of the Panel is to offer expertise and independence rather than representation. Its task is to give an independent overview of how agencies work together. For this review, representation was suggested from:

Education	Geoff Wood
Housing	Mike Ash
National Society for the Prevention of Cruelty to Children	Charlotte Brand
Police	Nick Bancroft
Swindon & Marlborough Trust	Dr Janet King
Gloucester Primary Care Trust	Nuala Livesey

Representation from The National Society for the Prevention of Cruelty to Children who had no involvement in the case was suggested to give an independent perspective.

4. Chairing of Overview Panel

4.1. It was agreed that Julie Downey, Head of Safeguarding for Children Services, who has no operational responsibility, chair the Overview Panel. It was acknowledged that, in the light of possible criminal proceedings, it might be difficult for a Police representative to take on this role.

4.2. It was agreed that the review should be completed, as far as possible, within the agreed timescales. The review was extended to allow time for the Management Reviews to be completed and amended. The review commenced September 2005 and was adopted by the Local Safeguarding Children Board on 11 April 2006.

5. Contributions to the Review

5.1. Individual agency management reports and chronologies were provided by the following:

Education Manager	Nigel Pickering, Social Inclusion
Housing	Sylvia Darragh, Head of Landlord

	Services
Wiltshire Police	Steve Hedley, Detective Chief Inspector
Swindon & Marlborough NHS Trust	Joanne Smith, Senior Nurse, Children's Services
Consultant Paediatrician/ Clinical Director	Dr Paul O'Keefe
Head of Midwifery/ Senior Nurse Gynaecology, Nursing	Christina Rattigan
Wiltshire Probation Area	Phil Smith, Assistant Chief Officer (Specialist Services)
Social Services	Gill Cutter, Children's Services Practitioner NSPCC South West Specialist Investigation Service
Swindon Primary Care Trust	
Health Visiting, Community Paediatrics and Out of Hours	Adina Grace, Assistant Director of Commissioning Children, Designated Nurse Child Protection.
GP Service	Dr Liz Mearns, Clinical Governance Lead
Wiltshire Ambulance Service	Kathy Shears, Clinical Manager
Walcot Family Centre	Lynn Turner, Project Manager

5.2. Previous Serious Case Reviews have highlighted the need for agencies to respond to the request for information including when they have had no involvement with the family. No involvement was noted from:-

School Nursing	confirmed by e-mail 2.08.2005
The Welcome Centre	no involvement letter dated 1.07.2005
Children and Family Court Advisory and Support Service	no involvement but no letter formally received
National Society for the Prevention of Cruelty to Children	no involvement letter dated 2.08.2005
Women's Refuge	Limited involvement. Letter dated 27.07.2005

6. Parental involvement in the review

6.1. M's parents were visited by the Chair of the Overview Panel and the serious case review process was explained to them. They were invited to contact Julie Downey direct if they had anything they wanted to contribute to the review.

7. Panel Comments on Significant Events

7.1. "Reviews are of little value unless lessons can be learned from them" (Working Together 2006). The aim of this section therefore is to provide a short summary of significant facts and events to assist agencies in this process.

7.2. The Overview Panel read and analysed the chronology of this case from the birth of the couple's first surviving child to the death of M in April 2005 and found that, at an early stage in this family's life, a pattern began to emerge of feeding difficulties with the children and many contacts with Health professionals because of these problems, a variety of childhood ailments, fluctuating weight gain and loss, and also some injuries.

7.3. There was also a long history of failed appointments with medical professionals and follow up appointments with Consultants, often not attended, that was established as early as the birth of the couple's first child and continued through to M's death in 2005. There was also a pattern of mother discharging herself against medical advice including following M's birth. **Recommendation 9.1.4.**

7.4. On a significant number of occasions mother would present herself or the children at the A&E department or the Out of Hours GP services with various complaints such as chest infections, difficulties with children's feeding and injuries, deemed accidental, to the children. Some of the contacts refer to mother's depression and she was seen on two occasions at A&E. **Recommendations 9.1.6., 9.9.1., 9.9.2**.

7.5. Mother often sought advice on the same evenings of days where the Health Visitor, Midwife or Nursery Nurse had visited but had not been able to gain access. It is likely that the ailments complained of to the Out of Hours Services could have been addressed through the planned appointment system. **Recommendation 9.1.4**.

7.6. There were missed opportunities for inter-departmental liaison at a higher level when these crises occurred, particularly within the Health Service. Concerns by the Health Visitor, Probation Officer,

GP's, hospital doctors were noted, reported, passed on to each other informally but not appropriately followed up.

7.7. There was a pattern of informal discussion of the family between health professionals but the many concerns were not coordinated or followed through to a referral to Social Services or a full case discussion between all the professionals involved and a joint strategy agreed. A formal meeting at this or at subsequent points, also including the Social Services, would have had the effect of highlighting the collected concerns of the professionals, and raising the profile of the case. **Recommendation 9.11.1**.

7.8. There were several occasions when a referral to Social Services or convening a strategy discussion[1] might have seemed appropriate, for example, at the time of the Probation Officer's concerns about mother's mental ill-health when she was pregnant, and the possible risk to her unborn child. In March 2000 the Probation Officer's assessment of the risk of mother's re-offending was changed from low to medium and a range of mental health problems were identified including poor eating, self-neglect and depression.

7.9. In January 2001 Social Services received a telephone call from the Special Care Baby Unit requesting financial help for the family as they were not visiting at feed times. On two different days the parents separately presented themselves at the Social Services office with requests for financial help but the files, which would have given some background information on the family and raised concerns about their vulnerability, were not accessed and therefore an opportunity for an Initial Assessment was missed. **Recommendations 9.1.5., 9.8.2**.

7.10. There seemed to be evidence of uncertainty on who should take the lead in coordinating the concerns when they arose. For example the Probation Officer contacted Social Services in February 2001 regarding failed appointments and gaining access. The Duty Officer at that time felt there were no grounds for intervention and referred the matter back to the Health Visitor via the Probation Officer.

7.11. In October 2001 a letter was sent by the Liaison Health Visitor to the Paediatrician expressing concern that the family were not accessing medical services and requesting that the children be admitted for assessment if and when they attended at the hospital

[1] Strategy discussion.
Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm, there should be a strategy discussion involving the social services department and the police, and other agencies as appropriate (e.g. education and health), in particular any referring agency. A strategy discussion may take place following a referral, or at any other time (e.g. if concerns about significant harm emerge in respect of child receiving support under s.17). Where a medical examination may be needed, a senior doctor from the providing service should be included in the strategy discussion.

in the future. No such action was taken and an opportunity for further assessment of the children's development needs was missed in January 2002 when they presented at A&E. **Recommendations 9.11.1., 9.11.3**.

7.12. During the period under review (over five years), the Health Visitor assumed a disproportionate responsibility for the case. In April 2002 the Community Paediatrician, following a concern by the Health Visitor that M's sibling had not been taken to an arranged paediatric appointment, decided to await further findings from the Health Visitor rather than take the matter further within the department. There was frequent discussion of the family and many concerns were raised but not addressed in a unified way.

7.13. Concerns regarding the children extended beyond those of the professionals involved. On one occasion in 2001 neighbours reported to the Police and Health professionals concerns regarding the care, health and safety of the children.

7.14. In 2002 neighbours alleged the children were not fed properly and that both the parents refused to see the GP with the children when they are unwell. Whilst both incidents were reported to the relevant agencies it did not culminate in an Initial Assessment[2] of the family situation.

7.15. Domestic abuse was a feature in this case and M's mother was observed fearful in her partner's presence on occasions. There were two reported incidents that were attended by the Police, the first in November 2001 and the second in February 2002. Domestic reports of the incidents were forwarded to Social Services but no record of the children's welfare was recorded during the second case. Because of the nature and infrequency of these incidents the threshold was not reached whereby an initial assessment would have been undertaken by Social Services. **Recommendations 9.7.1., 9.8.1**.

[2] Initial Assessments

The process of initial assessment should involve: seeing and speaking to the child (according to age and understanding) and family members as appropriate; drawing together and analysing available information from a range of sources (including existing records); and obtaining relevant information from professionals and others in contact with the child and family. All relevant information (including historical information) should be taken into account. In the course of this assessment, the social services department should ask:

- Is this a child in need? (s.17 of the Children Act 1989).
- Is there reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm? (s.47 of the Children Act 1989).

The focus of the initial assessment should be the welfare of the child. It is important to remember that even if the reason for a referral was a concern about abuse or neglect which is not subsequently substantiated, a family may still benefit from support and practical help to promote a child's health and development.

7.16. In April 2002 the Health Visitor expressed 'grave concerns' about the family to social services. Despite the family history, no strategy discussion was convened or a Section 47[3] undertaken. An initial assessment was undertaken in October 2002 jointly by Social Services and Health. This is the first and only recorded visit to the family by a Social Worker but no interventions were made beyond support for a housing application and help for the mother to get more rest. There were subsequently two visits from a Family Support Worker to complete a charity application form and a further visit where they were unable to gain access.

7.17. The last referral to Social Services was in 2003 following notification of an injury to one of the children. Medical opinion agreed that it was accidental therefore a decision was taken that no further action was needed. Previous historical concerns were not taken into consideration and the opportunity to assess the family was missed. **Recommendation 9.8.2**.

7.18. There was a well-established pattern of help being requested by the couple and referrals being made to support services; but there was difficulty of access even after workers made repeated attempts to contact the family.

7.19. In November 2003 the Walcot Family Centre visited both the parents and left leaflets and timetables and the couple considered attending a group; however no services were taken up. In the same month the house was described as warm and the children were dressed and happy. The family were not attending Walcot as arranged and they were advised that, whilst a further referral could be made, they would need to access the service. **Recommendation 9.3.1**.

7.20. The family had frequent moves and in March 2004 eventually attained their ultimate aim of securing the tenancy of a three-bedroom property. This was the fifth move for the couple since the first pregnancy in 1999. From the early days when claiming as homeless until they obtained the house there was frequent contact from the couple, in particular visits to Housing reception; the significance of the moves, increasing debt and the impact on the children did not culminate in a referral to Social Services for an assessment of the family's situation.

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[3] Section 47
The Section 47 Enquiry is the means by which further information is pooled together from the child, the family, and from other agencies to help to establish whether or not a child is or is likely to suffer significant harm. Section 47 Enquiries may follow a referral or an Initial Assessment; they may take place during the course of a core assessment or they may be carried out following emerging concerns about a family who are in receipt of services under Section 17 of the Children Act 1989.
The Children Act 1989 places a statutory duty on Health Services, the Education Department, Schools and other agencies to assist Social Services with their enquiries.

7.21. M was born in May 2004 by an emergency caesarian section weighing 3.010kgs. Following her birth she was transferred to the Special Care Baby Unit having developed a temperature soon after delivery. Her mother was advised of the need to remain in hospital in view of her own medical history but she discharged herself against medical advice three days after M's birth. This was the fourth occasion where mother discharged herself against medical advice and despite concerns regarding her health no planning or discharge meeting was convened. **Recommendation 9.11.2**.

7.22. M remained in hospital alone. She was visited by both parents until the 22nd May when she was discharged from the special care baby unit and returned to her parents' care. Throughout May, although there were a number of no access visits recorded by health professionals, when M was seen she was feeding well and appeared an alert baby.

7.23. There was frequent contact by health professionals to the family home during June and July 2004 where they were able to gain access on all but one occasion. M was making excellent weight gain and feeding well. She had begun to start looking around and was beginning to smile. However, she was not taken for her first triple immunisations and the rescheduled appointment in August was also not kept. **Recommendation 9.11.1**.

7.24. During a visit from health professionals early in September 2004 the family were reminded of the importance of M having her 6-week check and immunisations and the Health professionals stressed the need to attend the clinic. The family also failed to attend Paediatric Out Patients on the 7th September and, as there were no concerns on discharge from the Special Care Baby Unit, M was discharged from outpatient clinic. **Recommendation 9.1.4**.

7.25. The last date that M was seen by any professional prior to events leading to her death was on the 22.09.2004 for her 6-week check and first triple immunisations at the GP surgery. No concerns were expressed by Health Professionals regarding M's development. She was taking formula, weaning had been commenced and M was generally sleeping well. She was described as vocalising, reaching, grasping, alert and responsive.

7.26. Throughout the history of this case the couple experienced financial difficulties, particularly in relation to their rent arrears, which continued to escalate. By October 2004 the couple were advised that they were no longer a secure tenant and were at risk of eviction. During this period mother had increased contact with the Housing Department, rather than father as previously, but was not in when Housing Estates visited in November 2004.

7.27. Health professionals continued to visit the family home on a number of occasions in January 2005 and to leave messages as there was no access. In February access was gained to the family home where it was alleged that M was not in. The no access visits were not flagged up with the relevant line manager. **Recommendation 9.1.4**.

7.28. Mother's sixth pregnancy was confirmed by her GP in March 2005 and she was booked by the midwife at home in April. It was a late booking and she appeared well and appropriately dressed. On this and a subsequent visit to the home it was described as dark, smelly, and sparsely furnished. There were dirty nappies around and two of M's siblings asleep on the sofa. The situation was relayed to the Health Visitor with the intention of discussing with the family the following week a referral to the Local Preventative Group to assess the family's needs and support. However, M died on 26.04.05 before this meeting was convened.

8. Summary and conclusion

8.1. Throughout the timeframe of this case a number of practice issues referred to in the report had been addressed prior to this Serious Case Review through the reviewing of policies and procedures, the facilitating of training programmes and through the implementation of learning from previous serious case reviews. In addition it is important to remember that comments are made in hindsight.

8.2. The key issues of the Review, were the long standing difficulties with feeding of the children, mother's own eating disorder, her depression, a history of missed appointments, domestic violence, many self referrals to Out of Hours Services and self discharging from hospital, several recorded injuries to children and problems of debt. It concluded that at no time was the case considered formally as a Child Protection issue, relevant procedures followed and concerns recorded and, although many of the indicators of neglect were apparent, the main input of Health and Social Services seems to focus on the mother's health and general family support. **Recommendations 9.1.1., 9.1.2**.

8.3. There were many concerns expressed informally by a number of different disciplines and, although many professionals were involved and showing appropriate concern, these never culminated in a Strategy Discussion, a Section 47 investigation or request for the convening of a Child Protection Case Conference (as outlined in 8.2 above). There is evidence of uncertainty as to who should take the lead role in coordinating concerns and the Health Visitor continued for a number of years to carry much of the responsibility for the case. It is perhaps difficult to focus objectively for so many years on the multiple needs of the family. It is possible that the focus was on

the mother's and children's health rather than identifying child protection concerns.

8.4. On more than one occasion discussions took place between health professionals and Social Services regarding escalating concerns about the family and there were missed opportunities at these points for the Social Services to intervene and to undertake an assessment of the family situation. On the one occasion that an Initial Assessment was undertaken, the assessment focused mainly on the material needs of the family, housing, lack of money, rest for the mother. Much reliance was placed on what the couple saw as the problems – the shortage of money, the wrong housing, which served to deflect attention away from the real issues. **Recommendation 9.1.6**.

8.5. On some occasions when health professionals gained access to the family home the children were described as clean, happy, well dressed and the house also tidy and clean. This may have made it more difficult to focus on the parallel issues of mother's depression, domestic violence, poor nutrition of the children, constant self referrals to A&E and missed appointments. It therefore appears that there were periods when the family were doing well and it is clear that the primary health team made strenuous efforts to engage with the family.

8.6. There is no evidence to suggest that the multiple issues for this family were much discussed at Management level. There was no mention of managerial attitudes in supervising the case or if Health and Social Services managers ever discussed the case together even informally. **Recommendations 9.1.3., 9.10.1**.

8.7. M was last seen alive in September 2004 but died in April of 2005. It is acknowledged by health professionals that the baby was doing well in September but following this, there was a period where she was not seen by any professional although other children in the family were seen. It is of significant concern that such a young child, with a family background of feeding problems, maternal depression and domestic violence incidents, was not seen by any professionals between then and the time she died.

8.8. There were opportunities, from the birth of the first child and the early missed appointments, for joint discussions, rather than the family's many problems being seen as a string of isolated events. It is likely that a core assessment[4] involving other disciplines would

[4] Core Assessment.
A core assessment is defined as an in-depth assessment which addresses the central or most important aspects of the needs of the child and the capacity of his or her parents or care givers to respond appropriately to these needs within the wider family and community context. While this assessment is led by Social Services, it is likely to involve other disciplines, either providing information they hold about the child or parent, contributing specialist knowledge or advice to Social Services or undertaking specialist assessments. At the conclusion of this

have addressed the central and most important aspects of the needs of the children and the capacity of M's parents to respond appropriately to their needs had this been viewed as a Child Protection case. A Strategy Discussion or Child Protection Conference[5] involving all the relevant agencies would have raised the profile of this family and resulted in shared information, and clear identification of possible risks.

9. Recommendations – Overview Panel

9.1. All agencies (LSCB Actions):

9.1.1. Receive training in identifying indicators of neglect.

9.1.2. Work towards a shared threshold criteria for intervention in cases of neglect and that this be disseminated through training.

9.1.3. Are provided with specific training for supervising staff in Child Protection for line managers.

9.1.4. Develop a multi agency protocol for no access visits.

9.1.5. Ensure that Children's Case Files contain a properly maintained chronology of significant events.

9.1.6. When working with a parent / carer with mental health issues, assess its implications for children in the family.

9.2. Wiltshire Ambulance Trust

9.2.1. Follow up calls which may potentially affect ambulance crew to be offered counselling, particularly new technicians.

9.2.2. Training for staff in Child Protection and vulnerable children.

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phase of assessment, there should be an analysis of the findings which provides an understanding of the child's situation and informs planning, case objectives and the nature of service provider.

[5] Child Protection Conference
The initial child protection conference brings together family members, the child where appropriate, and those professionals most involved with the child and family, following s.47 enquiries. Its purpose is:

- To bring together and analyse in an inter-agency setting the information which has been obtained about the child's health, development and functioning, and the parents' or carers' capacity to ensure the child's safety and promote the child's health and development;
- To make judgements about the likelihood of a child suffering significant harm in future; *and*
- To decide what future action is needed to safeguard the child and promote his or her welfare, how that action will be taken forward, and with what intended outcomes.

9.3. **Walcot Family Centre**

9.3.1. Liaise with referrer on closure of a case to ensure a plan is in place to promote the welfare and safety of the child.

9.4. **Wiltshire Probation Area**

9.4.1. The panel had no additional comments.

9.5. **Education**

9.5.1. The panel had no additional comments.

9.6. **Housing**

9.6.1. The panel had no additional comments

9.7. **Wiltshire Constabulary**

9.7.1. That Domestic Incident reports forwarded to Social Services record if child/children are seen and their welfare assessed.

9.8. **Social Services**

9.8.1. That the threshold for undertaking an Initial Assessment following a domestic incident report be seen in the context of family history and agency involvement not solely on the nature or number of incidents.

9.8.2. That appropriate background information is gathered to inform the assessment process when concerns are raised about vulnerable families and it is recorded that this has been undertaken on case notes.

9.9. **General Practice**

9.9.1. If the parent is seen as vulnerable, particularly in relation to mental health issues that this is communicated to Primary Health Care Team and other professionals.

9.9.2. Training for general practitioners as clinicians in parenting capacity and its impact of relation to parental mental health on parenting capacity.

9.10. **Swindon Primary Care Trust**

9.10.1. That practitioners take indicators of neglect as defined in Working Together into account through supervision.

9.10.2. That a lead professional is identified when more than one Trust is expressing concerns regarding a child.

9.11. **Swindon and Marlborough NHS Trust**

9.11.1. That Swindon and Marlborough NHS Trust develop and implement a policy for dealing with failed appointments and to include considerations whether a referral be made to Social Services for an initial assessment.

9.11.2. That where there is discharge against medical advice involving a child at risk or a vulnerable family, that all the relevant professionals involved with the family are notified and the discharge plans are distributed.

9.11.3. That information of a significant nature should be read and appropriately logged, flagged on the IT system and accessed when the child presents, and action taken.

9.11.4. That a lead professional is identified when more than one Trust is expressing concerns regarding a child.