HAMPSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

Multi-Agency Review of 'Hattie'

Chronological overview of Hattie's case

In December 2017 Hattie's mother had a telephone consultation with her GP. She stated that she thought she was 16 weeks pregnant and requested a termination. She described her life as chaotic and that she had addiction problems. The GP gave her the information to self-refer (this is usual practice) for a termination of pregnancy.

In February 2018, a referral was made into Hampshire Multi-Agency Safeguarding Hub (MASH) by the British Pregnancy Advisory Service (BPAS) raising concerns about the challenges they had encountered with Hattie's mother. She had not attended or had cancelled a number of termination appointments (five in total). They also reported that Hattie's mother disclosed that she was addicted to Dihydrocodeine (a semi-synthetic opioid analgesic prescribed for pain) but was receiving support from her GP to stop taking it.

At the same time, Hattie's father was one of two males stopped in a car which was found to contain numerous wraps of a class A drug and a large quantity of cash. He was subsequently convicted of possessing heroin and crack cocaine and fined. It is worthy of note that Hampshire Constabulary have almost 300 recorded involvements with Hattie's mother and father dating from 1991 to 2018.

In March 2018, Children's Services made telephone contact with Hattie's mother who stated that she did want a termination of pregnancy and would book urgently. Hattie's mother was considered to be 23 + weeks gestation and at the cut off point for a termination. The case was allocated for a S17 (Child in Need) Children and Family Assessment. Announced and unannounced home visits were attempted by Children's Services, to no avail.

Hattie's mother attended the Emergency Department around this time, with abdominal pain. She was accompanied by her sister, who refused to continue to care for her. She was described as pregnant, living in a squalid flat, using crack cocaine and had taken an overdose of paracetamol. She was discharged from the Emergency Department, with a referral to Adult Social Care reportedly being made.

In April 2018, the case was progressed to a S47 Child Protection investigation due to a lack of engagement and continued risk taking behaviour and Unborn Hattie was made subject to a Child Protection Plan in May 2018. It was noted that Hattie's mother had older children who were removed from her care in a different local authority.

The Child Protection Plan was sent to Police and Midwifery Services. Midwifery in turn notified the Health Visiting Service. Information was shared across Hampshire and Southampton midwifery services in case the mother made contact with them, a national alert was also requested as part of the Child Protection Plan. The mother did not engage with any maternity service throughout the duration of her pregnancy.

In May 2018, Hattie's father failed to appear at the Magistrates Court for the offence of recklessly endangering an aircraft arising from an incident in November 2017.

Hattie was born in July 2018 in a hospital outside of Hampshire's geographical boundaries – she was estimated to be 36 weeks gestation. Her mother, who arrived in labour, provided false personal details. She reported to be 40 years old and living with a travelling community in Belfast and she stated that it was her 2nd pregnancy. She stated that she had not received any antenatal care in either pregnancy; the care she had received was from a 'lay person' within the travelling community and that she was currently living in a car. The false details which were provided did not correlate or match to anyone on the NHS Spine.

The hospital commenced the 'Concealed Pregnancy Pathway', which includes undertaking urine toxicology, referring to Children's Services (in this case the Children's Services where she presented to (not Hampshire)) and arranging a discharge planning meeting. Neonatal withdrawal symptoms were observed including jittery movement and unsettled behaviour. The midwives had some concerns about maternal drug use; however the mother denied drug misuse.

The local Children's Services Department based on information provided did not think that the threshold for social care intervention had been met. Therefore, a discharge planning meeting was not held. Instead they indicated that they would follow up with the family at the address mother had provided – which was false.

Two days after discharge the toxicology report confirmed Hattie had traces of heroin, cocaine and morphine in her system. A strategy meeting was held and she was reported missing to the Police on the same day.

Coincidently, Children's Services and Hampshire Police were completing an unannounced joint visit to the suspected property of mother and father at the time mother and Hattie were reported missing. Hattie was found on the same day, at her maternal aunt's house and was made subject to Police Protection and taken to hospital for examination.

An Emergency Order was subsequently granted and Hattie was placed in foster care following discharge from hospital on the same day.

Learning from the case

1. Antenatal Care

The initial referral into Children's Services by BPAS was considered to be good practice. BPAS as a charity work with the NHS to provide women with a safe service when they have decided to have a termination of pregnancy. To access this service, a woman must present her NHS number to them. In this case, that allowed them to make a referral to Children's Services, with the correct demographical details when concerns regarding non-engagement and substance misuse arose.

Aside from initial contact with the BPAS service, Hattie's mother did not engage with any health professional throughout the duration of her pregnancy. It was also difficult to ascertain who held ultimate responsibility for her care, as there seemed to be, at times, different providers taking the lead. This was compounded by Hattie's parents moving across geographical boundaries, which led to a lack of clarity in terms of residence.
There was an opportunity in March 2018 when Hattie's mother presented to the Emergency Department, at approximately 5 months pregnant with abdominal pain, for her to be assessed by a midwife. From what was ascertained at the learning event, a referral was made to Adult Services, not Children's Services and she was accompanied by her sister (ultimately whose care Hattie would later be found in). On this occasion she did not use false details, however, it is likely that she informed professionals that she intended to have a termination of pregnancy. It was considered at the learning event, if the repeated declaration regarding her planning to have a termination was a distraction tactic, intended at this stage to deceive professionals. There was also a discussion about the need for professionals to ensure they remain curious and pause to reflect on all of the information known and that not known to properly evaluate risk.

Learning Point:

Hampshire Safeguarding Children Partnership is to consider providing training and development for professionals working with parents and carers who may seek to manipulate and deceive. This should include the phenomenon first described by Reder & Duncan (1999) as 'closure', 'flight' and 'disguised compliance'.

2. Child Protection Planning

Within Hampshire there was evidence of an appropriate escalation of concern in response to mother's failure to engage with services and given the issue with her contact details and addresses, indication that she may be actively evading Children's Services and other professionals. When progress was unable to be made with the Child and Family Assessment, an investigation under s47 Children Act (Child Protection) was triggered leading to an Initial Child Protection Conference, all without engagement from the parents. A robust plan was developed and shared across partner organisations, and there was evidence that the plan was included within partner organisations records (Police, GP, HV & Midwifery).

One element of the plan however, which appeared to have lacked sufficient rigour was in relation to the 'national alert'. It was unclear how the national alert had been issued, and it was Children's Services understanding that this was completed by health professionals. There was no evidence that a national alert had been shared regarding Hattie's mothers non-engagement with professionals and concern for Hattie. Indeed the hospital where Hattie was born stated that they had not been in receipt on an alert in respect of the mother.

On reviewing NHS England's policy in relation to alerts, it is clear that the national team no longer issue national alerts and that it is the responsibility of local statutory agencies to collaborate with the Designated Professionals in the local area, to agree how to use existing networks to safeguarding the child/individual.

Learning Point:

West Hampshire CCG in collaboration with Hampshire Safeguarding Children Partnership and partners are to consider the requirement for a succinct process which details how to raise an alert across health services. This should include the need for as much information as possible about the individual, such as NHS Numbers, due date and photographs (where possible) to ensure that they can be utilised by receiving organisations. Consideration will also need to be given to how widely the alert is to be distributed around the county, region and/or country.

3. Delivery and post-natal care

At the point of admission, there was a deliberate action taken by Hattie's parents to deceive and lie to professionals. The details of her name, date of birth and social circumstances were all fabricated. Despite not being able to identify a NHS Number the hospital did allocate a hospital number so that her care could progress (e.g. blood tests could be completed). This lack of a NHS number, should have served as an indicator or red flag in terms of what the midwifery service were being told by the mother. Without access to the correct demographical details, systems such as Child Protection – Information Sharing (CP-IS) would not have highlighted to professionals that Unborn Hattie was subject to a CPP.

Hattie's mother did inform the hospital that she had not been in receipt of any antenatal care and this led to the initiation of the 'Concealed Pregnancy Pathway'. This pathway indicates that a referral should be made to Children's Services and that a discharge planning meeting should take place. This internal hospital process is corroborated by the local areas LSCP Procedures which highlight that a 'Multi-agency meeting should be held prior to discharge to assess risk and agree plan'.

Despite a referral being made to Children's Services and known risk factors being present (no antenatal care, living in a car, suspected drug use, demographic details not corresponding with the NHS Spine), a discharge planning meeting did not happen as the local Children's Services Department decided that the threshold for social care intervention had not been met. This decision was not challenged or escalated by the midwifery service, despite a clear process for escalation being in place for all professionals.

Another area which is part of the pathway is in relation to urine toxicology. In Hattie's case, the urine toxicology was not collected until 24 hours post-delivery and not processed as urgent. This resulted in her being discharged with her mother, prior to the results being available, which in retrospect, if they had been available could have potentially changed the decision to allow discharge.

Action Point:

Hampshire Safeguarding Children Partnership should review the existing Unborn Baby Protocol to ensure that they reflect the learning from this case; including guidance on the management of demographic information, the importance of discharge planning meetings, the use of

toxicology results and the risks of decision making without them and the escalation of professional concerns between agencies. Once reviewed and if necessary, updated, the Partnership should seek to explore how embedded the Protocol is within practice.

4. Conclusion

Hattie's case was challenging for all professionals involved, primarily due to the laws around unborn babies, and the fact that professionals can only intervene when the baby is born. In this case, Hattie's parents did not willingly engage with professionals and falsified details when they had engaged with services out of necessity. There are some learning points from the case which may help to ensure that professionals are more alert to features from this case, namely the importance of alerts, corroborating demographic details and escalating concerns when professionals step away from due process.

Ultimately, Hattie was located quickly and did not suffer harm as a result of being in her parents care and she is now safe in the care of the local authority.

Learning event completed on: 21/05/2019

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This report has been shared with the Local Safeguarding Children Partnership of the geographical area where the hospital and Children's Services Departments are based. This has allowed them to contribute to the report and to adopt relevant learning points within their own learning and improvement programme.