city & hackney safeguarding children board

Serious Case Review

Overview Report – Child H

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APPENDICES

1. INTRODUCTION

1.1 Child H died at the age of six weeks in the spring of 2014. Medical advice indicated that the death had been caused by inflicted injuries.

1.2 The circumstances of the death therefore met the statutory requirement[1] that a Serious Case Review (SCR) be conducted and that was formally confirmed by Mr Jim Gamble QPM, the Chair of the City and Hackney Safeguarding Children Board (CHSCB), on 15th July 2014. This is the Overview Report from that SCR.

2. FAMILY COMPOSITION

2.1 Ms M and Mr F are in their twenties. Ms M lived with her parents (MGM and MGF), and Mr F had also lived there for about for 2 ½ years. The couple had formed a relationship a year before that. His family live in Kent.

3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

3.1 The CHSCB convened an SCR Panel (the Panel), consisting of senior representatives from relevant agencies, to lead the SCR. That panel was chaired by Mr Rory McCallum, Senior Professional Advisor to the CHSCB. The CHSCB appointed a suitably experienced independent person – Kevin Harrington[2] - to act as Lead Reviewer and to write this report.

3.2 All relevant agencies were required to submit an Individual Management Review (IMR), either containing a narrative and an analysis of their involvement where that had been significant, or a narrative account of events where involvement had been less significant. Those agencies are detailed in the table below, and are subsequently referred to by the acronyms / abbreviated forms provided.

AGENCY	NATURE OF INVOLVEMENT
London Borough of Hackney Children's Social Care services (CSC)	CSC carried out an assessment of the family situation during the pregnancy.
The General Practitioners (GP)	The family was well known to their GPs
Homerton University Hospital NHS Foundation Trust (HUHFT)	This Trust provided maternity and health visiting services to the family. Some other HUHFT services were indirectly involved.
East London Foundation Trust (ELFT)	This Trust carried out an assessment of Ms M's mental health during her pregnancy.
City and Hackney Clinical	This agency has provided an overview of

[1] This is set out in the government's guidance, Working Together to Safeguard Children (2013), referred to in this report as "Working Together".

[2] Appendix A of this report contains brief autobiographical details.

Commissioning Group (CCG)	all health services contributing to this report.
Children's Centre	This agency had no direct contact but was involved in determining which services might be offered to the family.
Metropolitan Police Service (MPS)	The MPS had no significant contact before the identification of the injuries which led to the death of Child H.
London Ambulance Service NHS Trust (LAS)	The LAS has confirmed that they conveyed Child H to hospital when her fatal injuries were reported.

3.3 The Terms of Reference for the review are at Appendix B. They are drawn from Working Together, amended to reflect issues specific to the circumstances of this case. The review considers the period between October 2013, when the pregnancy was confirmed, and June 2014 when Child H died.

4. METHODOLOGY USED TO DRAW UP THIS REPORT

4.1 This report is based principally on the IMRs, background information submitted and subsequent Panel discussions and dialogue with IMR authors and other staff. Both of Child H's parents, and their extended families, have met with the author of this report and spoken about the services the family had been in contact with.

4.2 This report therefore consists of:

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by of each agency, and of their submissions to the review.
- Closer analysis of key issues arising from the review.
- Conclusions and recommendations.

4.3 The conduct of the review has not been determined by any particular theoretical model but it has been carried out in accordance with the underlying principles of the statutory guidance, set out in Working Together: The review,

- *"recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight[3];*

[3] This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings"*

4.4 The government has introduced arrangements for the publication of Overview Reports from SCRs, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published.

5. KEY EVENTS

5.1 Background

5.1.1 Ms M was adopted at an early age, having been the subject of serious abuse and neglect in her infancy. She has since then lived with her adoptive parents (referred to throughout this report as her parents), though she has had some continuing contact with some members of her birth family. Her parents had also adopted an older child, a boy, who had a number of difficulties in his life. He died during the period under review in this report.

5.1.2 Ms M's GP has helped her with anger management and some mental health issues, believed to be linked to her experiences in her early years. However it was never necessary, prior to her pregnancy, that she should have contact with specialist mental health services. Mr F has had no significant previous contact with health or social care services. Both parents had some special educational provision as children.

5.1.3 In May 2011 Ms M was brought to hospital by police following a disturbance, in which she was said to have threatened her boyfriend with a knife. She was seen by psychiatrists who found no evidence of mental disorder. She was discharged and no follow up by psychiatric services was judged necessary. This appears to have been an isolated incident – there is no knowledge of any similar event.

5.1.4 Ms M is at times described by agencies as having learning difficulties or a learning disability. That issue is discussed separately below.

5.2 October to December 2013

5.2.1 In October 2013 Ms M's pregnancy was confirmed by her GP who made referrals to maternity services and the Perinatal Mental Health Team. The GP also contacted a Learning Disability Liaison Nurse for advice.

5.2.2 Ms M had an ante-natal booking assessment when she was 9 weeks pregnant. She was reported to be in a good mood and feeling well. The midwife noted a history of depression and "mild learning disability". The midwife referred her to "Stop Smoking" services and the Consultant Obstetrician. Ms M was then compliant with

ante-natal services throughout the pregnancy and this chronology does not contain a detailed account of subsequent contacts.

5.2.3 The midwife also completed a Common Assessment Framework (CAF). The CAF is a national "tool" used for identifying and assessing the situation of children, including unborn children, who may have additional needs, which require the involvement and co-ordination of more than one agency.

5.2.4 In Hackney a Multi-Agency Team (MAT), led from the Children's Centre covering the home address, is responsible for the oversight of arrangements which seek to help families at an early stage. The MAT assessed the report from the midwife and, while noting that referral to CSC might be necessary, concluded that Ms M be invited in the first instance to attend a parenting group.

5.2.5 Ms M attended the Perinatal Mental Health Team in early November for her initial assessment, which was conducted by a senior nurse. She was accompanied by Mr F. That assessment was detailed, and concluded that Ms M did not suffer from any acute mental health problems. Her GP was already prescribing some medication to help her when her mood became low and that should continue. The risk posed by the patient to herself or others was judged to be low. Her partner was considered knowledgeable and reliable in the event that her mental health deteriorated.

5.2.6 The perinatal mental health nurse noted that the GP had made revisions to medication prescribed for Ms M, and so one further follow-up appointment was arranged for later that month. From that second meeting the nurse concluded that Ms M had *"personality issues and anger management issues"* but that there was again no evidence of severe or enduring mental illness: any necessary treatment could be provided by the GP.

5.2.7 Ms M had initially agreed to attend the group for expectant mothers but then decided that she did not wish to do so and declined offers from the midwife to assist her with this. The midwife therefore, as a result of her non-engagement, made a referral to CSC for an assessment of Ms M's overall situation and parenting capabilities.

5.2.8 That referral was considered promptly at CSC and allocated for assessment with specific reference to:

- Ms M's parenting capabilities in the light of her possible learning disability
- The extent of any learning disability and her functional abilities
- Current living and support arrangements
- The nature and extent of engagement with maternity services
- The relationship with Mr F and the extent to which he would be supportive

5.2.9 The CSC assessment was based on two visits, the first in mid-November and the second in early December, and on checks with other agencies. Ms M and Mr F had been in a relationship for about 3 ½ years and lived together for 2 ½ years. There

had been some difficulties between them, including a brief separation in 2011. There was some evidence of Ms M having difficulties in managing her anger. However CSC concluded that the situation overall was stable, Ms M was well supported and that there was probably no need for their continuing involvement. After the second visit the plan was to close the case once all checks with other agencies had been carried out.

5.2.10 Just before Christmas the case was reviewed by the MAT at the Children's Centre. The MAT noted that CSC were now involved and suggested that they consider a "step down" referral – an arrangement where specialist providers, such as CSC, are terminating contact with a family and make a referral back to universal or less specialised services. CSC did subsequently consider this but decided that there was not sufficient indication of cause for concern to make such a referral.

5.3 January to April 2014

5.3.1 Around the turn of the year there was an argument between Ms M and her parents. She and Mr F left the home and went to his home but returned in early January. The home situation then appears to have settled down although Mr F lost his job around that time.

5.3.2 In early February, CSC liaised with the "Learning Difficulties Team" (sic). A social worker in that team advised that their only knowledge of Ms M was that some years previously she had been in touch to request a travel pass. They had never made any assessment of her.

5.3.3 CSC closed the case in mid-February. It had been established that both extended families were supportive, there was good engagement with maternity services and Ms M was compliant with her medication regime. This was explained to the family (but they were not given a copy of the assessment, as they should have been). All relevant agencies were informed of this decision and the recording also states that *"Notification of case closure is to be sent to Adults Learning Difficulties Team (sic) in Hackney".* It is not clear why this team was to be notified. They had had no significant involvement in the past and there was no plan for any future involvement.

5.3.4 In early April, Ms M saw her GP and said that her father had been diagnosed with a terminal illness. She told the GP that she was often tearful and was irritated by her mother. She was worried that she might develop post-natal depression and expressed anxiety about her ability to look after the baby in the future. She declined re-referral to the perinatal mental health team but said she would like some counselling and support. The GP made a referral to primary care psychology services (PCP), requesting an urgent appointment. There was no telephone number on the referral so PCP wrote to Ms M inviting contact. She did not respond and the PCP service closed the case. Around this time Ms M's brother died after a long illness.

5.3.5 A midwife contacted the local authority's Learning Disability Team at the end of April and spoke to a social worker, who suggested that the midwife could make a formal referral to them if she felt an assessment was indicated. A referral was made and Ms M was eventually seen after the death of Child H.

5.4 May 2014

5.4.1 In early May, a midwife and a Health Visitor carried out a pre-birth visit but Ms M and Mr F had gone to the hospital as they felt that the birth of the child was imminent. MGM told the midwife and health visitor that she had concerns about Ms M's ability to care for the baby, describing her background, her immaturity and the problems of bereavement and illness currently facing the family. The HV decided to provide an enhanced level of input after the child was born.

5.4.2 In fact the baby was born, at home, later that day. Ms M had been sent home from hospital as she was not in established labour when she went there. The baby was born some hours later, delivered by Mr F, and was then admitted to hospital after an ambulance had been called. The baby went to the Special Care Baby Unit and Ms M was admitted to the post-natal ward.

5.4.3 Staff on the post-natal ward asked for an assessment of Ms M's mental health and she was seen, with Mr F, by a junior psychiatrist. Ms M reported no concerns and no unexplained 'odd' experiences or episodes of low mood. She presented with stable mental health and reported that she was compliant with medication. She wanted to leave the hospital and was discharged with advice on recognising symptoms of low mood, restlessness or difficulties in relationships, which might signal a recurrence of depressive illness. A letter was sent to the Perinatal Mental Health Team requesting a follow-up appointment because of Ms M's history.

5.4.4 The baby remained in hospital for 12 days. During that time the situation was discussed at a regular psychosocial meeting and staff contacted CSC. CSC advised that the situation had been recently assessed, that there would be no concerns about discharge to the family home, because of the support and supervision of family members, and that continuing input from CSC was not necessary. CSC had not been made aware of the death of Ms M's brother and the terminal illness of MGF when giving this advice.

5.4.5 Ms M and Mr F visited the hospital at least once daily and participated in the care of the child. Good interaction with the baby was noted. The child had a minor physical problem, a tongue tie, which can cause difficulties in feeding and was referred to the maxillofacial team for this to be addressed.

5.4.6 While the child was in hospital the HV and midwife made a joint visit to the family home. There was no immediate evidence of cause for concern but they talked with the family about making a re-referral to CSC, and referring to Learning Disability services, and the parents agreed to this.

5.4.7 On the day that the baby was discharged a perinatal mental health nurse telephoned the family, in response to the referral from maternity services, and spoke to Ms M. She reported feeling very well and that her partner was supportive. She did not feel the need to see the perinatal mental health team, and was therefore discharged to the care of her GP.

5.4.8 Over the next two weeks the HV and midwives saw the family, in total, three times and had no specific concerns. They observed good physical care of the baby, who was undressed by the midwife. The HV discussed the family with the GP and it was agreed that there were no current concerns regarding the care of the baby. However they acknowledged the stresses of bereavement and terminal illness in the family, and agreed that the midwife would re-refer to CSC.

5.4.9 However, the following day an ambulance was called to the family home. Mr F reported that the child had appeared well that morning but later he had found the baby was blue. Child H was admitted to hospital and was found to have intracranial bleeding .The parents and extended family members attended and were directly asked about the possibility of trauma and non-accidental injury but were all adamant that this could not be the cause of the problems. CSC and police were contacted and child protection investigations commenced.

5.4.10 Child H was promptly transferred to Great Ormond St Hospital (GOSH) where further investigations revealed a fracture to her left ankle. She remained unconscious for nearly two weeks and then died.

5.4.11 The provisional cause of death was noted as “head injury”. While in GOSH it became apparent that the injuries might have been inflicted. Both parents were arrested on suspicion of murder. Neither offered any explanation or knowledge of the cause of the child’s injuries.

5.4.12 A full review of the evidence was conducted by both the CPS and a QC from the CPS Special Case Unit. It was accepted that the injuries were non-accidental, but the evidence did not indicate with sufficient certainty when the fatal injuries were inflicted, nor who was looking after Child H at the relevant times.

5.4.13 On the basis of the evidence available the prosecution could not allege homicide against either parent, nor could they allege the other parent was an accomplice. No other/alternative charges were deemed suitable. In August 2015 both parents were informed that they would not be the subject of any further enquiries.

6. THE FAMILY

6.1 Ms M and her family

6.1.1 Ms M's father died soon after the death of Child H. (As indicated above, her brother also died during the period under review). Ms M and her mother met with the author of this report to discuss the events under review.

6.1.2 There was no disagreement between Ms M and her mother in their views of the services they had contact with. They could not recall much about the contact with the social worker but spoke highly of all the health professionals they had been in contact with during the pregnancy and Child H's short life. The exception to that was when, immediately before the birth of Child H, they had presented at hospital but had been sent home because Ms M's labour was not sufficiently advanced. The baby had then been born soon after they returned to their home.

6.1.3 That would of course be a difficult situation for any family to manage. In the course of this SCR maternity services were asked to review their actions on that day and they did confirm that the decision not to admit Ms M had been in line with the hospital's guidance. They could not have foreseen that the labour would progress so quickly.

6.1.4 The family had mixed feelings about their involvement with police. They described the way in which Ms M had been arrested when the injuries to Child H were identified. The arrest took place very publicly at the hospital, involved several police officers and was of course distressing for the family. However they also wanted to stress how much support, as a family, they had subsequently received from the police Family Liaison Officer.

6.1.5 After the death of Child H, Ms M had received specialised counselling at Great Ormond Street Hospital. She had chosen to bring her mother with her to these meetings and both described how helpful they had been.

6.1.6 Looking back, Ms M's mother wondered if they might have tried to make better links with local community services for new and vulnerable mothers. She acknowledged that she had adopted her children as toddlers and it was a new experience for all of them to have a baby in the house. She also thought that Mr F had little idea of how to care for a small baby, giving examples of him behaving inappropriately when handling the child, without due regard to the baby's safety.

6.2 Mr F and his family

6.2.1 Mr F has left London and returned to live with his family. He, his mother, sister and maternal grandparents were all involved in a meeting with the author of this report.

6.2.2 Overall, like Ms M and her mother, they spoke warmly of many services they had been in contact with. Like Ms M they referred in particular to the help they had received from the Public Health Midwife in Hackney, and some staff at Great Ormond St Hospital after the injuries to the baby. Like Ms M they also had reservations about the contact with maternity services on the day that the baby was born.

6.2.3 The point they stressed most strongly was that agencies failed to give sufficient weight to the news that Ms M's father was diagnosed as terminally ill. As well as the overall emotional turmoil this caused, it meant specifically that the capacity of Ms M's parents to support Ms M as a new mother was weakened. They also felt that agencies then did not share that information adequately. These causes for concern have already been recognised and accepted by the relevant agencies.

6.2.4 Mr F's family felt that he had taken on most of the responsibility for the practical care of Child H, and that agencies perhaps under-estimated the amount of help Ms M needed. They contrasted this with events after the injuries to Child H, when they felt some hospital staff did not liaise adequately with the paternal family.

6.2.5 Overall the family feel that the agencies failed to recognise the strains in a situation involving:

- Two young people who had not previously been parents
- The sudden and terminal illness of Ms M's father
- Ms M's limited capability to parent her baby

The agencies then did not share information about these issues thoroughly with each other.

6.3 Conclusions

6.3.1 Although there is no contact now the two families had got on well before the events leading to this review. Ms M's mother talked of how they had happily taken Mr F into their home and helped him over the years that the couple had been together. Mr F's family similarly had some warm memories of the families doing things together.

6.3.2 Meeting Ms M, it is evident that she has what she calls "special needs". However that is not the case with Mr F, whose presentation would not suggest any such conclusion. It is understandable that professionals meeting them before the injuries to Child H might have assumed that his presence would be supportive and reassuring, and indeed there is no evidence to the contrary.

6.3.3 Ms M's family environment is warm and caring, something which was evident when visiting the home, despite the stresses necessarily arising from all the losses they have suffered since she became pregnant.

6.3.4 All those factors go some way to setting the context in which the family was seen by professionals, and the judgments made by those professionals. This was not an unhappy or troubled family situation where cause for concern was evident.

7. THE AGENCIES

7.1 The General Practitioners

7.1.1 The first contact with professionals during the period under review was with the GPs, when Ms M's pregnancy was confirmed. All the members of this family, including more recently Mr F, had been with the same GPs for some years and were well known at the practice. Overall the way in which the GPs dealt with them through these events was appropriate.

7.1.2 When Ms M first discussed her pregnancy with the GPs their response was thorough. Appropriate referrals were made promptly to maternity and mental health services. The GP also sought to make a referral to learning disability services and this issue is discussed further below.

7.1.3 The most significant learning point for the GPs, which they accept, relates to information sharing. During the pregnancy the GPs became aware of the terminal illness of MGF. However they did not share that information appropriately, within their practice or across the network of agencies.

7.1.4 The IMR explains that*"Ms M accompanied by Mr F told the GP that her father was ill and she was anxious about the future. At around the same time, her parents also told different doctors (at the practice) about his ill health and concerns they had about the future".* However *"A connection was not made by different clinicians that the grandfather's illness might impact on the grandparents' ability to support Child H's parents in caring for Child H".*

7.1.5 The GPs had referred Ms M to psychological services but did not take any further action in respect of Child H on receipt of the information about MGF's ill health and Ms M's concerns about caring for the baby. It would have been appropriate to reconsider whether the overall arrangements for supporting Ms M and Mr F, which were very dependent on the grandparents, were sufficiently robust. It would have also been appropriate to have discussions with child care services at this time. This may have been significant to the course of events because CSC, in deciding to terminate their involvement, had placed a substantial emphasis on the role of the grandparents in both a protective and a supportive capacity.

7.1.6 It is important to be mindful of the clarity that hindsight can bring. Had the GPs, as a whole, been fully alert to the changes in the family situation they probably would have re-referred to CSC, who probably would have re-assessed. But even then there is no indication that such a re-assessment would necessarily have resulted in actions that would have altered the overall course of events.

7.1.7 Nonetheless this further underlines the need for a "Think Family" approach, and it offers an important learning point for these GPs and more widely. National research[4] has found *"anecdotal evidence that GPs in particular do not see the Think Family approach as part of their role, and that information sharing with GPs is a particular challenge. Nonetheless…GPs are universal, non-stigmatising parts of society, and their engagement in whole-family working would be likely to increase its purchase across all services".*

7.1.8 These GPs have developed appropriate changes to the way information is shared between doctors and other relevant services at their practice, and there is consequently no recommendation from this report.

7.2 London Borough of Hackney, Children's Social Care

7.2.1 The family were visited twice by a social worker, in November and December, following the referral from maternity services. These visits and the standard checks which were made with other relevant agencies constituted the evidence base for the assessment by CSC.

7.2.2 The input from CSC was generally proportionate to the referral they received. There was no evidence to suggest any cause for serious concern. The maternal grandparents were seen as protective, the relationship between Ms M and Mr F seemed generally stable when the visits were made and they were both happy and positive about the pregnancy. The suggestion that Ms M had a learning disability should have been explored more thoroughly and that is discussed separately below. There was no indication that continuing involvement from social workers was necessary or appropriate.

7.2.3 However, in closing the case, there was an expectation within CSC that it would be considered at "psychosocial" meetings at the hospital. The social worker wrote to the Named Midwife asking that the meetings be used for tracking the case. In fact those meetings usually only monitor situations involving children subject to child protection or formal "child in need" arrangements. That begs the question of how the situation of unborn children, who may be "in need" but not subject to a Child Protection Plan is addressed. The Named Midwife did not respond to the notification from the social worker so the service remained unaware that the case would not automatically be considered at these meetings. The agencies need to clarify this, and the issue of the use and understanding of psycho-social meetings is considered separately below.

7.2.4 When this case had first been considered by the MAT they had recommended use of "step-down" arrangements if and when contact with a social worker was concluded. This was considered at the relevant time by CSC but it was decided that there was no need for such arrangements, largely because of the judgment that the extended family would provide continuing support. That was a reasonable

[4] SCIE: Think Child, Think Parent, Think Family

assumption although when stresses in the family emerged – the death of Ms M's brother and the illness of her father – these changes should have prompted a re-evaluation of the situation. The social work team was not made aware of these changes and the need to re-assess.

7.2.5 Service arrangements for social work with children and families are unusual in Hackney. The IMR explains that *"Hackney Children's Social Care operate a Unit model whereby cases are jointly allocated to small units. Each Unit is led by a Consultant Social Worker who has responsibility for the management and decision making in respect of all cases. Case supervision and management is undertaken within Unit meetings and recorded on individual children's files".* A Consultant Social Worker is deliberately not "just" a manager, but will also work directly with families. So, where the officer carrying out an assessment is the Consultant Social Worker in that Unit, that officer may also be responsible for "signing it off" and closing the case. That was the case here.

7.2.6 The Hackney model has attracted a great deal of positive comment, broadly to the effect that it promotes a collaborative approach within teams, avoids the pattern of losing skilled social workers to the ranks of management and engenders a working environment that proactively seeks to develop the skills of its workforce. The service reports that *"Hackney's model of social care promotes conversation, discussion and dialogue. Senior managers sit alongside practitioners, are accessible to staff and are regularly involved in case consultation. The weekly unit meeting, which is led and chaired by the Consultant Social Worker, is the key mechanism for risk assessment, analysis and decision making. Service Managers and Heads of Service regularly attend unit meetings to provide additional oversight. All practitioners receive individual professional development supervision. Consultant Social Workers receive monthly supervision from a Service Manager. Hackney also has a comprehensive quality assurance framework in place, including a monthly audit programme and quarterly thematic case review days involving all senior managers".*

7.2.7 This review does raise issues about aspects of these arrangements. The Consultant Social Worker made no case records following the two visits to the family. The IMR judges that concerns about this are lessened because of the work model used in Hackney, where cases are frequently discussed by the responsible Unit and that discussion is recorded. But recording of one's individual involvement, assessments and actions is a fundamental professional requirement. The IMR accepts that this is a weakness, commenting that *"if the records available were complemented by more detailed case notes this would better enable the reader to understand what the analysis was based upon".*

7.2.8 There was also a degree of apparently avoidable drift in the management of the case. This was not an assessment that needed to be concluded quickly and the Panel noted the IMR's comment that *"the London Borough of Hackney hold dispensation for assessment timeframes agreed by the Department for*

Education[5]". Nonetheless there was no reason why some of the tasks in the assessment might not have been done more promptly. In particular the assessment process at the outset identified cause for concern in relation to *"untested parenting (in context of learning disabilities)".* This had been raised as a potentially significant issue by both the GP and by midwifery services. However it was not until February, three months after their work commenced, and after the decision to close the case had already been taken, that the Consultant Social Worker liaised directly with Learning Disability services.

7.2.9 That contact was then not sufficient – it served to confirm that Ms M did not have a learning disability, as far as services were aware, but did not explore whether the issue should now be assessed by the relevant service. (In fact, having met Ms M for the purposes of this review, it was clear to me that she has some degree of intellectual impairment, and she acknowledged that directly). There is no recording to suggest that this change in emphasis was a deliberate decision – a judgment, after seeing the family, that the issue did not have the significance suggested by the original referrals. Rather, it appears gradually to have been perceived as less significant while that shift was not identified by any supervisory or management arrangements.

7.2.10 These weaknesses – insufficient recording, drift in executing work plans and a failure to meet all the requirements of a plan – are frequently identified in case reviews. It is not suggested that more conventional approaches to managing casework are guaranteed to prevent them. However the difference here was that there was no routine managerial process to identify and deal with those problems. The responsible social worker was not required to report to a named manager on the detail of the progress of the casework, nor on the rationale for deciding to close the case before all necessary investigative tasks had been carried out. The level of oversight offered by the Unit meetings did not provide an adequate challenge to the drift in the case, and the failure to make adequate case records was not identified until this review.

7.2.11 Subsequent reviews within the CSC service have not found problems similar to those identified here. However they could be systemic issues – that is, they could recur in the service arrangements as they are currently designed. There is consequently a recommendation that this be examined further, with a view to building in continuing quality assurance arrangements as necessary.

7.3 Homerton University Hospital NHS Foundation Trust

7.3.1 This Trust provided maternity and health visiting services, the Primary Care Psychology service (PCP) and was the employing agency for the Learning Disability Liaison Nurse. This was also the Trust providing a range of services in respect of MGF's serious illness.

[5] Hackney has been working with the Department for Education since March 2011, trialling more flexible ways of working and has been granted dispensation on a number of statutory requirements, including not imposing fixed timescales for completing assessments.

7.3.2 The report from this Trust identifies one incident outside the period under review, which may be relevant. In 2011 Ms M was brought to hospital by police after an incident in which she was said to have threatened someone known to her with a knife. Police were concerned about her mental health and her understanding of the situation.

7.3.3 This was an isolated incident which did not lead to any continuing contact with services and is probably in itself not significant. However maternity services, from the same hospital, and health visiting services, had no knowledge of it. As the Health Overview report notes *"This suggests that within HUHFT it may be possible for a patient to present to one department without staff being aware of previous presentations to different departments".*

7.3.4 As indicated above Ms M's contact with maternity services was largely unremarkable. She was entirely compliant with the requirements and expectations of the service. From her first contact her vulnerabilities were identified. The Health Overview report notes that *"the case was held by a public health midwife and a targeted service was offered. The public health midwife is a senior midwife with additional knowledge, skills and expertise in working with vulnerable clients".*

7.3.5 This Trust also manages the relevant Health Visiting service. SCRs have often commented on issues arising in respect of handovers from maternity to community health services. There were no such problems here, with evidence of good liaison between the two services and early involvement by the Health Visitors, in recognition of Ms M's vulnerabilities.

7.3.6 The documented work of these services illustrates how the agencies could not have envisaged the injuries to Child H. A few days before the fatal injuries were inflicted a Health Visitor saw the family at home and recorded that *"The post-natal and neonatal checks were completed … and no concerns were noted, baby was gaining weight…. parents' interaction with (baby was observed and) …they handled her well including dressing, making formula and feeding".* There had been a degree of concern while the child was in hospital about the parents' understanding of how to feed the baby safely, so it was reassuring that this no longer appeared to be a problem.

7.3.7 However this "joined up" approach of maternity and health visiting services was not similarly evidenced between maternity and psychology services. Maternity services were unaware of the GP's referral to PCP, and PCP staff, although they knew of Ms M's pregnancy, did not liaise with colleagues in maternity services when seeking to contact the family. Had they done so they could have been provided with a contact telephone number, which would have offered a speedier and perhaps more effective way of contacting Ms M in response to the GP's urgent referral. Ms M did not respond to their letter and this was a missed opportunity to engage her when she was asking for help. The service has made changes to their administrative processes so that, if patients do not engage with the service

following GP referral, a referral back to the GP, requesting re-assessment, is automatically triggered.

7.3.8 The Health Overview report judges that the intervention by the PCP service could generally have been more thorough, especially in relation to the lack of response from Ms M: *"This referral was flagged by the GP as urgent. Ante-natal depression, anxiety and bereavement are independent predictors of post-natal depression and so failure to engage in the presence of those risk factors should be considered as a possible safeguarding concern. The Primary Care Psychology service should recognise the risk and should have clear processes with regard to identification, risk assessment and management of clients that fail to engage with the service. For such clients there should be prompt referral back to primary care combined with an explicit requirement for re-assessment".*

7.3.9 The Primary Care Psychology Service is a service for adults and it may be of value for the service to provide training in relation to the "Think Family" concept. This approach is widely promoted in adult mental health and other services to ensure that staff working with an adult think about the impact of the adult's difficulties on children in the family. This will increase the awareness of the risks to children when their parents suffer from poor mental health. Two training sessions have already been agreed for all relevant staff.

7.3.10 As with all the agencies involved with the family there was confusion around the issue of learning disability, which HUHFT acknowledges in its IMR: *"There is a need for a greater understanding of the care and assessment pathway for learning disabilities in the context of parenting and appropriate support of vulnerable parents".*

7.4 East London NHS Foundation Trust

7.4.1 This agency worked directly with the family through the City and Hackney Perinatal Mental Health Service (PMHS). The PMHS works with women who have moderate to severe mental health difficulties in pregnancy or within the first year after childbirth. Ms M was seen by the PMHS for two assessment appointments in November 2013, following which she was discharged as not requiring further intervention at that time.

7.4.2 Ms M was then seen on the post-natal ward by an on-call liaison psychiatrist, the day after the baby was born, and re-referred to the PMHS. A Clinical Nurse Specialist from the PMHS telephoned Ms M some 10 days later. Ms M reported that she was well, that Child H would be discharged from SCBU that day and that she was confident about being able to look after the baby. She did not feel that she needed to be seen by the PMHS and said she would contact her GP if necessary.

7.4.3 Recording of the two contacts with the PMHS has been provided to this review. The assessments of Ms M's mental health are thorough and find *"no symptoms indicative of a mental illness".* The assessment reports do comment that *"she does*

appear to have anger management issues possibly related to her personality". Ms M was on continuing anti-depressant medication and the assessment included advice on managing her medication as her pregnancy progressed.

7.4.4 The assessments place a significant emphasis on Mr F providing support to Ms M, and to his responding to any significant changes in her mood or presentation. It was noted that he *"seems very knowledgeable about her relapse indicators and the importance of getting help should she not identify and seek professional support".*

7.4.5 The issue of learning disability is touched on, to the extent that it is noted that Ms M described herself as having "special needs" (as she immediately did when she met the author of this report). There is no further exploration of that issue. The Modern Matron carrying out the assessment did liaise with CSC but there is no indication that learning impairment was discussed between them, although, as described above, this had been a headline area to be investigated when CSC first became involved.

7.4.6 The GP had not specifically mentioned learning disability in referring Ms M to mental health services. However the subject was discussed between the GP and a psychiatrist from ELFT who rang the GP, prior to the assessment visit, principally to advise on medication.

7.4.7 In framing their submissions to this review agencies were asked to consider the question *"Were practitioners alert and responsive to any indicators of additional needs that the parents may have had?"* We now know that Ms M's IQ was subsequently found to be in the category of those with a learning disability. It may be that issues potentially arising from her self-proclaimed "special needs* should have been recognised and given greater weight in this assessment of her mental health. That is a judgment informed by hindsight but there are undoubtedly aspects of Ms M's presentation that indicate some degree of intellectual impairment. All other professionals who had contact with her noted this.

7.5 City and Hackney Clinical Commissioning Group – the Health Overview Report

7.5.1 The City and Hackney CCG has submitted a Health Overview Report in line with local and national requirements. Its purpose is to review all the health services provided to the family during the relevant period. The findings of the Health Overview Report are in line with those emerging from this report.

7.5.2 The report notes that we do not know the circumstances in which Child H was injured but comments on the stresses all new parents experience when caring for a baby. It mentions developmental work underway in Hackney to address this:

"Research shows that babies' crying is associated with parental stress, depression and relationship problems. Crying can disrupt parents' developing bonds with their babies, and in extreme cases, can cause parents to get angry and harm their babies. Hackney is currently working with the NSPCC, piloting the Coping with

Crying programme in Children's Centres. This programme involves showing a short film to new parents. The film is designed to help parents in the UK care for a crying baby and reduce the risk of them becoming stressed and harming their baby. Evaluation suggests that the film is helping to keep babies safe:

- *99% of parents remembered the film 6 months after watching it*
- *82% of parents said they used advice from the film when caring for their baby*
- *the rate of reported injuries among babies with feeding, sleeping or crying difficulties was lower if their parents had seen the film"*

7.6 The Children's Centre

7.6.1 The Children's Centre had no contact with the family. Their only involvement was to manage the process arising from Ms M's first contact with maternity services. Those arrangements were satisfactory.

7.7 Metropolitan Police Service

7.7.1 The MPS had no contact with any family member during the review period and no significant contact before then.

7.8 London Ambulance Service NHS Trust

7.8.1 The LAS was involved only in responding to a 999 call from MGM on the day that Child H's injuries came to light. There was no delay in their response and Child H was promptly conveyed to hospital. There are no matters arising for the LAS from this SCR.

8. CROSS-CUTTING ISSUES

8.1 Learning disabilities and learning difficulties

8.1.1 This case serves to illustrate a confusion, which is not uncommon, about whether parents may be eligible for services provided by multi-agency Learning Disability teams. This often arises from a lack of clarity about what constitutes a learning disability and can be linked with an inaccurate, interchangeable use of the terms "learning difficulty" and "learning disability". It is also an area in which precise assessment is difficult.

8.1.2 The terms may also carry additional complexities, with a socio-political dimension to their use: People First[6], an advocacy organisation, prefers only to use the term "learning difficulty" *"when we talk about people with learning difficulties, we mean 'people labelled as having a learning difficulty'. …We choose the term 'learning*

[6] www.peoplefirstltd.com

difficulty' instead of 'learning disability' to get across the idea that our learning support needs change over time".

8.1.3 Broadly a learning difficulty does not affect general intelligence. Examples of a learning difficulty would include dyspraxia or dyslexia. A learning disability is linked to an overall cognitive impairment.

8.1.4 Looking at the events in this case, the key issue is that there was no assessment by the Learning Disability service when such input would have added to the agencies' understanding of the overall situation, and what can now be recognised as the vulnerabilities in that situation.

8.1.5 There was a "side issue" here arising from a quirk in the organisational arrangements for learning disability services. Those services are provided by the multi-agency, multi-disciplinary Learning Disability service which is located organisationally within the local authority. However there was also one "stand-alone" post, funded by the CCG and physically located at the Homerton Hospital, of a "Learning Disability Liaison Nurse". The hospital's report to this review explains that the post forms *"part of the adult community nursing service and provides an advice and signposting service for general practice who have queries about patients who may have a learning disability. She advises on how to refer to the Learning Disabilities Service but is not employed by the London Borough of Hackney's LD service".*

8.1.6 The GP, as part of her first response to the pregnancy, contacted this nurse. They discussed whether Ms M might be eligible for and appropriately assisted by learning disability services. The nurse advised the GP to make a referral to the mainstream Learning Disability service where an assessment would be conducted. The GP recalls making such a referral and the Health Overview report states that *"The referral is recorded in the GP records".* However the service has no record of receiving any such referral. This review has been unable to determine what happened in this respect.

8.1.7 Setting that aside, the difficulty is that this post of Liaison Nurse, which clearly provided accessible advice for GPs, also constituted another link in referral arrangements. Experience tells us that the simpler such arrangements are, the more effective they are likely to be, and it became clear in the review process that there was confusion across agencies about the role and responsibilities of this post. In fact, in part as a consequence of the learning from this review, agencies are considering changes to organisational arrangements. That could include this post being managed within the mainstream Learning Disability service, where it could be integrated with other services for adults with learning disabilities and their families.

8.1.8 In any event the starting point was the GP's uncertainty about whether Ms M might be eligible for services from the Learning Disability service. That uncertainty is understandable because there is a considerable variety across the country in the

arrangements used by services to determine eligibility for such services. Eligibility will be determined by an assessment of the individual's IQ and their social functioning. Commonly, to satisfy eligibility criteria, individuals will need to have:

- A significant impairment of intellectual functioning (an IQ score of below 70 for a mild LD and below 50 for a moderate to profound LD), and
- a significant impairment of adaptive behaviour/social functioning (difficulties with learning, understanding, communicating or daily living skills)

8.1.9 Following the death of Child H there was an assessment by the Learning Disability service which eventually concluded that there was insufficient evidence of difficulty in social functioning to satisfy the eligibility criteria, although Ms M's IQ did meet that requirement. The Health Overview report confirms this: *"The psychology assessment showed her to be in the LD range but the OT assessment showed that she had sufficient life skills to operate independently and therefore was not eligible for the services of the LD team".*

8.1.10 If Ms M had been assessed before the death of her child, had satisfied both criteria and had been offered services, it is still of course not necessarily the case that such services would have made a significant difference to her parenting capability. However it is possible that the assessment would have prompted the Learning Disability team to liaise with children's services. That would be sensible because, among other considerations:

- in general terms, adults with very low IQs are unlikely to be able to parent adequately
- there is evidence for a genetic link between parental learning disability and child developmental delay
- vulnerability to developmental delay may be compounded by lack of environmental stimulation
- behavioural problems may arise when the child's intellectual capacity exceeds that of their parents.

8.1.11 In fact one would expect, even if an assessment did not meet the criteria for the provision of services by the adults' team, that it might still have prompted liaison with children's services. There must be eligibility criteria but inevitably they are not an exact science and, in any event, the fact that an individual does not meet such criteria does not mean that they might not need and welcome assistance with parenting.

8.1.12 Taking a step back though, one might have expected that CSC themselves would have asked the Learning Disability service to conduct an assessment. There was only one brief contact from CSC to the Learning Disability service, in February when a decision had already been taken by CSC that there should be no continuing social work input. The CSC IMR notes that *"Contact with the Learning Disabilities Team …confirmed that Ms M did not have a diagnosed learning disability".* That is

correct, literally, but one reason why she had no such diagnosis is that there had been no assessment which could have produced a diagnosis.

8.1.13 The IMR from CSC tells us that the social worker recognised that Ms M *"presented in a number of respects in a way that was consistent with information received about her having a learning difficulty".* It is unclear then why the social worker did not suggest that there be an assessment by the Learning Disability service. The GP and the Health Visitor both felt such an assessment would be helpful. In fact one of the principal aims of the social work assessment had been to evaluate *"parenting capacity in the light of her possible learning disability".*

8.1.14 The IMR notes only that *"an additional assessment may not have significantly influenced the assessment on the case".* Equally that indicates that such an assessment **may** have been significant. In any event the aim of this review, which has the benefit of hindsight, is to identify learning which might be useful in the future –the learning point here is that the Learning Disability service was never asked to carry out an assessment. Yet there seems no reason not to seek this additional contribution to the overall assessment, and no reason why this was not explored at an earlier stage – certainly before the decision by CSC to close the case.

8.1.15 We now know that Ms M's IQ was found on assessment to be in the category of those with a learning disability. Whether or not she acquired a label of "learning disabled" and received continuing services from the Learning Disability team, that level of intellectual impairment was significant to her parenting capability and a factor that might be expected to introduce new stresses into the family situation. The Health Overview report helpfully suggests that *"It may be helpful to produce a tool to assist agencies to assess parenting when learning difficulties are present that do not formally meet the learning disabilities threshold. This is not an action for health services alone but may warrant consideration across the partnership".*

8.1.16 That suggestion is reflected in a recommendation from this report. Also the Learning Disability service has already taken action that allows for strict eligibility criteria to be waived and direct liaison with CSC to be prompted when they become involved in situations such as this. A "pathway" to be followed is being developed across the key agencies.

8.2 Psycho-social meetings

8.2.1 The term "psycho-social meetings" refers to arrangements often in place in hospitals for discussing cases where input from social care or mental health services may be appropriate. A range of hospital staff might attend these meetings with, sometimes, input also from external agencies such as CSC. They are used at HUHFT and they come to attention on two occasions during the events under review.

8.2.2 When the social worker was closing the case in February following her assessment she referred to the psycho-social meeting as one of the potential monitoring arrangements. She apparently assumed that Ms M's situation would be raised as necessary at these meetings. That was an incorrect assumption because those meetings at HUHFT only considered situations involving children formally assessed as "in need" or for whom there was a Child Protection Plan. Unborn children can be subject to such arrangements, where that level of need or concern is anticipated, but that was not the case here.

8.2.3 The social worker may also have over-estimated the extent to which these meetings could be relied upon as a monitoring arrangement, even if the case had met their criteria. They offer a useful opportunity for cases to be highlighted and discussed where there may be cause for concern but they are not constituted or administered so as to form part of a rigorous case monitoring system. The extent to which they are multi-disciplinary is limited with social workers often not in attendance.

8.2.4 The arrangements in Hackney also target the early stages of pregnancy, as the Terms of Reference[7] make clear *"The meeting is a forum for multi-agency discussion of psychosocial concerns about the pregnant woman and their unborn or mothers and their babies in the very early neonatal period".* Consequently the meeting was not designed to serve as a continuing monitoring arrangement.

8.2.5 However a few days after the baby was born there was a neonatal unit psychosocial meeting at which the family situation was discussed. The meeting recommended that ward staff contact CSC and they did so. CSC confirmed their previous contact and advised that *"as long as Ms M remained in the home of her adoptive parents, they would have no concerns about Ms M taking baby home. However if Ms M at any time left the family home, a new referral would need to be made to CSC".*

8.2.6 That advice again illustrates the significance placed on the grandparents by CSC and, yet again, the fact that MGF was so seriously unwell was not communicated to them.

8.2.7 Overall there are risks associated with a reliance, or a presumed reliance, on the psychosocial meetings as part of inter-agency case management arrangements. It was clear from discussions at the SCR Panel that there was a lack of clarity across the agencies on the purposes of these meetings. The agencies should re-issue the Terms of Reference for the psychosocial meetings, to ensure that their role is understood, or review them if it is felt they can usefully be updated.

[7] Psycho-social meetings- Terms of reference

9. CONCLUSIONS AND KEY LEARNING POINTS

9.1 The death of Child H could not have been anticipated by any of the services or professionals involved with the family. This sort of review with its close scrutiny of a complex set of multi-agency relationships and responsibilities will inevitably identify learning points. Nonetheless, even if those matters had been addressed, it is very unlikely that there would have been evidence suggesting that this baby would suffer serious inflicted injuries.

9.2 The potential causes for concern were identified immediately by the GPs and maternity services and appropriate referrals were made. Subsequently there was good liaison and collaboration between maternity and health visiting services.

9.3 Ms M and Mr F co-operated with specialist assessments by social care and mental health agencies. Those assessments were generally thorough although the issue of Ms M's intellectual impairment and its potential consequences was not given adequate weight by either service.

9.4 There was some avoidable drift and incomplete case recording within Children's Social Care services. This was not identified before this review and that may be linked to the service model in Hackney.

9.5 There was confusion across the network of agencies as to whether Ms M had a learning disability, how that should be assessed and addressed and how the relevant specialist services were configured and accessed. Consequently there was no referral to learning disability services until shortly before the death of Child H.

9.6 During the pregnancy there were some significant changes in the family's circumstances as a result of serious illness in the immediate family and the death of a relative. That information was not shared comprehensively across the network of agencies. Had it been shared there should have been a re-assessment by children's social care services though this would not necessarily have led to any change in service provision.

9.7 The review revealed some confusion across agencies in respect of the role and purpose of "psychosocial meetings" in maternity services. The family circumstances, in themselves, would not necessarily trigger a referral to psychosocial meetings, and those meetings do not provide continuing monitoring of a family situation.

9.8 The family did not avoid contact with services. Ms M talked to her GPs about her fears and apprehensions about being a parent. The GPs made an appropriate referral to psychological services but the referral did not lead to any contact. Those services, aimed at adults, may not have been sufficiently alert to the child care implications of the GP's referral.

10. RECOMMENDATIONS TO THE CITY AND HACKNEY SAFEGUARDING CHILDREN BOARD

10.1.1 These recommendations to the Board reflect the key lessons to be learned from this review. They draw on the views of the SCR Panel and the author of this report.

10.1.2 The review does not make a recommendation for every point of learning that has been identified. These recommendations are complemented by more detailed recommendations, specific to each agency, contained in the management reviews conducted by those agencies.

Recommendations

1. The Board should promote, across all agencies, a clearer understanding of the nature of adult Learning Disability and the thresholds for eligibility for Learning Disability services.

2. East London NHS Foundation Trust to provide reassurance to the Board that appropriate assessment guidance is in place, that this guidance is explicit with regards to engaging relevant specialists when learning disabilities are either known or suspected, and that ELFT staff adhere to this guidance.

3. The Board should require the London Borough of Hackney to review the local protocol for assessment as required by statutory guidance in Working Together 2015. LBH should ensure this protocol is understood by staff and clearly sets out and clarifies how statutory social care assessments are informed by, and inform, other specialist assessments, including those on learning disabilities.

4. The London Borough of Hackney should provide reassurance to the Board that its quality assurance arrangements for all individual cases (including those where a Consultant Social Worker is working directly with a family) are sufficiently robust to test the quality, thoroughness and timeliness of social work activity.

5. The Board should require the Homerton University Hospital Foundation Trust, in the light of the issues identified in this review, to review their arrangements for:

    - psychosocial meetings
    - liaison between maternity services and the Primary Care Psychology Service.
    - promoting awareness of child safeguarding issues across adult mental health services (in partnership with East London NHS Foundation Trust).

APPENDIX A - The Lead Reviewer

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 50 SCRs in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile SCR reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX B - The Terms of Reference

Review scope

Building on learning from previous cases, the objective of this review is to consolidate learning about what is working well and what presents challenges to organisations both child and adult-facing. We will do this in line with the principles in Working Together 2013 as outlined below.

The review will follow the principles laid out in *Working Together to Safeguard Children 2013 (4:10)*:

SCRs and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

Agencies will be asked to comment on:

1. Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

2. When, and in what way, were the child's experiences ascertained and taken account of when making decisions about the provision of services? Was this information recorded?

3. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way? Did you agency liaise/engage appropriately with other agencies?

4. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments and was the family signposted to appropriate support?

5. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

6. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

7. Were senior managers or other organisations and professionals involved at points in the case where they should have been?

8. 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?

9. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

10. Was there sufficient management accountability for decision making?

    Agencies are asked to comment specifically on:

    - Where vulnerabilities were identified in pregnancy, what measures were taken?
    - Where agencies sufficiently alert to the role of the father or need to include in assessments?
    - Where practitioners alert and responsive to any indicators of additional needs that the parents may have had?