Serious Case Review
Child D

November 2016

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1. INTRODUCTION

1.1 Child D died unexpectedly in March 2015 aged 2 weeks. His mother had slept with him on the sofa. At the time of his death, child D was known to Children's Services as his older sibling was subject to a child protection plan. No inquest was held as a post mortem examination concluded that his death was due to natural causes.

1.2 This matter was referred to Swindon Local Safeguarding Children Board (SLSCB) in Swindon where child D lived. In April 2015, the Independent Chair of the LSCB decided that a serious case review (SCR) should be undertaken, because his sibling was subject to child protection plan and neglect might have played a part in his unexpected death.

1.3 There is a legal requirement, as defined in statutory Guidance, Working Together to Safeguard Children 2015, to undertake a serious case review when abuse or neglect of a child is known or suspected and

- either a child has died, or
- a child has been seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.4 The purpose of a serious case review, as set out in statutory Guidance, Working Together 2015, is to identify improvements which are needed and to consolidate good practice in order to prevent similar deaths or serious harm.

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2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 Initially, a review team coordinated the arrangements for this review; it reported to the SLSCB Case Review Group (CRG). In 2016, the CRG became the formal reference group for this review. It was chaired by Alex Walters, the Independent Chair of the Board. Its function was to manage and oversee the conduct of the review. The membership of the CRG is set out at Appendix A. In June 2016, there was a change of lead independent reviewer with the Board appointing Helen Davies to write this overview report. She was assisted by Fiona Francis, Swindon Borough Council (SBC) Service Manager, Quality Assurance and Review (SCR Champion). Further details are at Appendix B

2.2 Seven Individual Management Reviews (IMRs) were requested from the following agencies which had substantial contact with child D and his family:

- Great Western Hospitals NHS Foundation Trust
- Local Clinical Commissioning Group (Swindon general practitioners)
- Swindon Borough Council Early Help Services, including Heath Visiting
- Swindon Borough Council Children and Families Services
- Wiltshire Police
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Domestic Abuse Service in Devon

2.3 In addition, a background report was requested from Oxford University Hospitals NHS Foundation Trust

2.4 This report was written in anticipation that it will be published. Consequently, the information in the report is limited so as to;

1) take reasonable precautions not to disclose the identity of the child or family

2) protect the right to an appropriate degree of privacy of family members

2.5 Terms of Reference for this SCR are at Appendix C. Child D was the main subject of the review and its principal focus was from March 2013 (when local services became involved with his older sibling) until March 2015 (when child D died). However, all agencies were asked to provide a summary of any significant events and relevant family history outside the specific timescale and to consider any safeguarding issues in the mother's background.

2.6 Nearly all the individual management reviews addressed the terms of reference. All the authors of the individual reviews were independent of the case management, apart from the Domestic Abuse Service, and five conducted interviews with staff involved with child D and his family. At least 15 members of staff were interviewed.

2.7 Following consideration of the combined chronology of events and the individual reviews, the first lead reviewer and members of the review team met in October 2015 at two learning events with sixteen frontline staff who had worked with child D and/or his family. They included midwives, health visitor coordinator, social workers and their managers, child protection conference chairpersons, GP, and hospital paediatric staff. Four IMR authors also attended

these events. This provided a valuable opportunity to gain the perspectives of frontline professionals' work with child D's family and to consider lessons learned.

2.8 In November 2015, thirteen staff who attended the learning events met with the first lead reviewer and members of the review team for an analysis meeting.

2.9 After the first draft of this report had been compiled, the second lead reviewer and the SCR Champion met with IMR authors and key professionals in August 2016 in order to seek their views on preliminary findings and on recommendations. Four IMR authors attended this meeting along with four of the professionals who had attended the earlier learning events, together with three members of the original review team.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1. This overview report relies on:

- the agency IMRs and background report
- minutes of the learning events and analysis meeting
- subsequent discussions with the CRG reference group
- the views of Child D's mother and grandmother, recorded by the first lead reviewer, set out in section 5
- views of IMR authors and frontline professionals at a meeting in August 2016

3.2. This report consists of:

- a factual context and chronology
- commentary on the family's input to the SCR
- analysis of the part played by each agency
- closer analysis of key issues arising from the review
- conclusions and recommendations

3.3 The conduct of the review has not been determined by any particular theoretical model. However, it endeavoured to use an appreciative enquiry approach involving the practitioners in the exploration and learning from the case. It has been carried out in keeping with the underlying principles of the statutory Guidance, set out in Working Together 2015 (Appendix D).

4. BRIEF CHRONOLOGY OF KEY EVENTS

4.1 This section of the report briefly describes key events from the birth of child D's sibling. Further detail is then provided at appropriate points throughout the report.

4.2 Child D's family consisted of his mother and older sibling, child C, all of whom are white British. The identities of the children's fathers were unclear, due to conflicting accounts from the mother. She also has two other children, who were removed from her care in 2010, and now live in permanent placements elsewhere.

4.3 The mother had very difficult childhood and spent long periods in care from the age of 5. She experienced 15 different placements including secure accommodation. Her first child was born when she was still in care and a second child was born 2 years later. They were made subject to care proceedings in 2010 by a neighbouring local authority, due to concerns about neglect arising from the mother's transient lifestyle, multiple partners, use of alcohol and domestic abuse.

4.4 Following their removal, the mother continued to misuse alcohol, took several overdoses, and moved frequently, fleeing domestic abuse.

4.5 The mother returned to Swindon at the end of 2012 and a core assessment was completed in March 2013 before the birth of child C. A pre birth child protection conference was held in April 2013 when child C was made subject to a child protection plan under the categories of emotional and physical abuse.

4.6 There were some concerns about the mother's use of alcohol during the spring and summer of 2013, and about changes of partner. In December 2013, a review child protection conference decided to remove child C from a child protection plan; she was designated a child in need.

4.7 In February 2014 the mother and child C moved to a refuge in Devon. The refuge staff were concerned that the mother was leaving child C with unsuitable carers, so an initial child protection conference was convened in April 2014 following their return to Swindon. Child C was made subject to a child protection plan under the category of neglect, and a legal planning meeting was recommended.

4.8 In August 2014, the mother was so drunk that police were called and she was admitted to hospital. Child C was also admitted to hospital very briefly for her own protection. A review child protection conference later that month recommended that the Public Law Outline (PLO) process should start in respect of child C. In the same month, it was confirmed that the mother was pregnant (with child D) and that the pregnancy would be high risk.

4.9 A legal planning meeting within the PLO process took place in November 2014. A follow up meeting scheduled for January 2015 was cancelled due to the mother's deteriorating health. She was admitted to hospital in Swindon at the end of January due to serious complications with her pregnancy and subsequently transferred to a hospital in Oxford in mid February for specialist care. The review child protection conference in respect of child C, scheduled for the end of February 2015, was postponed as the mother was in hospital.

(Child C was in the care of her maternal grandmother). This was to be the pre birth conference in respect of child D.

4.10 Child D was born 6 weeks prematurely in Oxford and placed in the neonatal unit. The mother underwent major surgery following his birth. A week later child D and the mother were transferred to the Swindon hospital. Child D was placed in special care for two days, and then joined his mother on the post natal ward. Mother and baby were discharged home when child D was 12 days old.

4.11 During the following three days child D was visited by midwives, his health visitor and his social worker. The latter had no concerns about the home conditions or the mother's capacity to parent him. Child D was also taken to the GP practice when his mother requested painkillers for herself. It is reported that his mother was in a pub with child D the night before he died. The following morning he was found dead (aged 16 days) on the sofa after his mother had fallen asleep after breast feeding. No criminal charges were brought.

4.12 Child C was subsequently made subject to care proceedings and lives with a family member.

5. THE FAMILY

Child D's mother

5.1. Child D's mother was invited to contribute to this review and had a conversation with the first lead reviewer. She was guarded about her past but said that she could not remember when anyone had protected her. She had a difficult pregnancy with child D from the beginning and she was fearful that she and the baby would die. She said the care at the Oxford hospital was good. She described how she found the baby dead.

Child D's father

5.2. As child D's paternity is uncertain, it was not possible to involve his father.

Child D's maternal grandmother

5.3. The maternal grandmother was also invited to contribute to the review. She had considerable involvement with child C and looked after her during her mother's 8 weeks in hospital between January and March 2015. She had a lengthy phone conversation with the first lead reviewer. She expressed a number of concerns about the care and support given to her daughter and grandson by Children's Services and by the Swindon hospital staff:

- Children's Services staff just assumed that she would look after child C during her daughter's long stay in hospital. She was surprised that no one made any checks or visited her house. She did not feel that she had received enough support.
- she understood from the staff at the Oxford hospital that there would be a discharge planning meeting before her daughter and grandson left the Swindon hospital, but this did not happen. She thinks it was inappropriate to discharge them with no help or plan as her daughter was so exhausted and the baby was premature.
- she considered that the quality of care that her daughter and grandson received at the Swindon hospital was inferior to that received at the Oxford hospital; she understands that her daughter made a complaint to PALS about the way she was treated by nursing staff.
- two days after child D's discharge from hospital, she was present when a midwife visited the family home and she heard her daughter tell the midwife that she was worried about child D because his lips were blue and he was a bit snuffly. The midwife allegedly told her not to worry.
- she acknowledged that the mother had experienced lots of challenges and she worried about how she would cope with the baby – she had problems with relationships, alcohol and mental health issues. She commented that the health visitor knew her well.

Overall, the grandmother did not consider that she, the mother, child C and child D were adequately supported by social workers and the Swindon hospital staff.

6. THE AGENCIES

6.1 Wiltshire Police

6.1.1 Wiltshire Police had involvement with child D's family on two relevant occasions during the time frame of the review. The first involvement was in August 2014 when information was received at night from NSPCC, who had received an anonymous referral that there were concerns for the welfare of a child (child C) because all adults at an address in Swindon were drunk and the child was crying. Police officers called at the address and found that one adult was drunk, but the mother and her boyfriend were sober. There were no concerns about the child's welfare. Therefore, the Children's Services Emergency Duty Service (EDS) was not contacted, and as there were no perceived safeguarding issues, a PPD1 was not submitted.

6.1.2 The next involvement was the following day, but just 3.5 hours after the above incident. The call was from the Ambulance Service at the above address, where the mother had suffered a fit, was intoxicated and aggressive, and the paramedics were concerned for the safety of child C. The Ambulance Service was aware that child C was subject to a child protection plan. The Police were unable to assist at the hospital (where child C and the mother had been taken by ambulance) until 3.5 hours after the first call from the Ambulance Service. In the meantime, the hospital staff had requested police assistance as Police Protection might be required for child C. The hospital staff had resolved the immediate problem by placing child C on the children's ward overnight. By 5am it was agreed by Wiltshire Police and EDS that child C would stay at her grandmother's while the mother went home. The next day a strategy discussion was held between Police and Children's Services. The IMR author comments that the significant delay in the availability of police units to deal with this incident could have presented a problem if the mother or her boyfriend had tried to remove child C against the wishes of medical staff and Children's Services.

6.1.3 The IMR author makes no recommendations for Wiltshire Police.

6.2 The General Practitioners

6.2.1 The mother and child C were registered at the same GP practice, which has a very high caseload of vulnerable families. The practice was aware of the mother's history of alcohol and substance misuse. Her GP considered her to have a personality disorder, but there was no formal diagnosis as the mother missed psychiatric appointments.

6.2.2 During the timeframe of this review, the practice's involvement was around the mother's pregnancy with child D when she attended regularly for ante natal appointments. During 2014, she also attended on two occasions expressing concerns about an increase in the frequency of seizures. The GP believed these were alcohol related but she denied drinking alcohol. The mother did not follow up referrals to neurology, so there was no diagnosis or treatment for the

seizures. Child C also had frequent routine attendances at the GP practice in 2014.

6.2.3 The day after her discharge from hospital in March 2015, the mother was seen by a locum GP when she requested painkillers, denying that she had received painkillers on discharge. The practice had not received discharge information from the local hospital so Tramadol was prescribed.

6.2.4 The IMR author notes that there was clear recording on the front of the mother's and child C's medical records that child C was subject to a child protection plan, and that minutes of child protection conferences were in the records. However, there is no record of communication between GPs and Children's Services. The IMR author notes that the GPs shared information about the mother's mental health with staff from the Devon refuge and from the Oxford hospital.

6.2.5 The IMR author recommends that:

- the named GP or Nurse should monitor/assist practices in safeguarding policies and training to improve liaison between GPs and Children's Services
- level 4 training programme should be developed for practice leads

The author endorses these recommendations.

6.3 Great Western Hospitals NHS Foundation Trust

6.3.1 Child C was brought to the Emergency Department of the local hospital on two occasions, once in July 2013 when she was admitted for health reasons, and once in August 2014 when her mother was inebriated and unable to care for her. The IMR author notes that safeguarding checks were not always initiated or documented, nor was her health visitor always notified. The author notes that changes have subsequently been made to the electronic recording system, which requires safeguarding checks, and the discharge checklist is sent electronically to a child's health visitor.

6.3.2 The IMR author comments on learning arising from child C's very brief admission to the children's ward (as a place of safety) in August 2014. She was seen by a paediatrician, who was concerned about neglect, as she was grubby and the mother did not know the identity of all the men with her. The Children's Services EDS was involved that night, but the paediatrician was not invited to attend the strategy meeting the next day, nor did staff convening the meeting seek information from paediatric staff about the mother's and child C's presentation at the hospital. The author also notes that the mother was demanding discharge to the maternal grandmother and queries whether child C's interests were paramount.

6.3.3 The IMR author also highlights learning arising from the mother's three presentations to the Emergency Department, with seizures after consuming alcohol, during the timeframe of this review. She notes that there was little consideration of child C's wellbeing (apart from the August 2014 incident); no checks were made about the child and there were no referrals to Children's Services. Consequently, she recommends that Adult Services within the Trust

should ensure that staff are aware of their duties in relation to the 'See the Adult, See the Child' protocol and the South West Child Protection Procedures, and that each division has a way of monitoring their safeguarding processes. The lead reviewer endorses this recommendation.

6.3.4 The community midwifery service provided by the local hospital was involved with child D's mother during her pregnancy with him. A midwife notified the social worker of the pregnancy, and information was shared at the joint meetings of health visitors and midwives at the GP practice. However, the midwives were not aware of all the risks (eg the three attendances with alcohol related concerns) because information about the mother was on different systems within the Trust. Also, the mother was seen by three different midwives between November 2014 and March 2015. The IMR author notes changes being made within the Trust to ensure that all maternity safeguarding information is in one place.

6.3.5 The IMR author notes that there was no formal record of the mother being discussed in the midwives' formal supervision; just ad hoc discussions took place. The workload of the safeguarding midwife is noted, with suggestions how to make the role more manageable. It is also noteworthy that a midwife did not feel able to challenge why child D would not be subject to a child protection plan when she attended the pre birth strategy meeting about him in March 2015. Although an experienced midwife, it was her first strategy meeting and she was not accompanied by a manager.

6.3.6 Significant learning is highlighted about the inadequate information sharing when child D and his mother were transferred from the Oxford hospital to the Swindon hospital seven days after his birth. The Swindon hospital received no written information from the Oxford hospital about any safeguarding concerns about child D and nor were any concerns mentioned on handover of the baby. However, it was acknowledged by staff from both hospitals at the professionals' meeting in August 2016 that a phone conversation about safeguarding concerns had taken place between neonatal staff from both hospitals. Child D's Special Care Baby Unit (SCBU) nurse in Swindon knew that the mother was a 'patient of note' as this was in the SCBU file, so she tried to contact his social worker several times, unsuccessfully. Regarding the transfer of the mother, there was no transfer form from the Oxford hospital to the Swindon hospital and no record that the post natal ward in Swindon was informed in advance of her transfer. However, the Oxford hospital staff stated that they had faxed information and provided oral information about the mother. It was clear at the professionals' meeting in August 2016 that there had been gaps in communication between both hospitals at the point of transfer of mother and baby to Swindon. The IMR author, therefore, recommends that liaison with other hospitals where women are transferred to and from should be reviewed. She also recommends that there should be a formal review of the transfer documentation relating to any safeguarding issue. The lead reviewer endorses these recommendations.

6.3.7 The most significant learning is around child D's and his mother's discharge from the Swindon hospital, 12 days after his birth. He moved from SCBU to the post natal ward on a Friday and the SCBU nurse had still not been able to speak with his social worker, despite leaving messages. By the following

Monday, the mother wanted to go home; the ward staff spoke to child D's social worker by phone in the afternoon and told him that she and child D were being discharged, a paediatrician having confirmed that he was fit for discharge. The social worker did not insist that a discharge planning meeting was necessary. Neither the postnatal ward nor SCBU staff were aware of the strategy meeting in March about the need for a child protection conference. The health visitor was not formally notified of the impending discharge; she found out from the mother.

6.3.8 The IMR author concludes that the lack of a discharge meeting is a significant concern, as the mother's need for ongoing support around the emotional and physical impact of a serious complication of pregnancy was not addressed. Nor were the needs addressed of a premature baby, who had experienced a difficult delivery, living with a neglectful mother. She notes that there is a new process on the postnatal ward, whereby the paediatricians do a daily round. She recommends that there should be a formal pathway to ensure that safeguarding concerns are discussed and documented, and that action plans are clear to ensure safe discharge. The lead reviewer endorses this. At the professionals' meeting in August 2016, the IMR author confirmed that there has been an increase in discharge planning meetings in recent months following learning from serious case reviews.

6.3.9 The IMR author also notes that the mother was given explicit advice about safe sleeping by her midwife prior to discharge. She and child D were visited three times after discharge by community midwives, one of whom checked child D thoroughly after the mother reported that he had rolled off the sofa onto a carpeted floor. The midwives do not recall the mother mentioning that he was snuffly with blue lips and they had no concerns about his condition.

6.3.10 At the professionals' meeting in August 2016, the grandmother's perception about the different levels of care provided at the two hospitals was discussed. The health professionals present confirmed that the level of care would be more intensive at the specialist units at the Oxford hospital, as both mother's and child's conditions required this in the first week after child D's birth. The Swindon hospital has no record of the mother making a formal complaint about her care.

6.4 Swindon Borough Council, Children, Families and Community Health

Health Visiting

6.4.1 The same health visitor worked with the family throughout the timeframe of this review, delivering a service to the mother and child C from her birth and one visit to child D after his discharge from hospital. There was good practice in that she made frequent visits to child C because of her deep professional concerns about her wellbeing. She had a clear focus on child C and her safety and often visited unannounced between 6-7pm to check whether the mother was drinking and whether there was a male presence in the family home. She was clear that the child protection plan for child C needed to continue in discussion at the review conference in January 2015, despite some apparent progress by the mother. The IMR author notes, however, that practice would have been improved if she had used assessment tools to measure change.

Also, there was a lack of clarity about the mother's mental health diagnosis and no follow up with her GP to clarify this, along with her alleged use of diazepam.

6.4.2 The health visitor was frustrated about the delays in implementing the PLO process in autumn 2014 and about her difficulties in communicating with new social workers. However, she did not escalate this to her own manager or to the social workers' manager via the formal escalation process.

6.4.3 The health visitor had serious concerns about the pre birth planning for child D. She believed that he should be subject to a child protection plan, but did not discuss her concerns in supervision or escalate them. She was also concerned to hear from the mother that discharge of herself and child D from hospital was imminent. She advised the ward staff and child D's social worker that a discharge planning meeting should be held. However, she did not escalate her concerns to relevant safeguarding staff at the hospital or to her own managers.

6.4.4 The IMR author praises the health visitor for her thorough visit to child D and his mother the day after they were discharged. She ensured that the mother had the Lullaby Trust information leaflet (which includes pictorial information) on safe sleeping and emphasised the vulnerability of premature babies. She was reinforcing safe sleeping practice, which she had previously addressed for child C. She also focused on the mother's vulnerability after such a difficult pregnancy and birth.

6.4.5 The IMR author notes that, at the time of the work with child C, the health visiting service was under considerable pressure. There were insufficient health visitors, with staff trying to deliver services to high numbers of families as well as training health visitor students and inducting newly qualified staff. Consequently, the health visitor had a heavy workload during the timeframe of the review. She also comments on the challenges of working with a mother who focused very much on her own needs and issues, and whose apparent compliance with professionals was often disguised.

6.4.6 The IMR author makes appropriate recommendations about reviewing the supervision arrangements for health visitors, including the opportunity for reflection, about the importance of health visitors having shared ownership of child protection processes, and enabling staff to challenge parents effectively. She also makes recommendations about reviewing the nature of supervision of safeguarding cases, which the lead reviewer endorses.

Social work

6.4.7 This service's involvement with the mother began in her childhood. She spent much of her childhood from the age of five in care, experiencing fifteen different placements, all over England. Her childhood was extremely traumatic and she had significant needs as an adult care leaver. However, her involvement with the care leaving service ended in 2011, shortly after her 21st birthday. Her two older children were subject to care proceedings in a neighbouring authority between May 2010 – June 2012 due to neglect and concerns about the impact of the mother's alcohol use and domestic abuse. The recent involvement in Swindon began in December 2012 when the

mother returned there, fleeing domestic abuse and pregnant with child C. The brief chronology in section four outlines key details of Children and Families' involvement between March 2013 and March 2015 so they will not be repeated here. The IMR author draws attention to numerous issues in social work practice during this period.

Assessment

6.4.8 There was no multi agency pre birth assessment for child C even though the care proceedings on the mother's two older children had ended just six months before she returned to Swindon in December 2012. (The older children's social worker had notified Swindon's Children's Services of the pregnancy). A single agency assessment took place without reference to the detailed assessments undertaken during the care proceedings. It appears that this was due to the mother presenting as having learned lessons from the removal of her older children and maintaining that she had changed. Likewise, there was no pre birth assessment of child D. This was requested at a legal planning meeting within the PLO process in November 2014, but was never completed by the newly allocated social worker and not recognised by a manager, due to a 2 months gap in supervision, until mid January 2015 following a change in management. Another (agency) social worker took over responsibility for the case in February 2015, but he and his manager did not give priority to undertaking the pre birth assessment, as the mother was in hospital, and expected to remain there for a long time after child D's birth. Therefore, it was judged that there would be plenty of time to assess child D's situation after his birth, so, at a time of considerable organisational change and pressure of work, their focus was on children deemed to be of higher priority.

6.4.9 Despite there being several assessments during the timeframe of this review, there remained significant gaps. There was no assessment addressing the extent of the mother's alcohol use and its impact on her parenting, or its link with seizures. Likewise, there was no understanding of the mother's use of diazepam, or of her mental health diagnosis. It appears that, in these areas, there was too much reliance on the mother's reports, without checking with relevant health professionals. There was no full assessment of the nature of the mother's relationship with various male partners (and the possibility of sexual exploitation does not appear to have been considered) or of their suitability to care for young children. When child C began living with her maternal grandmother in January 2015 following her mother's admission to hospital, there was no viability assessment of her, despite this having been requested by the legal planning meeting in November 2014. Therefore, the potential risks to child C from the alleged abusers in her grandmother's network remained unassessed during the timeframe of this review. This appears to have been for the same reasons of changing staff described in the above paragraph.

Child protection processes

6.4.10 Child C was subject to a child protection plan from her birth in April 2013 until December 2013, and from April 2014 until March 2015 when the timeframe of this review ends. The IMR author concludes that the child protection processes were not as effective as they could have been. Core groups met

infrequently and when they did meet, they did not 'flesh out' or monitor the child protection plan. Review child protection conferences did not review the child protection plan effectively, as outstanding actions were not challenged. There was no escalation by conference chairs to managers. It was explained that, at that time, there was no culture of challenge by child protection chairs in Swindon, but that has now changed and chairs are expected to challenge and notify managers of any failures to action plans. It was also explained at the professionals' meeting in August 2016 that the structure of conferences has changed in order to ensure that chairs focus on reviewing the progress of child protection plans. Training has been provided to the conference chairs in this area.

6.4.11 There was no pre-birth conference for child D. A review child protection conference in respect of child C was scheduled for February 2015, which was intended to be the pre birth conference for child D. However, it was postponed because the mother was in hospital and there was no progress on the pre birth assessment. The decision was also likely to have been influenced by the recently allocated social worker's understanding that child D would be in hospital for some time after his birth, allowing for a conference then.

Use of Public Law Outline

6.4.12 The PLO was not used at the time of child C's birth, despite the opportunity to do so. She was born just ten months after the conclusion of care proceedings in respect of the mother's two older children. The mother professed that she had changed and wanted the opportunity to care for C. However, there was limited demonstrable evidence of her capacity to sustain change. Similar circumstances would result in the use of the PLO in many local authorities, in order to set out formally the concerns that had led to the earlier proceedings and the necessary changes to protect the new baby. The IMR author notes conflicting views among social workers about the use of the PLO in Swindon, with some staff confident that it is embedded in practice, while another commented that it was not accepted practice to use the PLO for a new baby in the above circumstances. Social work staff confirmed at the professionals' meeting in August 2016 that use of the PLO is now more rigorous in circumstances where parents have had previous children removed from their care.

6.4.13 There were two incidents of significant risk to child C in 2014, which could have justified immediate legal action but neither did. The first was the reported incidents in March of the mother leaving child C with unsuitable carers in Devon, which resulted in a second child protection plan and a recommendation for a legal planning meeting. The next was the incident in August when the mother was in the company of several men, was intoxicated and had a seizure while caring for child C. The subsequent review child protection conference recommended a legal planning meeting in September 2014. In the event, there was no such meeting until November 2014, seven months after it was first recommended in a conference. The delay between September and November was explained as due to staff holidays.

Recording

6.4.14 The IMR author makes a number of comments about recording on social work files, which she states have been remedied, so they will not be repeated here. However, she makes two comments that are very relevant to this review – the lack of a chronology on child C's file, and the lack of transfer summaries written by the social worker responsible for the case from April 2013 – November 2014, or by the social worker between November 2014 – February 2015. These gaps meant that the new social worker who took over responsibility in February 2015, and his manager (also new), did not fully appreciate the history and potential risks.

Discharge planning meeting

6.4.15 As child D was not subject to child protection plan, there was no procedural requirement to convene a planning meeting before his discharge from hospital. However, the manager responsible for the case had given a clear direction (in the supervision record) to the social worker who took over in February 2015 that a discharge planning meeting should be held. She was unaware that child D was at home until she was notified of his death. The social worker told her that the hospital had rung him at the time of discharge. As he no longer works in Swindon, it was not possible for the IMR author to clarify exactly what happened.

Working with mother

6.4.16 The mother was a care leaver, whose experience of care had not been positive. It is very likely that the first two social workers responsible for child C were influenced by their desire to do all they could to support the mother in parenting this child successfully. However, it is probable that her needs took precedence over those of child C at times. The second social worker, who worked with the mother for 19 months, was described as having a positive relationship with her. However, the IMR author concludes that the mother's apparent engagement with her and with the health visitor was disguised compliance. She concludes that there was a lack of curiosity on the part of Children's Services staff, along with a lack of challenge (mother's statements were often taken at face value) and false optimism about her capacity to change. The lead reviewer agrees with this conclusion.

Impact of staff and organisational changes

6.4.17 There was continuity of social work from child C's initial child protection conference in April 2013 until the legal planning meeting in November 2014, when child C's social worker was changed at the request of the mother. Until then, supervision had been frequent. Thereafter, there were two social workers (one permanent and one agency), neither of whom got to grips with the case, apparently due to ill health and/or to workload. Around the same time, there were two changes of manager (one of whom was permanent, the other being agency), who were under pressure due to social worker vacancies.

6.4.18 The broader context was that a four week Ofsted inspection had taken place in March 2014, for which staff had been preparing for some months, and left staff morale low. It resulted in a significant turnover of staff, as described above. At one point during late 2014, around 35% social workers were agency

staff and three of the four team manager posts were covered by agency managers. During the same timeframe, issues with the structure of the long term social work teams were also identified, which were impacting negatively on children (and staff), so a new structure for the long term teams was developed and implemented. This should not have resulted in substantial changes to social workers' cases. However, in the team responsible for child C, changes were made in February 2015. The consequences were that there were changes in social workers and line managers, and actions to protect child C within the PLO were delayed, the pre birth assessment of child D was not undertaken, and the importance of convening a discharge planning meeting was missed.

6.4.19 The IMR author notes positives in that the second social worker had very regular contact with child C and her mother, there was good joint working with the health visitor, there was good liaison with the staff at the refuge in Devon. Also, despite staff turnover, child C was visited very regularly at her grandmother's between January and March 2015.

6.4.20 The IMR author makes a number of constructive recommendations, including:

- a training programme to address working with men, use of chronologies, identifying sexual exploitation and assessing parental capacity to change
- up to date chronologies present on each child's file
- review of child protection process, ensuring link between conference, child protection plan and core group is clear and consistent
- implement escalation procedure for child protection chairs
- review implementation and existing local guidance of the PLO pre-proceedings process

The lead reviewer endorses all these.

6.5 Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust

6.5.1 The mother had contact with three teams within AWP between 2010 and 2015. She was mainly under the care of the secondary care team (CMHT) between October 2011 and November 2013. During the timeframe of this review, she was mentally very well during her pregnancy with child C and afterwards. Although she lived outside the catchment area of the CMHT on her return to Swindon in December 2012, the care coordinator continued to work with her for an extended period, apparently due to concerns by the coordinator and the mother that discharge from mental health services may adversely affect the protection of C. She was eventually discharged from the CMHT in November 2013.

6.5.2 At that time, a new referral was made to the Swindon primary care liaison team by the mother's GP. She was invited to two assessment appointments but did not attend either, so the referral was closed. During the mother's pregnancy with child D there were no referrals to AWP.

6.5.3 The IMR author concludes that the risk assessment and practice by CMHT professionals demonstrates good working knowledge of safeguarding policy

and procedures and shows active involvement with partner agencies in ensuring the safety of the mother and child C in pregnancy and post birth. The author also notes that the mother had declined a range of psychological therapies that were offered to her.

6.6 Domestic Abuse Service in Devon

6.6.1 The mother and Child C spent March 2014 at a refuge in Devon, fleeing domestic abuse from two male perpetrators in Swindon. The IMR author documents a number of concerns about the care of child C during this period, notably leaving her with unsuitable carers, which the refuge staff were quick to challenge and to report to child C's Swindon social worker. There were no recommendations.

6.7 Oxford University Hospitals NHS Foundation Trust

6.7.1 The mother spent five weeks receiving specialist maternity care at an Oxford hospital from mid February 2015 due to a serious complication of her pregnancy with child D. The briefing report notes that the ward staff experienced her behaviour as difficult, so obtained psychiatry input to assess her and support staff in maintaining boundaries to ensure a consistent approach to manage her borderline personality disorder traits.

6.7.2 The hospital records documented the history of Children's Services' involvement and the reasons for concern about the care of child C. They also documented liaison with the social worker, the GP and health visitor and the information that was passed to the Swindon hospital.

6.7.3 There were no records of concern about the mother's care of child D on the neonatal ward.

7. KEY ISSUES

7.1 Communication

7.1.1 Between April 2013 and November 2014, the key professionals working with child C and the mother were the social worker and health visitor. They appeared to communicate well with each other. In 2013 the mother's care coordinator was also involved in conferences and core group meetings, but input from mental health services ended by the autumn. Likewise, there was involvement from the mother's Independent Domestic Violence Adviser (IDVA) early in 2013, but this tailed off. (During the timeframe of this review, there were no reports to the police of domestic abuse).

7.1.2 Other examples of good inter agency communication were the refuge staff in Devon persistently communicating their concerns to child C's social worker, and the local hospital ensuring that the EDS was involved during the incident in August 2014.

7.1.3 However, there were also significant gaps in communication. For child C, the mother's attendances at the local hospital with seizures following alcohol consumption were not always notified to Children's Services as the Emergency

Department staff did not 'Think Child'. Following child C's very brief admission to the children's ward in August 2014, when her mother was incapable of looking after her due to seizures and intoxication, the paediatrician who had examined her (and was concerned about neglect) was not involved in the subsequent strategy discussion. Child C's admission to hospital on another occasion for medical reasons was not communicated to her health visitor due to changes in the notification system: it is reported that they have been rectified. Also, the GP did not attend child protection conferences or provide reports, which resulted in gaps in information about the mother's mental health and use of benzodiazepines.

7.1.4 For child D there were very significant gaps in communication across Children's Services and the two hospitals. The change of social worker in November 2014 (after 19 months) resulted in other agencies, notably the health visitor, becoming frustrated about difficulties in contacting the two social workers responsible for child C and unborn child D between November – February 2015, and February 2015 onwards. As neither was available for interview with the Children's Services IMR author, it is difficult to piece together key events. It seems that, in February 2015, the allocated social worker told staff at the Oxford hospital that a discharge meeting should be held in respect of child D. It also seems that the staff told him that child D would be in hospital for a long time after birth as he would be premature; hence the delay in completing the pre birth assessment and convening an initial child protection conference.

7.1.5 When child D and his mother were transferred from Oxford to the Swindon hospital, this information about the need for a discharge planning meeting was not communicated to the SCBU staff, but maternity services had this information. Nevertheless, the SCBU staff at the Swindon hospital recognised that there were some concerns and made repeated efforts to phone the allocated social worker to clarify these. They failed to speak with him until the day of discharge when he accepted that child could be discharged without a meeting, contrary to a written instruction in the supervision record.

7.1.6 Regardless of the view of the social worker, the hospital's failure to convene a discharge planning meeting on a vulnerable lone parent, who had experienced a traumatic pregnancy, was recovering from major surgery, and had a premature baby, resulted in lack of formal communication with the community midwife, health visitor and social worker about the needs of the mother and baby.

7.2 Professional Standards

7.2.1 During the period of the review, despite very regular visits to child C and her mother by the health visitor and by the social worker (until November 2014) and their undoubted commitment to safeguarding her wellbeing and engaging with the mother to support her as a parent, there were a number of concerns about professional practice.

Assessment

7.2.2 The gaps in the social work assessments of the mother and viability assessment of the grandmother have been addressed in detail in paragraph 6.5.3.They were exacerbated by the lack of a chronology on child C's record

and no transfer summaries between her social workers (see paragraph 6.5 8). The gaps in the health visitor's recorded assessments of child C have been addressed in paragraph 6.4.1. There were also gaps in the community midwives' assessment of the risks to child D due to difficulties in accessing all the information about the mother's medical and social history (it was stored on several information systems). Despite several assessments of the mother and child C during the period of this review, there was insufficient analysis of the risks to this child and to child D.

Identification of capacity to change

7.2.3 The nub of this case is identification of the mother's capacity to change within a timescale that would meet the needs of child C and child D. There was extensive documentation available to Children and Families staff about her traumatic childhood experiences and about the neglect suffered by her two older children as a result of her alcohol misuse and lifestyle. At that time (2013) the social work service had a strong focus on and investment in keeping children with their parents in cases of neglect through effective intervention. However, there was limited assessment about how the factors contributing to the neglect of the older children were likely to affect child C. The changes that the mother had apparently made were taken at face value without an in depth assessment.

Mother's impact on staff

7.2.4 The IMR reports and discussion at the learning events indicate how the mother's needs often took precedence over those of child C and child D. She was described as presenting a list of her own needs to professionals. As a care leaver who had experienced little stability in her childhood in care, it is not surprising if professionals were sometimes sidetracked by her own needs and wanting to do their best to compensate for her past experiences with Children's Services. She was described as difficult and uncooperative at times, but was also described as engaging and friendly at other times, leading to the conclusion that she had engaged with the social worker and health visitor. However, events would suggest that this was disguised compliance.

7.3. Child protection processes

7.3.1 This review has addressed several flaws in the child protection processes – few core group meetings and failure to address how the child protection plan had been implemented at review conferences. These are addressed in paragraph 6.5.4. There was also a failure to involve hospital paediatric staff in a strategy discussion when their input was relevant. The most fundamental flaw was the failure to convene a pre birth child protection in respect of child D (or shortly after his birth), resulting in him being discharged home with no protection plan.

Escalation

7.3.2 There was no evidence of chairs of child protection conferences escalating to managers concerns about professionals' failure to implement agreed actions. Likewise, there is no evidence of the health visitor formally escalating her concerns to the social work manager about difficulties in communicating with the social workers after November 2014 or of escalating to her managers or named safeguarding professionals her concerns that child D was being discharged without a planning meeting. Nor did the community midwife escalate

her concerns about the failure to convene a pre birth conference in respect of child D.

7.4. Use of the Public Law Outline (PLO)

7.4.1 There was ample evidence to use the PLO from the birth of child C, as she was born just 10 months after the conclusion of care proceedings in respect of the mother's two older children. This would have ensured that all the evidence and assessments from the care proceedings were available to Swindon social workers, that a structure was put around assessments of the mother's capacity to change sufficiently to parent child C safely, and legal advisers would have been involved. It would also have had the advantage of providing challenge to the mother about her alcohol use and lifestyle, while specifying what she needed to change and how she would be supported to do so.

7.4.2 It would also have had the advantage of facilitating possible legal action to protect child C following key events in 2014.

7.4.3 Even when action under the PLO was finally recommended by a child protection conference in April 2014, it was 7 months before a planning meeting took place. The failure to progress legal action in respect of child C meant that there was no consideration of whether legal action was required to protect child D.

7.5. Organisational issues

7.5.1 There seems little doubt that the changes in social workers and managers between November 2014 and March 2015 affected planning and decision making for both children. Relevant factors were:

- acceding to the mother's request for a change of social worker in November 2014, even though the social worker had worked with her for 19 months and the mother was considered to have engaged with her.
- the subsequent social worker's failure to get to grips with the case and undertake assessments was not identified for 2 months due to absence and change of supervisor
- the next social worker and manager, under workload pressure because of social worker vacancies, considered that child C and child D were of lower priority than other cases, without understanding the social history

7.5.2 The health visitor was also working under the pressure of an increasing workload at this time, due to insufficient health visitors, and her split supervision between her line manager and safeguarding lead did not appear to address the key issues of the mother's capacity to change and her disguised compliance.

7.5.3 The capacity of the safeguarding midwife was also highlighted, as the mother's community midwife did not receive formal supervision.

7.5.4 There are concerns about how effective the Swindon hospital's information systems are in safeguarding children

7.6. Sound professional practice

7.6.1 There was continuity of health visitor throughout the two years of the review and she made very regular visits. Likewise, there was the same social worker for 19 months, who also had very regular contact with child C and her mother. The two professionals made a number of joint visits.

7.6.2 The health visitor and community midwives made prompt visits to child D after his discharge from hospital. They ensured that safe sleeping was addressed with the mother, giving her literature, and specifically addressing the additional risks to premature babies.

7.6.3 The staff at the Devon refuge were quick to recognise the risks to C from her mother's lifestyle, were assertive and challenging to the mother, and liaised well with child C's social worker.

7.6.4 The care coordinator worked effectively with the mother until her case was closed in November 2013, because her mental health had improved.

7.6.5 The Oxford hospital obtained psychiatry input to assist staff in managing the mother's behaviour on the ward.

7.7. Safe sleeping

7.7.1 The midwives and health visitor working with child D ensured that his mother was aware of latest NICE Guidance on co-sleeping and sudden infant death syndrome (SIDS). The public health message recommends that parents are informed that there is an association between co-sleeping (parents sleeping on a bed or sofa or chair with an infant) and SIDS. The association is likely to be greater when they or their partner smoke. The association may be greater with:

- parental recent alcohol consumption, or
- parental drug use, or
- low birth weight or premature infants

7.7.2 The mother was given these messages on three occasions, including the Lullaby Trust literature. The mother said that she smoked outside the family home, and there was no evidence to the contrary. The mother had a longstanding pattern of alcohol misuse, and had been to pubs with child D on the night when she slept with him. She was also taking powerful painkillers following her surgery and acknowledged to the community midwife that they 'knocked her out'.

7.8. Impact of parental ill health and hospitalisation

7.8.1 The mother had a traumatic pregnancy during which she feared that she and child D would die. She spent eight weeks in hospital and underwent major surgery which left her exhausted and in considerable pain. These factors would inevitably impact on her capacity to care, as a lone parent, for a vulnerable premature baby. The lack of a discharge planning meeting meant that her needs were not addressed and key professionals, notably the social worker, were not necessarily aware of the full impact on her functioning.

8. CONCLUSIONS AND LESSONS LEARNED

8.1 At the time of his death, child D was just 2 weeks old and had only been at home with his mother for 4 days. He was vulnerable as a premature baby dependent on a mother who had experienced a traumatic pregnancy, was recovering from major surgery, misused alcohol and was taking powerful prescribed painkillers. His sister was subject to a child protection plan under the category of neglect and was also subject to the PLO process. Although the potential risks of significant harm through neglect were recognised before his birth, he had not been made subject to a child protection plan, nor had a discharge meeting been held prior to his leaving hospital. There was no multi agency pre birth assessment of specific risks to him nor was there any detailed plan of how key agencies would protect him and address his mother's additional needs arising from her lengthy period of hospitalisation. The delays in progressing the PLO process for child C meant that there was no consideration of legal action to protect him.

8.2 This review has highlighted lessons about the complexity and pitfalls when working with a mother who has multiple needs as a care leaver; she often distracted professionals from focussing on child C by her chaotic lifestyle. Professional practice was often characterised by false optimism about her capacity to change sufficiently to provide safe care for child D and his sibling, child C. There was often insufficient challenge of the mother and insufficient focus on child C and how her mother's behaviour and lifestyle were affecting her development. There were examples of disguised compliance on the part of the mother being construed as engagement with professionals. There was also a lack of professional curiosity by several agencies.

8.3 This review has also revealed many lessons about information sharing within and between agencies, about the effective use of the PLO by Children's Services, notably in circumstances where previous children of parents have been removed through care proceedings, about the quality of multi agency assessments, about the necessity of improving child protection processes, including escalation of concerns, about addressing health visiting and social worker workloads, and addressing effective supervision of these professionals, especially during times of change.

9. RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW

9.1 Introduction

9.1.2 These recommendations reflect the key issues arising from this review. Agencies have not awaited the completion of this review in order to address issues arising from this case. Some of these recommendations, or aspects of them, have been identified and addressed already. Individual agencies have made recommendations following their own reviews, not all of which are listed here.

9.2 Recommendations to the Swindon Safeguarding Children Board

9.2.1 The Board should ensure that expectations about minimum requirements of GPs' involvement in child protection processes are agreed with the Clinical Commissioning Group and that their implementation is monitored

9.2.2 The Board should satisfy itself that there is sufficient capacity to fulfil the requirements of the safeguarding midwife role

9.2.3 The Board should ensure that the South West Child Protection Procedures and the Swindon Procedures Manual concerning strategy meetings (notably the involvement of health professionals in these meetings), child protection conferences, child protection plans and core groups are being implemented effectively, through regular audit

9.2.4 The Board should review its escalation policy and ensure that staff from all agencies are aware of it and are encouraged to use it, where appropriate

9.2.5 The Board should consider providing multi agency training on working with challenging parents

9.2.6 The Board should satisfy itself that the heavy workloads identified in the health visiting and social work services during the timeframe of this review have been addressed

9.2.7 The Board should satisfy itself that the Swindon hospital information systems are fit for the purpose of safeguarding children

9.2.8 The Board should ensure that the Swindon hospital discharge planning processes are strengthened.

9.3 Recommendations to Swindon Borough Council

9.3.1 These recommendations from the individual reviews are endorsed:

- the policy for child protection supervision of health visitors should be reviewed, addressing the use of reflection
- the Children and Families Service should ensure that there are up to date chronologies on every child's file
- the Children and Families Service should ensure that child protection conference chairs continue to challenge poor practice across all agencies
- the Council should review existing local guidance and implementation of the PLO pre-proceedings process

- training to be made available to Children and Families staff about working with men, use of chronologies, identifying sexual exploitation and assessing parental capacity to change (ie Harriet Ward et al research, 2014)

9.4 Recommendation to Great Western Hospitals NHS Foundation Trust

9.4.1 The following recommendations from the Trust's review are endorsed:

- Adult Services within the organisation should ensure that staff are aware of their duties in relation to the 'See the Adult, See the Child' protocol and the South West Child Protection Procedures and that each division has a way of monitoring the safeguarding processes
- There should be a formal review of the transfer documentation between hospitals relating to any safeguarding issue
- There should be a formal pathway on the postnatal ward to ensure that safeguarding concerns are discussed and documented and that action plans are clear to ensure safe discharge

Appendix A

Composition of Case Review Group

Alex Walters, Independent Panel Chair

Designated Doctor, Swindon Clinical Commissioning Group

Head of Children, Families and Community Health, Swindon Borough Council

Service Manager, Early Help Children Families and Community Health, Swindon Borough Council

Service Manager, Quality Assurance and Review, Children, Families and Community Health, Swindon Borough Council (SCR Champion)

Area Manager, Gloucestershire/Wiltshire Probation Trust

Continuous Improvement and Strategic Support, Public Protection Unit, Wiltshire Police

Service Manager, Swindon NSPCC

LSCB Strategic Manager

LSCB Quality Assurance and Training Manager

Divisional Director of Nursing, Women and Children's Division, Great Western Hospitals NHS Foundation Trust

Trust Lead Nurse Safeguarding Children (Interim), Oxford Health NHS Foundation Trust

In attendance

Helen Davies, Independent Lead Reviewer

Appendix B: Details of the independent lead reviewer/author of this report.

Helen Davies trained in social work and worked in local government in a range of social work and management positions, including thirteen years as an assistant/deputy director of children's services. Since 2011, she has worked as an independent consultant and been involved in a number of reviews in respect of children and adults. She has never worked in any of the agencies involved in this review.

Appendix C: Terms of Reference for this Serious Case Review

The serious case review primarily considered events in the period from March 2013, when the mother's pregnancy with child D's older sibling became known to Children's Services until March 2015 when child D died. However, all agencies were requested to include relevant background information about the mother. Child D is the main subject of this review but the circumstances in relation to any safeguarding issues for his sibling needed to be fully considered.

The agencies were asked to draw up their individual management reviews around the following issues:

- Were local and national procedures, policy, guidance and regulations followed in relation to the quality of care, safeguarding and protection of the child?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Was there sufficient management oversight and sound decision making?
- Were the agencies involved in the child's case fully aware of any risk issues and if so, were they subject to appropriate consideration, planning and management?
- Is there evidence that staff within individual organisations used any processes or procedures to escalate concerns relating to the management of the case?
- Establish how we work with mothers who have been unable to protect other children of the family but then become pregnant
- How we work with absent fathers
- How we assess risk to the family from males who may be perpetrators of domestic abuse
- How we manage and assess a mother with multiple risk factors
- How we best support safe sleeping arrangements for babies, particularly those who present with known risk factors such as prematurity

Appendix D: Principles Underpinning this Serious Case Review

The conduct of this review has not been determined by any particular theoretical model. It has been carried out in keeping with the underlying principles, set out in the statutory Guidance, Working Together to Safeguard Children 2015:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections;
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did;

Appendix E: References

This report has been generally informed by the following publications

- Working Together to Safeguard Children (Department for Education 2015)
- In the Child's Time: professional responses to neglect (Ofsted 2014)
- National Institute for Health and Care Excellence (NICE) Guidance on co-sleeping and sudden infant death syndrome (updated 2014)
- Public Law Outline :Guide to Case Management in Public Law Proceedings (updated 2015)
- Assessing Parental Capacity to Change when Children are on the Edge of Care, Harriet Ward et al, June 2014