Hampshire Safeguarding Children Board

Baby Z SCR

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Table of contents

1 INTRODUCTION 3

1.1 Initiation of serious case review 3

1.2 Summary 4

1.3 Structure of Report 6

2 REVIEW PROCESS 7

2.1 Agencies and geographical areas involved with this review 7

2.2 Scope and terms of reference 8

2.3 Review methodology 8

2.4 Practitioner involvement 8

2.5 Family involvement 9

2.6 Limitations to serious case review 9

3 PROFESSIONAL PRACTICE EVALUATION 10

3.1 Introduction 10

3.2 Recognition of child protection concerns: May 2016-June 2016 11

3.3 Unborn baby subject to child protection plan: 24.06.16 – 16.09.16 12

3.4 Baby Z born & in hospital: 16.09.16 – 26.09.16 14

3.5 Baby Z's first home for 9 days: London 26.09.16 – 05.10.16 16

3.6 Baby Z aged 19 days, in Hampshire: 05.10.16 – 13.10.16 16

3.7 Baby Z's first hospital admission, 4 weeks old 17

3.8 Baby Z cared for by MGGM: 17.10.16 – 18.10.16 18

3.9 Baby Z and mother: events on 18.10.16 to 31.10.16 18

3.10 Mother in hospital and baby z placed with carers: 01.11.16 – 11.12.16 20

3.11 Care proceedings initiated & mother and baby move to mother and baby unit: 12.12.16 – 31.12.16 22

3.12 Concerns about baby's Z and mother's health: January 2017 24

4 FINDINGS & RECOMMENDATIONS 28

4.1 Insufficient focus on Baby Z's needs as a vulnerable premature baby 28

4.2 Impact of hIgh mobility within the safeguarding system 32

4.4 High usage of health services 36

4.5 Support and treatment of mother's mental ill health 41

4.6 Mother and baby unit placement 42

4.7 Care planning 47

4.8 Father and partners 48

GLOSSARY OF TERMS AND ABBREVIATIONS 49

APPENDIX 1: 50

1 INTRODUCTION

1.1 INITIATION OF SERIOUS CASE REVIEW

1.1.1 Hampshire Safeguarding Children Board [HSCB] initiated this serious case review on Baby Z on 28.06.17, following two life threatening episodes, necessitating emergency hospital medical intervention in January 2017. Baby Z was nearly 4 months old at the first episode and just over 4 months old on the second occasion.

1.1.2 On the second occasion, Baby Z was found to have a partially healed fractured rib, and toxicology reports identified that Dihydrocodeine was present in Baby Z's urine. This was a medication prescribed to the mother. During a police investigation, the mother was arrested. The investigation into harm caused to Baby Z centred around the offence of administering poison (other destructive or noxious thing) so as thereby to endanger life. Following a police investigation and in early consultation with the Crown Prosecution Service [CPS] it was established there was no possibility of meeting the evidential threshold to enable a realistic prospect of conviction. This was due to a number of factors including; medical and forensic evidence and other lines of enquiry being unable to categorically prove how and by whom the drug was administered and whether it was done so wilfully or accidentally. In addition, it cannot be concluded that the drug found within the baby's system was the actual cause of the medical episodes suffered by the baby.

1.1.3 Baby Z was subject to an interim Care Order to Surrey County Council at that time, living with her mother in a Mother and Baby Unit within a psychiatric hospital in Hampshire. The Care proceedings continued and have now concluded: Baby Z was not returned to the care of her mother.

1.1.4 Hampshire SCB took responsibility for initiating the serious case review, with the agreement of Surrey Safeguarding Children Board [SSCB], because Baby Z was living in Hampshire at the time of the events mentioned in 1.2 above and there were concerns about the way agencies had worked together to safeguard Baby Z.

CASE SUMMARY: WHAT HAPPENED?

1.1.5 This serious case review covers a period of 7 months from late June 2016 to the end of January 2017. The mother in this case moved to Surrey early 2016 when she was pregnant and homeless. She had a history of physical and mental ill health and a diagnosis of borderline personality disorder, also known as Emotionally Unstable Personality Disorder [EUPD].

1.1.6 During her pregnancy with Baby Z there were concerns about mother's self-harming and suicide attempts. This led to the making of a child protection plan [CPP] for the unborn baby being agreed in late June 2016, which continued after her birth in September 2016, until an interim Care Order [ICO] was made to Surrey County Council in December 2016.

1.1.7 During the pregnancy the mother continued to have frequent hospital presentations reporting physical ill health symptoms and / or overdose of prescribed medication. She moved to Hampshire, which was the family's permanent address. However, the plan to safeguard the unborn baby involved mother and baby moving to stay with maternal great grandmother [MGGM] in West London, following the birth.

1.1.8 Baby Z was born prematurely and discharged to the mother's care to MGGM's address at age 10 days, at the end of September 2016. At age 19 days, Baby Z moved with mother to their permanent home in Hampshire, but 8 days later Baby Z was admitted to hospital for 4 days due to concerns about feeding.

1.1.9 During the next few weeks the mother's mental health deteriorated becoming acutely unwell and was admitted to a psychiatric hospital. In the meantime, Baby Z had a number of carers including mother, MGGM and a placement with a family friend selected by the mother, following MGGM feeling unable to care for Baby Z.

1.1.10 During this chaotic period in Baby Z's life the case responsibility for her remained with Surrey Children's Services [SCS], whilst Surrey mental health service providers provided the mental health support and treatment for mother. The plan agreed in November 2016, was for mother and baby to move to a mother and baby unit [MBU], which is part of a psychiatric facility provided by Southern Health NHS Foundation Trust in Hampshire.

1.1.11 Mother and baby were re-united in early December, the day after an Interim Care Order [ICO] was made to Surrey County Council [SCC} and moved together to the MBU. Within the first day, the MBU decided that the mother did not meet their admission criteria, as no longer acutely mentally ill. In consequence SCS identified a residential mother and baby unit, experienced in providing parenting assessments, as opposed to one providing psychiatric treatment for the parent. This residential unit offered a place subject to mother having no further episodes of overdosing or self-harming.

1.1.12 The move from the MBU was delayed due to both mother and baby ill health in January 2017, with Baby Z's suffering 2 life threatening episodes requiring emergency medical intervention. The latter of these, described in 1.1.2 resulted in Baby Z being removed from mother's care and the initiation of this serious case review.

1.2 SUMMARY

1.2.1 One of the major factors in this case was the short period the professionals knew the mother and the difficulty professionals had in obtaining an assessment of the mother's ability to care for Baby Z in the long term. The mother was new to Surrey in 2016 and frequently presented at different health settings in various geographical locations, often reporting acute medical and psychiatric symptoms requiring urgent responses. During the period under review mother had at least 47 hospital presentations, including routine ante natal care.

1.2.2 In this context professionals appropriately responded to the presenting emergencies, but the impact of constant crisis was to limit professional capacity and ability to progress holistic protection assessment and planning for Baby Z.

1.2.3 The mother presented with a variety of self-reported physical illnesses at a large number of different health providers and received medication for a variety of conditions (including cardiac problems and diabetes). What is less clear is whether or not the mother ever co-operated with medical assessments so as to be able to confirm the diagnosis made on her reported symptoms. During the period under review, when such medical investigations were offered at Frimley Park Hospital [Frimley Health NHS Foundation Trust], the mother declined tests or discharged herself from hospital before these were undertaken.

1.2.4 It was challenging for any one health practitioner or agency to obtain a holistic oversight and understanding of the mother's health because of the high number of practitioners involved in different locations, the relatively short time mother was known in Surrey and the systemic lack of a health practitioner with oversight and knowledge of all mother's ill health. This led largely to individual responses to mother's health presentations, relying on her explanations of what was behind her reported symptoms and without consideration of what might be behind such a high usage of health services. One possibility that could have been explored was the possibility of mother fabricating or inducing her own symptoms of illness. Had this possibility been explored, it may have intensified the attempts made at Frimley Park Hospital to fully understand mother's health history and the causes of her symptoms and greater caution in relation to Baby Z's safeguarding if in the care of mother.

1.2.5 In the practitioners' responses to mother's frequent crises, the needs of a new born premature baby for safe consistent care and nurture were given insufficient priority. The original plan for mother and baby, following a Family Group Conference, was for Baby Z to remain in the family, with help and support from extended family members and that a parenting assessment be undertaken to establish if mother would be able to care for Baby Z in the long term. However, the plan was never fully implemented: mother's emotional and mental health instability meant that the situation was never sufficiently stable to undertake the parenting assessment. This was perhaps compounded by the plan at that point to transfer social work case responsibility from Surrey to Hampshire: this never happened but the certainty in Surrey that it was imminent may have contributed to a lack of pro-active review during the last months of the pregnancy.

1.2.6 Following further deterioration in mother's emotional and mental health following the birth, mother was a psychiatric in-patient in Surrey and the hospital made a referral to the MBU. By the time mother and Baby Z were admitted to the MBU in December 2016, premature Baby Z had spent her first 3 months of life moving around, with 3 different carers, in 3 different settings and 2 hospital admissions.

1.2.7 The MBU is a psychiatric ward in Hampshire, where mothers were admitted due to their acute mental health needs, with the admission enabling mother and babies to be kept together, with support provided to develop attachment between baby and mother.

1.2.8 Although multi-agency planning at the child protection conference had considered a mother and baby unit [MBU] might be needed, the function and facilities of the chosen unit were not discussed within a multi-agency meeting. Surrey mental health services arranged this psychiatric MBU placement, on the basis of mother's acute mental health needs. What was not understood by professionals at the time was that it did not have the facility to provide the parenting assessment required by Surrey children's services [SCS} i.e. one that could advise on mother's long-term parenting capacity to be used as part of care proceedings, which SCS had by then appropriately decided to initiate.

1.2.9 The social work manager had tried to check that a parenting assessment could be provided but there was a misunderstanding between managers at the MBU and SCS on this issue: the social work manager erroneously understood that such an assessment was possible and the MBU manager did not appreciate that this was required. This error became clear to the social worker immediately after admission in December 2016, when the MBU explained that the mother did not meet the ward's admissions criteria: she was not acutely mentally ill and would need to move elsewhere.

1.2.10 The social worker identified an alternative specialist mother and baby residential assessment resource, experienced in dealing with child protection risks, and arranged for mother and baby to be admitted. This residential unit specified the admission condition that mother had no more overdoses or self-harm incidents. This planned move however was delayed due to the constant health emergencies for baby and mother in January 2017.

1.2.11 Whilst it is likely that Baby Z would have been safer in such an environment, the lack of full understanding about the mother's own physical and emotional health meant that not all possible risks to Baby Z if in the sole care of the mother were at this point identified.

1.2.12 In conclusion, in just over 4 months, Baby Z had a large number of moves and different carers including her mother, her maternal great grandmother [MGGM], a 'family and friends' placement, her mother in a mother and baby unit and foster carers, as well as 5 hospital admissions.

1.3 STRUCTURE OF REPORT

1.3.1 The remainder of the report is structured as follows:

- Section 2 explains the review process including the different agencies involved with the family, those participating in the review and the limitations of the process
- Section 3 provides a fuller account of what happened from the perspective of practitioners, with an appraisal of professional practice
- Section 4 provides the findings of the serious case review with considerations for action by the LSCBs involved in this review, and their agencies
- A glossary of abbreviations and terms used is provided at the end of the report
- The terms of reference for the serious case review are in the appendix

2 REVIEW PROCESS

2.1 AGENCIES AND GEOGRAPHICAL AREAS INVOLVED WITH THIS REVIEW

2.1.1 During the period under review mother lived in Surrey and Hampshire, and also stayed with Baby Z's maternal great grandmother [MGGM] in West London. In consequence there were professionals and agencies involved arising from these locations. Additionally, the mother accessed a variety of health services in additional locations.

2.1.2 Hampshire SCB initially identified agencies known to be involved with mother and/or Baby Z and requested that they each provide a chronology and agency report for the serious case review. On the basis of the information provided further agencies and professionals were identified as having relevant information and were asked for information or to produce a report and chronology. This was a lengthy process and caused delay on this data collection stage of the review. When further information identified limited health involvement with mother, the review has relied on information in the GP chronology and not sought further data.

2.1.3 The following agencies provided chronologies and reports to the review to the review:

- Surrey and Borders Partnership NHS Trust: provided Surrey psychiatric services to the mother through both community mental health services and acute inpatient services
- Frimley Health Foundation Trust [FHT] providing the following services in Frimley Park Hospital [FPH]: maternity, perinatal mental health, paediatric, Emergency Department [ED], diabetic and safeguarding services as well as the community midwifery services
- Hampshire Hospitals NHS Foundation Trust providing services at the Royal Hampshire County Hospital [RHCH]
- University Hospital Southampton [UHS]
- Clinical commissioning groups providing GP services to the family during the period of the review
- Surrey Children & Families Health service providing health visitor in Surrey to the family
- Southern Health NHS Foundation Trust mother and baby unit [Melbury Lodge] for mother and baby, and health visiting input during this admission
- Surrey County Council Children's Services [SCS]: provision of social work services to Baby Z and her mother throughout period under review
- Surrey County Council Adult Services
- Hampshire County Council Children's Services [HCS]: liaised with health and social work services in Surrey, but had no direct involvement with the family
- Surrey Constabulary

- Hampshire Constabulary
- South Central Ambulance Service
- Cafcass providing Children's Guardian for the Care Proceedings

2.1.4 Additional information was provided by Capita in relation to the process for transfer of GP records.

2.1.5 The following list of other health services involvement identified from GP records may not be comprehensive. Due to delays in transfer of such records, not all this information would have been available at the time to the GP, or to other professionals – although mother often did share details of these contacts:

- Baby Z was admitted into hospital in London for 5 days, aged one month: this admission does not appear in records from other agencies
- Mother attended 7 hospitals (6 in London and 1 in Berkshire) during this period for a variety of ailments, including gestational diabetes and supraventricular tachycardia (SVT)
- Mother attended 3 urgent care centres in London, a London out of hours health centre and a Berkshire Walk in Centre

2.2 SCOPE AND TERMS OF REFERENCE

1.1.1 The full terms of reference are set out in the appendix of this report. The period under review is from 24/06/2016 – 28/01/2017. In order to have a better understanding the author has also included contextual information from earlier May 2016, when child protection concerns were identified for unborn Baby Z.

2.3 REVIEW METHODOLOGY

2.3.1 The agencies above who provided information to this serious case review did so in the form of a chronology of their involvement and an agency report and recommendations for action.

2.3.2 The serious case review panel, consisting of senior members of the involved agencies, worked with the independent lead reviewer, Edi Carmi, to consider the management reviews, identify and request outstanding information, meet with practitioners and provide feedback to the report written by Edi Carmi.

2.4 PRACTITIONER INVOLVEMENT

2.4.1 The lead reviewer and panel members met with practitioners individually or in small groups so as to understand their perspectives and explanations of what happened.

2.4.2 Arranging practitioner interviews proved extremely challenging, and caused delay. These were finally completed in August 2018.

2.5 FAMILY INVOLVEMENT

2.5.1 The author of the review planned to involve Baby Z's mother, father and great grandmother.

2.5.2 The Board have advised the author that Baby Z's mother was informed of the serious case review and invited to contribute, however declined.

2.6 LIMITATIONS TO SERIOUS CASE REVIEW

2.6.1 There were limitations to this serious case review through being unable to obtain the mother's perspective through direct contribution to this review.

2.6.2 The perspective of community and hospital practitioners in London is missing, in terms of learning what understanding they may or not have had about both mother's health and Baby Z's needs. There was a need to maintain proportionality of this review, given the growing list of health practitioner involvement with the mother, which emerged during the course of the review. Attempts were though made to include the West London health visitor within the health visitor group, but HSCB received no response.

2.6.3 The lack of response of the Children's Guardian to contact by the LSCB is extremely disappointing. Her perspective appears to have been different to other professionals, and initially was concerned about the plan for a mother and baby unit placement, wishing this to be discussed within the legal proceedings. However, this did not happen as she discovered that mother and baby had moved into the unit the day before.

2.6.4 A few practitioners had not understood [or possibly not been advised of] the need to prepare for conversations with the lead reviewer, hence they did not recall some events or the rationale for their actions or lack of actions.

3 PROFESSIONAL PRACTICE EVALUATION

3.1 INTRODUCTION

3.1.1 Section 1.2 provides a brief summary of what happened during the period under review. Section 3 analyses what happened in more detail, broken into different time periods. The aim of this is to understand and appraise professional practice.

3.1.2 This has been a challenging task due to the constant moves and fast-moving changes of circumstances. A great deal more contact with Baby Z occurred than is apparent from some agency records.

3.1.3 Throughout the report the family are referred to by their relationship with Baby Z, so her mother, her maternal great grandmother [MGGM] and her maternal great aunt [MGA].

Context prior to period under review

3.1.4 Mother presented as homeless and pregnant in Surrey in March 2016, without links in the area. She was provided with temporary accommodation and a referral made to Surrey Children's Services [SCS] for support. She initiated contact herself with SCS and an assessment was appropriately initiated.

3.1.5 At 15 weeks pregnant in April, mother self-reported to the Surrey midwife that she was booked into both Frimley Park Hospital and Queen Charlotte's Hospital [West London], the latter associated with her heart condition. Mother highlighted having 2 cardiac arrests at age 17, social care involvement as a child and current mental health involvement. She mentioned 4 previous pregnancies, ending in miscarriages. The midwife appropriately made a multi-agency referral for social care help and support after booking-in – and spoke to a social worker.

3.2 RECOGNITION OF CHILD PROTECTION CONCERNS: MAY 2016-JUNE 2016

3.2.1 As explained in 2.2, the author has commenced the period under review from early May 2016, when the first child protection concerns were referred to Surrey Children's Services [SCS] following mother being found at a railway station, reporting she had cut her wrist, with visible injuries and blood on trousers. She was taken by ambulance to Frimley Park Emergency Department [ED] under s.136 Mental Health Act[i] and subsequently detained under Section 2, Mental Health Act[ii] 1983. ***This was the 1st known hospital admission for mother in the period under review.***

3.2.2 A s.47 enquiry[iii] [commonly called child protection enquiry] was appropriately undertaken by SCS. This established a complex history from previous supported housing, perinatal and mental health service providers in London including mother had made 2 previous suicide attempts in February 2016, had a pattern of hiding medication and of keeping sharp objects in her room – risks in relation to overdosing and self-harming. She was reported to not want a mother and baby home, of having changed her GP 13 times and being diagnosed with Borderline Personality Disorder. She had left London and moved to Lincolnshire with a man for 2 weeks – it was not known if he was the father.

3.2.3 The Surrey and Borders Partnership Mental Health Trust received a referral from Lincolnshire. Their report to the SCR refers to mother's long history of deliberate self-harm and hospital admissions with overdosing, as a way of coping with stressful situations. Also, that she had never previously lived on her own and was scared about this, having been in care or in supported housing schemes. There is no evidence that the social workers ever knew she had never lived on her won before.

3.2.4 An initial child protection conference (CPC) was held by SCS in late June 2016. It was shared at the meeting that whilst on the hospital ward, mother had self-harmed. The social worker's assessment included the information that mother had made 3 suicide attempts in the pregnancy. There was majority agreement for a child protection plan [CPP] under Neglect, due to concerns about maternal physical and mental health.

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[i] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

[ii] Section 2, Mental Health Act 1983 provides the legal framework for an assessment to take place and can last up to 28 days.

[iii] Section 47 of Children Act 1989, known as a s.47, refers to the local authority duty to make enquiries when they 'have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'.

PROFESSIONAL PRACTICE APPRAISAL

From the point child protection concerns were identified there was an appropriate response by SCS, initiating a s.47 enquiry, undertaking agency checks and learning sufficient to conclude the need for a child protection conference and plan.

The apparently unshared knowledge by the mental health trust of mother never previously living alone would have usefully contributed to post birth planning arrangements.

Not all professionals at the conference supported the need for a child protection plan: colleagues in conversations with the author were rightly concerned that two of the practitioners did not recognise the need for a child protection plan.

3.3 UNBORN BABY SUBJECT TO CHILD PROTECTION PLAN: 24.06.16 – 16.09.16

Mother's health

3.3.1 Mother continued to experience health problems in the remainder of her pregnancy with constant hospital presentations. It appears that mother had 12 hospital presentations / admissions in less than 3 months, but there may have been more at other hospitals, or not specifically itemised within the chronologies. Whilst most admissions were at Frimley Park Hospital [FPH], mother is known to have also presented at 3 hospitals outside of Surrey, with an admission at one.

3.3.2 The admissions concerned reported palpitations, suspected gestational diabetes, abdominal pain, vomiting, low mood, dizziness and hypoglycaemia. She often was brought into hospital by ambulance and self-discharged against medical advice. Sometimes this meant she missed, or possibly avoided, further medical screening / testing in relation to cardiac and diabetes symptoms e.g. glucose tolerance test, repeat BP and pulse examination.

3.3.3 Mother continued to have frequent contact for the rest of the pregnancy with the Surrey community midwife, FPH and GP1 with concerns about reduced foetal movement, antibiotics for chest infection, infective exacerbation asthma, back pain, palpitations, abdominal pain and dizziness and low mood. She also attended a London Urgent Care Centre for a cough and hip pain.

3.3.4 The mother registered at GP2 surgery on 31.08.16. The GP chronology notes 40 previous urgent care attendances in previous 12 months – this demonstrates how long standing this pattern of behaviour was, albeit mainly falling before the period under review and not known to practitioners at the time.

3.3.5 On the last FPH attendance just before Baby Z's birth, the mother walked out of hospital crying and her midwife was unable to convince her to stay. She subsequently would not allow the midwife on duty to see her at home that day. The next day mother reported reduced foetal movement [35 +4/40 gestation], but refused to follow midwifery advice to go to hospital (she had high blood pressure and a high pulse) and declined a further visit the next day.

3.3.6 Throughout the period of the pregnancy there were concerns about mother's emotional health and welfare, and the welfare of the unborn baby:

- A hospital consultant trying to establish the reality of mother's diabetes [see 4.3]
- Possible misuse of medication
- Child protection concerns: she told the midwife she had no attachment to the baby and that the baby '*will be taken away from me'*
- The out of hours [OOH] GP noted the flat smelled of smoke and was dirty and messy – there was no evidence that these concerns were escalated within health or to the social worker
- Mother's refusal to follow midwifery advice at the end of the pregnancy, potentially risking the welfare of her baby

Social care planning

3.3.7 A Family Group Conference took place on early August 2016. The plan agreed was for the family to support mother, with professional support. This is one of the few records of SCS involvement since the initial CPC and core group meeting, as opposed to what appears to be virtually daily health involvement. This may reflect recording shortcomings, but also a lack of parenting assessment activity too – see practice appraisal points below.

House move to Hampshire: 12.08.16

3.3.8 The mother moved over the border from Surrey to Hampshire on 12.08.16. From this point SCS planned to transfer the case to Hampshire, but this never actually happened [see 3.2].

PROFESSIONAL PRACTICE APPRAISAL

There was little progress on the SCS assessment of mother in this critical period. The efforts made to do this are not known to the author, albeit mother's frequent acute ill health presentations would have been a major obstacle. Also, the first social work manager [SCS] explained to the author that the plan at this point was to transfer the case to Hampshire; this may have discouraged further assessment (see 4.2 for further discussion).

The data on the frequency and variety of maternal health presentations is a critical part of any assessment, but within current systems it is not collected together and analysed by any one health practitioner, albeit the GP is informed of the presentations [see 4.2]

The role of the CPN was limited to one telephone and 1 direct contact: this should have been a critical time period for CPN intervention and involvement in multi-agency work.

The role of the FPH consultant was critical here, as s/he tried to understand what was behind some of mother's health presentations– see 4.3 for further discussion. The safeguarding children's team at FPH recognised some of the safeguarding issues and concerns and made significant attempts to explore and understand Baby Z mother's medical history and make sense of her hospital attendance.

3.4 BABY Z BORN & IN HOSPITAL: 16.09.16 – 26.09.16

Birth and plan

3.4.1 The day after the midwife advised mother to go straight to hospital (16.09.16) Baby Z was born by Caesarean section, 5 weeks prematurely. Mother and baby remained in hospital for 10 days prior to both being discharged to MGGM's home, in accordance with the original plan formulated at the initial CPC, the family group conference and agreed at the review CPC and pre-discharge meeting in September 2016.

Concerns

3.4.2 During this time there were some positive indicators with mother keen to provide care for Baby Z when visiting the neo natal unit and subsequently when mother and baby were reunited in the transitional care unit when Baby Z was 3 days old.

3.4.3 There were though also concerns about the circumstances of Baby Z's birth and mother's ability to consistently put Baby Z's needs first:

- SCS were notified of the birth and informed about mother's recent volatility, ignoring advice to return to hospital with high BP and pulse rate – in conversation for this review the midwife recalled perceiving this as mother risking her baby's safety and placing her own needs and wishes above the health of her baby.
- Mother did not rouse to see to Baby Z's needs on 21.09.16 when Baby Z was unsettled, although this may not be that unusual with mothers in the first few days

3.4.4 Concerns arose immediately following the review CPC (see 3.4.7 below): leaving the unit to have a cigarette when it was Baby Z's feeding time and not understanding the need to wake premature Baby Z for a feed every 3 hours [baby aged 7 days].

Mental health support

3.4.5 Mother requested to see the psychiatric liaison team at the hospital when Baby Z was 7 days old, as she said had had no contact with the Surrey CMHT. Records however show 3 contacts the previous week with the Enabling Independence Worker and also contact on the day of Baby Z's birth with the CPN -albeit this visit is contrary to what mother reported and not in hospital records.

3.4.6 The assessment by the psychiatric liaison team found no evidence of psychosis or post-natal depression and this was fed back to CMHT.

Review Child Protection Conference on 23.09.16

3.4.7 The review CPC acknowledged mother's failure to prioritise her unborn baby's needs by delaying receipt of medical support until it was an emergency situation. The meeting also discussed that mother had not been seen by the CPN or a psychiatrist as had been in the original CPP, along with practitioners referring to their difficulty contacting the CPN.

3.4.8 The midwifery report to the meeting noted 20 hospital contacts since last report – including routine maternity appointments.

3.4.9 The meeting unanimously agreed to continue the CPP. It was agreed that Baby Z and mother would go to maternal great grandmother [MGGM], a parenting assessment to be completed and a possible need for a mother and baby unit. The discharge plan confirmed support from all agencies, especially the CMHT as it was noted there had been difficulties communicating with them.

3.4.10 If concerns increased, the plan was for the social worker to request a legal planning meeting – this would be with the aim of considering the use of legal interventions. .

Discharge 26.09.16

3.4.11 A discharge meeting held on 26.09.16, confirmed the move to MGGM, despite the concerns that arose following the conference (see 3.4.4). There are no records of the content of the meeting, although the health visitor recorded that a core group meeting was held at same time as the discharge meeting with attendance of the health visitor, perinatal mental health midwife, social worker, CPN and MGGM.

3.4.12 The CSC chronology notes the lack of evidence that MGGM's local authority were informed. Within health appropriate communication and arrangements were made with the health visitor calling her counterpoint in London. Arrangements were made for the London midwife to visit until Baby Z was 28 days old and hand-over of care was made to the London hospital initially involved and mother's GP2.

3.4.13 The same day the health visitor undertook the new birth assessment. Baby Z's father was reported by mother as having *no* knowledge of or contact with Baby Z.

PROFESSIONAL PRACTICE APPRAISAL

There was a good structure around planning for the future, with a review conference, discharge meeting and core group meeting all held before discharge.

The plan was over reliant on MGGM, without a local professional network to support her and did not provide sufficient clarity around expectations e.g. what was expected of mother and baby prior to a move to Hampshire and over what period – previously 2 weeks had been mentioned which seemed very short given that mother's own experience of living on her own was limited, and involved frequent health crisis.

There is no evidence that the London borough where MGGM lived were informed that a baby subject to a child protection plan was staying in the borough (as per procedures), but health communication was good.

3.5 BABY Z'S FIRST HOME FOR 9 DAYS: LONDON 26.09.16 – 05.10.16

3.5.1 Mother and 10-day old Baby Z stayed with MGGM for 9 days before moving to Hampshire [see 3.6 for discussion about move}.

Baby Z

3.5.2 During the 9 days in West London Baby Z was seen at home by a midwife and by the Surrey social worker. Whilst there were no general concerns about her care, when the midwife visited, Baby Z aged 14 days old, had lost weight and the midwife arranged for her to be seen by a paediatrician that afternoon, at a West London Hospital. The Hampshire health visitor received notification from that hospital on 31.10.16, which said the plan was for twice weekly weighing, feeding advice and re-assurance.

Mother's health

3.5.3 During these 9 days, mother had 4 health presentations at Walk in Clinics, an out of hour health centre and a hospital. These concerned a chest infection, repeat medication requests and palpitations.

PROFESSIONAL PRACTICE APPRAISAL

During these 9 days it is of concern that having sent mother to hospital in relation to concerns about the health of a premature baby subject to a CPP, there appears to have been no follow up by the midwife to check if mother did attend hospital and the outcome.

The delay in the Hampshire midwife receiving notification of this meant that could have been no timely follow up, if the mother had herself not sought further help.

3.6 BABY Z AGED 19 DAYS, IN HAMPSHIRE: 05.10.16 – 13.10.16

3.6.1 Mother and 19-day old Baby Z stayed alone for 8 days in mother's flat in Hampshire (2nd home for Baby Z). This was the only time Baby Z lived alone with her mother.

3.6.2 This was a confusing period for practitioners, with uncertainty if this was a temporary move or not, and if social work case responsibility rested with Surrey or Hampshire, as the Surrey social worker said the case would transfer imminently – see 4.2 for further discussion. The London health visitor understood it to be temporary move, to enable mother to see her GP [which she did], whilst the social worker understood it to be a permanent move, following MGGM's verbal report that all was going well.

Baby Z's welfare

3.6.3 There were no identified concerns about Baby Z's care during these days, except that mother needed support as she was anxious about her daughter's health. After 3 days the mother contacted duty health visiting for advice, and then the GP, as Baby Z was reportedly constipated for 3 days and vomiting after feeds. She explained about Baby Z's failure to gain weight. The GP noted that Baby Z was settled, well hydrated, clean and advised to continue feedings as per paediatrician's advice and bring into the health visitor's clinic twice weekly. The GP contacted the Hampshire health visitor, who provided background information (the CPP and maternal mental health problems) and agreed to contact mother to attend her clinic. The GP also shared with the health visitor (but did not record in GP records nor inform SCS) that a man accompanied mother and Baby Z.

Maternal health

3.6.4 Mother presented at Frimley Park Hospital during this period with abdominal pains and bleeding. Oramorph (oral morphine) was given and she was discharged to GP care.

PROFESSIONAL PRACTICE APPRAISAL

The mother's decision for her and Baby Z to move to Hampshire was premature and should have been challenged by SCS, even if MGGM felt mother had coped over 9 days. This was an insufficiently long enough period to judge that mother could cope on her own, given her history during pregnancy and that during this brief time she had presented at 4 different health settings.

The household composition at this point is not clear, as a man accompanied mother and baby to the GP surgery – nothing was known by health staff of this relationship and impact on Baby Z's welfare. This relationship should have alerted professional curiosity and exploration, been included within any assessment by the social worker and discussed with professional colleagues.

3.7 BABY Z'S FIRST HOSPITAL ADMISSION, 4 WEEKS OLD

3.7.1 At 4 weeks old, Baby Z had her 1st hospital admission, lasting 4 days. It was prompted due to midwifery concerns about her reported unresponsiveness to feeds, with suspected sepsis and reflux. FPH children's ward records show that a new male partner accompanied mother, who was mistakenly assumed to be the father.

3.7.2 During this admission concerns about mother's care of Baby Z were identified. Ward staff noticed minimal interaction between baby and 'parents'. Overnight on her last night nurses fed Baby Z, with mother getting angry when woken and then leaving the ward to smoke, without first feeding Baby Z. Prior to leaving the hospital mother was noted to be aggressive towards nursing staff.

PROFESSIONAL PRACTICE APPRAISAL

Baby Z should not at this point have been discharged from hospital without, at minimum, prior discussion with SCS, but this did not happen. No discharge meeting was held either. FPH staff, in conversations for this review, have suggested this was associated with the difficulties experienced in general with getting hold of the Surrey social worker; however, the exact details of communication attempts and responses are not known by the author . Additionally, as discharge was to MGGM, as opposed to mother, it would have been considered as consistent with the child protection plan.

3.8 BABY Z CARED FOR BY MGGM: 17.10.16 – 18.10.16

3.8.1 On 17.10.16 Baby Z was discharged to MGGM's care. The social worker when informed what had happened by the hospital, had knowledge of the man with the mother, but advised the hospital he should not be present. She explained that MGGM cared for Baby Z overnight because her mother was feeling tired, but returned Baby Z to mother's care the next day.

PROFESSIONAL PRACTICE APPRAISAL

By this point there should have been major professional concerns at the thought of a premature 28 day old baby moving around in 3 weeks from hospital to London, to Hampshire, to hospital, to London and back to Hampshire, whilst suffering from an infection and without the security of a consistent carer or home. There was a lack of clarity about the domestic home environment, possibly including a new male figure and worrying reports of maternal aggression and neglect of meeting Baby Z's needs in hospital.

Good practice in these circumstances would have been for an emergency core group meeting to evaluate the safety of the plan and consider what action needed to be taken e.g. change in CPP with longer period with MGGM for assessment and/ or early review CPC, or a legal planning meeting (as had been suggested at the review conference if there was any deterioration in circumstances).

3.9 BABY Z AND MOTHER: EVENTS ON 18.10.16 TO 31.10.16

3.9.1 There is confusion in the information provided to the serious case review about what happened over the next days, where Baby Z was staying and who was caring for her. This reflects the different understandings of professionals and different agencies. It has been difficult to determine the exact sequence of events and who knew what and when. The following is an *attempt* to do so, but from the conflicting information provided by different agencies it is not possible to be confident of accuracy.

3.9.2 During these 13 days concerns increased rapidly about the mother's mental health and her ability to care for her baby, with at least 7 hospital presentations, including 2 admissions. It is in this period that plans for a mother and baby unit re- emerged, with the recognition that the planned move of Baby Z to mother's Hampshire flat should not take place at this point, the possible need for legal intervention and consequent inadvisability of transferring case responsibility to Hampshire.

Deterioration in mother's mental health and allied negative feelings towards her baby

3.9.3 The day after Baby Z was discharged from hospital [18.10.16] her mother texted maternal great aunt [MGA] reporting self-harm (lacerations on arm). MGA acted swiftly, taking mother to FPH where she was seen by psychiatric liaison but then sent home. Mother had told MGA that she did not want Baby Z near her and got annoyed or irritated when Baby Z cried or wanted attention and 'hated her'.

3.9.4 During the remainder of October (less than 2 weeks) mother's there was increasing concerns about mother's mental health arising from:

- 2 incidents when an ambulance was called to mother's reported self-harm and overdosing
- 4 hospital presentations -refusing to see psychiatric liaison on 1 occasion and leaving before an assessment on other occasions
- Mother found by police at a railway station, seen by psychiatric liaison and arranged for home treatment team [HTT] to see her the next day - she refused their visit, although did see them another day, when the unidentified male, her boyfriend, was present
- Mother was admitted to FPH following an overdose near the end of the month: she was described as 'absconding ', was found by police at a friend's home and returned to FPH, where she assaulted a member of staff, before being assessed as having mental capacity and discharging herself.

3.9.5 The GP discharge notification refers to mother's boyfriend smashing up mother's flat when the ambulance visited on 19.10.16 – it is not clear if the health visitor or social worker were ever informed of this, despite the risk to Baby Z and potential risk to professionals visiting the home.

3.9.6 The letter to the GP from the psychiatric liaison nurse on 28.10.16 additionally mentioned that the mother wanted to go to a mother and baby unit, that the CPN had been informed of discharge and planned to visit the next day.

3.9.7 Another GP discharge summary from FPH mentioned a referral had been made to the mother and baby unit and that mother had kicked a member of staff on 27.10.16. The GP at this point is noted to have appropriately called both the social worker and CPN to discuss the concerns.

Baby Z's welfare

3.9.8 The whereabouts of Baby Z during this period are not clear in the different agencies' chronologies, but it seems that on 18.10.16 Baby Z was with her mother when the mother texted MGA that she could not bear to touch or hold Baby Z and wished she had not had her, and later said she hated her. Baby Z was then taken by MGA to London and moved to MGGM, where she was visited on the next day by the social worker.

3.9.9 The next day Baby Z was taken to a West London hospital by MGGM with a high temperature and heart rate. She remained in hospital until 24.10.16 and discharged with antibiotics. ***This was Baby Z's 2nd hospital admission in her short life – aged just over a month.*** This information was in the GP chronology and it is not known if any of the professionals knew of this, as the social worker referred to Baby Z being with MGGM in conversation with the health visitor at that time.

Case transfer

3.9.10 The FHT safeguarding team liaised fully with both area Children's Services, so the concerns were fully known within both. At this point Hampshire Children's Services [HCS] were anticipating case transfer, but with the changed circumstances case transfer was recognised as no longer appropriate and on 27.10.16, in the social worker's supervision, the decision was made to obtain legal advice. Surrey at this point appropriately accepted responsibility for resolving the future care of Baby Z. HCS closed the case that day.

PROFESSIONAL PRACTICE APPRAISAL

Although FPH record that a mother and baby home placement was planned at this time, it is not known who was arranging this.

There seems to be little evidence of any professional understanding about mother's current state of mind, what had caused the deterioration and what she was feeling towards her daughter.

At this point there was an urgent need to secure Baby Z's care: she needed a stable, safe placement and for security to be provided by the initiation of care proceedings. It is of note that by 19.10.16, MGGM told the social worker that the mother would be unlikely to ever be able to care for Baby Z, and that she wished to do so in the meantime.

3.10 MOTHER IN HOSPITAL AND BABY Z PLACED WITH CARERS: 01.11.16 – 11.12.16

3.10.1 This 6-week period was one of upheaval in the lives of Baby Z and her mother. Baby Z was aged 6 – 12 weeks old. Mother was in and out of hospital and Baby Z was moved from MGGM, who felt unable to continue to care for her, to the family of one of mother's friends.

Mother's instability and health planning for mother and baby

3.10.2 During the first 10 days of November, mother overdosed 3 times.

3.10.3 On the 1st occasion she was assessed as high risk at FPH and admitted to a Surrey psychiatric hospital ward, where she overdosed again. She had told a friend she wanted to die and written goodbye letters to significant family members. The friend also spoke about mother's habit of hiding medication, presumably to enable her to overdose. In this period, she was also transferred to Royal Surrey Hospital for a kidney infection, but self-discharged and returned to the psychiatric hospital.

3.10.4 At this point the mother expressed her wish for a mother and baby unit, but the CPN's view, expressed to the review author, was that such a placement would not be suitable as mother was not depressed and showed no mania or any commitment to stabilise her emotions. The community consultant was said to feel that mother's presentation was Emotionally Unstable Personality Disorder [EUPD].

3.10.5 The ward at the Surrey psychiatric hospital sent a referral to the mother and baby unit [MBU] in Hampshire. The MBU responded that the placement was suitable but no beds were available.

3.10.6 Mother was discharged from this hospital after 3 weeks and during the rest of November presented at FPH on 3 occasions with back/kidney pain, chest/back pain and chest pains, arriving by ambulance on each occasion.

Baby Z's welfare and social care planning

3.10.7 MGGM told the social worker on 06.11.16 that she was exhausted and unable to continue caring for Baby Z. Whilst searching for a suitable foster placement the social worker appropriately arranged for a family support worker to care for Baby Z within MGGM's home.

3.10.8 An alternative 'friends and family' placement for Baby Z was chosen by mother with family friends, and Baby Z moved 5 days after MGGM's decision. Baby Z had contact with mother at a contact centre 3 times a week, increasing following mother's discharge from hospital to 5 times a week.

3.10.9 At the same time the Surrey children's social care's Head of Service agreed that the Public Law Outline [PLO][iv] | should be initiated. Some delay subsequently occurred due to pressures in the legal team. The social worker informed mother of the intention to begin legal proceedings on 24.11.16, trying to explain that this was parallel planning[v].

[iv] The Public Law Outline (PLO) sets out the duties local authorities have when thinking about taking a case to court to ask for a Care Order to take a child into care or for a Supervision Order to be made. This is often described as initiating public law care proceedings.

[v] When Proceedings are issued, the Local Authority can sometimes have several plans for a child at once. For example, the Local Authority may wish to do some assessments of the parents, if those assessments are positive, then the plan can be that the children are returned.

3.10.10 On 08.12.16 the MBU in Hampshire offered a place for mother and Baby Z and they moved in 4 days later on 12.12.16. In the intervening days there had been discussions between 'senior staff' at the MBU and the social worker and her team manager in relation to the service to be provided. In particular this centred on the provision of a full parenting assessment. The social worker manager understood that this was provided, but the record shows that the MBU said they provided observational work, but not a parenting assessment. This was a profound underlying misunderstanding.

3.10.11 The friends and family placement arranged occurred during the social worker's absence. On her return she considered it unsuitable due to her observations of the care and previous knowledge of the family held by SCS. Despite the social worker's subsequent concerns, management opposed a further move, on the basis that Baby Z had already experienced 3 carers in her short life and the imminent plans to move Baby Z to mother at the MBU.

PROFESSIONAL PRACTICE APPRAISAL

The different types of mother and baby units was by professionals not understood at the time. The referral was in accordance with the original contingency plan made at the child protection conferences, for the CPN to make such a referral if mother's mental health deteriorated. However, the selection of mother and baby unit within a psychiatric hospital did not meet the needs of Baby Z or of the assessments required by social care.

A misunderstanding had occurred between the social work manager and her counterpoint at the MBU, with records showing entirely different conclusions of what had been said and agreed. The MBU manager thought he had explained that no parenting assessments were undertaken at the MBU, but the social work manager believed that such an assessment was indeed possible, along with the provision of regular reports. This basic misunderstanding highlights the need for multi-agency involvement in such planning, as well as the need for practitioners to understand the different types and functions of mother and baby resources available.

The provision of a family support worker within MGGM's home to enable Baby Z to remain with MGGM was good practice, maintaining stability for Baby Z and reducing her moves.

The initiation of care proceedings was a positive move, albeit it took a month to progress from the decision, due it is understood to delays in the legal team. This was very poor practice.

The initial decision to place Baby Z with the particular family chosen by the mother was not good practice given information known at that point to SCS, but having made the placement it is understandable that a further move was avoided for Baby Z whilst waiting for the MBU placement.

3.11 CARE PROCEEDINGS INITIATED & MOTHER AND BABY MOVE TO MOTHER AND BABY UNIT: 12.12.16 – 31.12.16

3.11.1 Mother and baby moved into the Hampshire MBU on 12.12.16 and the next day Baby Z, aged 8 weeks old became subject to an interim Care Order [ICO] to Surrey County Council. The Judge is understood to have expressed support for the MBU placement. At this point Baby Z was 12 weeks old and had previously only been in her mother's care for 8 days from 05.10.16 before being admitted to hospital.

3.11.2 Following admission, the MBU confirmed that they do not offer parenting assessments and this could *not* be done on the unit by others, albeit could be undertaken off site at a children's centre. Moreover, immediately after mother and Baby Z moved into the ward, the MBU told the social worker that mother was not acutely mentally unwell and so not needing the MBU services, hence a specialist resource may be best option.

3.11.3 On 16.12.16 SCS ended the CPP on the basis of there being an ICO; this is usual practice. Instead of multi-agency core group meetings, looked after children statutory reviews are held, which may be multi-agency.

3.11.4 The MBU consultant psychiatrist wrote to the social worker on 16.12.16, confirming a diagnosis of Complex Traumatic Stress Disorder – also known as Emotionally Unstable Personality Disorder and asking for mother and baby to be allowed out together unescorted and that mother had not having overdosed since admission [4 days].

3.11.5 On 21.12.16 a specialist mother and baby parenting residential assessment unit on the South coast confirmed a 12-week placement starting 12.01.17, if mother remained stable. However, the placement would end if mother should self-harm or attempt suicide. This plan was agreed at the Care Planning (CPA) meeting the next day, where the social worker and health visitor observed Baby Z to be calm and content in mother's care, feeding appropriately, clean and well dressed. The issue of mother being able to take Baby Z out unescorted was discussed, but the outcome is not clear, other than SCS service manager said the original decision had been made because mother herself indicated worries about her coping abilities. Although the outcome is unclear in the records, subsequently the MBU proceeded on the basis that this had been agreed and all staff at the MBU who participated in this review understood mother and Baby Z were allowed out unescorted.

3.11.6 Ward rounds and recording generally emphasised the positive progress being made by mother in her care of Baby Z, the interaction between them and her engagement in therapy. Most records state that mother provided all care for Baby Z, but the occasional comment shows that this was not entirely accurate e.g. putting her own needs to go outside for a cigarette for periods, over Baby Z's needs; sometimes taking a while to respond to Baby Z's crying and times when staff helped as mother was feeling unwell or dizzy. There is though no evidence that this was ever discussed with the mother, and how she would manage without staff around to assist. Nor is there any evidence this was communicated to the social worker.

3.11.7 Within the records, although not causing staff concern, it was noted that mother was not eating sufficient food herself, possibly becoming more anxious and found it difficult to discuss her feelings, especially in relation to her lack of bonding with Baby Z. Again, there is no evidence this was communicated to the social worker.

3.11.8 Mother's own physical health caused her problems by the end of the month, with ED attendance on 27.12.16. Mother continued taking a wide variety of medication for pain relief, anxiety and various physical symptoms, including cardiac problems. Her lack of food consumption continued and she reported suffering with gastric problems.

PROFESSIONAL PRACTICE APPRAISAL

The ending of the child protection plan [CPP] once an interim care order was granted is usual practice. However, this brings with it the loss of multi-agency fora i.e. core groups and conferences (this is discussed further in findings 4.6.

No LAC review was held before or following the placement move, on the basis of the move being part of the pre-existing care plan. This meant that there was no formal opportunity to consider the detailed care planning within the MBU, for Baby Z, and to share significant health information. This issue is discussed in findings 4.6.

The specialist mother and baby parenting assessment unit was not likely to be suitable for mother and Baby Z, on basis of mother's previous emotional health, as it required that mother should be stable, not self-harming or overdosing. This was also a realistic requirement if mother was going to be able to make an early success of caring for her baby. Even, if as seemed in December 2016, that mother could be stable, a contingency plan was needed, should matters change.

The detailed records from the MBU do provide some potential concerns about mother's self-care and of Baby Z. These issues were not identified or articulated and were not communicated to the social worker. There appears to have been no link made by MBU staff between concerns about maternal self-care and implications for her ability to care for her baby.

3.12 CONCERNS ABOUT BABY'S Z AND MOTHER'S HEALTH: JANUARY 2017

3.12.1 Throughout January there were constant concerns about the health of mother and Baby Z, which delayed plans for them to move to the specialist mother and baby parenting assessment unit.

1st life threatening event and 3rd hospital admission for Baby Z

3.12.2 On the evening of 04.01.17, Baby Z was increasingly drowsy along with episodes of rapid breathing. She was taken to Royal Hampshire County Hospital [RHCH] where she suffered a cardiac arrest, was resuscitated. The following day Baby Z was transferred to University Hospital Southampton [UHS], on breathing support. She was eventually diagnosed with meningococcal meningitis and returned to RHCH on antibiotics.

3.12.3 Whilst Baby Z was a patient at RHCH, her mother was admitted to hospital with reported symptoms of meningitis and subsequently diagnosed with influenza A. She was discharged the next day, returned to the MBU before staying with MGGM. At this point the MBU were aware of 14 Dihydrocodeine tablets that were missing from the last time when the mother was on leave a few days earlier.

3.12.4 Mother continued to be unwell, attending an urgent care centre with palpitations on 10.01.17 and admitted to a West London Hospital on 10/11.01.17 due to self-reported tightness in her chest and accidental [according to mother's report to the MBU] overdose of anti-psychotic medication and strong painkillers. The hospital wanted to do a CT scan on her brain because of concern about a possible harm, but mother left before this was done.

3.12.5 Whilst the social worker was informed by the MBU of what was happening, there was delay on each occasion. In contrast, UHS staff liaised frequently with the social worker whilst Baby Z was there.

3.12.6 As a result of Baby Z's illness, the move to the specialist mother and baby unit was postponed till 17.01.17. The social worker noted that mother was quite distressed at this time and the Surrey CMHT were asked to provide support to mother.

Baby Z placed with foster carers

3.12.7 Baby Z was ready for discharge on 11.01.17, but because of mother's illness, she was placed with a foster carer, a nurse for 6 days, until the MBU was able to have them back again.

3.12.8 On return to the MBU, mother was tearful, asking for more time on the MBU to prepare her for the move to the specialist mother and baby assessment unit. Arrangements were made for the psychiatrist to see mother and Baby Z slept in the nursery for 2 nights because of her mother's anxiety and distress. The report written at MBU on 19.01.17 refers to Baby Z being a 'protective factor' for mother, but there is no mention of impact of mother's mental health on Baby Z (see comment about this below).

Baby Z suffering from food poisoning and a 4th hospital admission

3.12.9 On 20.01.17 Baby Z was presented at Royal Hampshire County Hospital [RHCH] having reportedly been unwell for several days and diagnosed with food poisoning [campyolacter], unusual in a child not eating solids. The foster carer reported she had herself been sick the night before Baby Z left and thought it may be food poisoning. The Surrey social worker did not warn the MBU, despite the risk for other babies.

3.12.10 Baby Z remained in isolation for 10 days within the MBU on anti-biotics. It is of note that the stool/vomit chart initiated on 19.01.17 was inconsistently completed, so unable to monitor Baby Z's health. Staff continued to care for Baby Z at night, albeit Baby Z was in her mother's room. This continued intermittently during the remaining days, with one mention of mother not waking up when her baby was crying on 25.01.17

3.12.11 Baby Z was taken by ambulance to RHCH with her mother on 22.01.17, as she was unresponsive and not feeding. Medical view was dehydration and she was kept in overnight and discharged with a feeding plan. From the records the MBU did not inform the social worker of Baby Z's hospital admission**,** despite the social worker's repeated requests for updates and information of concerns about Baby Z's health and welfare. It is not possible to tell if Baby Z was consistently fed according to the plan as the feed charts were incomplete.

Mother's emotional and mental health

3.12.12 Following the 2 bouts of Baby Z's illnesses, and with the move to the specialist residential mother and baby assessment unit approaching, mother became increasingly stressed and anxious, suffering nightmares and worrying if Baby Z had brain damage or that she no longer liked her mother as she was not laughing and giggling. She was not eating much food herself and walking out of 'emotional coping skills group' during discussions of healthy eating as means to increase emotional resilience.

3.12.13 Generally, the judgments of mother's progress at the MBU were positive, despite frequent recorded descriptions of mother's worrying behaviour [see 3.12.12] so close to discharge. Instead of identifying risk factors to Baby Z from mother's state, concern was focused on suggesting that the identified plan be changed and a mother and baby foster placement be provided as an alternative with medications for mother changed/ increased. The MBU advocated this to other professionals and in a letter to the court on 26.01.17, despite the social worker not considering this as a safe option.

3.12.14 Mother declined to see the worker from the specialist residential parenting assessment unit when she visited on 24.01.17, saying she was unwell: in fact this was untrue as she was in the lounge being taught to knit. The MBU did not inform the Surrey social worker of this. The specialist mother and baby assessment unit worker asked the Surrey social worker if the mother was reluctant to leave what was a protected environment and whether mother was involved in any of Baby Z's recent significant illnesses.

Baby Z's 2nd life threatening event and 5th hospitalisation

3.12.15 On 28.01.17 mother was concerned that Baby Z was sleepy. Staff kept checking Baby Z and the view was that her temperature and breathing were normal and her colour good. She had fed during the day, but the recording is not comprehensive and also contradictory, so the extent to which she fed is not clear. In the evening mother became more concerned but declined the offer of going to the local hospital, RHCH, or obtaining advice from a paediatrician there. Instead she decided that UHS would be better and arranged for a friend to take her there. The friend's car reportedly broke down, so staff called a taxi for mother at mother's request. They did not call an ambulance as Baby Z was not judged to be unwell.

3.12.16 By the time mother and baby arrived at UHS Baby Z was critically ill, having seizures with a low temperature and placed on breathing support. Many investigations were undertaken and on 01.02.17 a strategy meeting and child s.47 enquiry was initiated because of the discovery that Baby Z had an unexplained rib fracture, thought to be 10 days old. The health visitor records include that it was considered possible that the fracture could have been a result of CPR at RHCH, or whilst in the care of mother and staff at the MBU. Subsequently there was doubt about the diagnosis of meningitis at Baby Z's earlier hospital admission at the beginning of January – the cause of her illness then remains unknown.

PROFESSIONAL PRACTICE APPRAISAL

Communications between the MBU and the Surrey social worker were slow and incomplete during January 2017, despite repeated recorded requests by the social worker for regular and prompt information and regular written reports. MBU staff also experienced some difficulty getting hold of the Surrey social worker by telephone, but this should not have stopped written communications.

Conversations as part of this review with staff at the MBU indicate that the lack of such communications was associated with a lack of understanding of the implications when the local authority share parental responsibility and a child is subject to care proceedings e.g. that the local authority need to be informed of any changes in:

a) Baby Z's health and welfare including all hospital presentations.

2. The mother's deteriorating emotional state and associated need for increased staff involvement in the care of Baby Z in this period

The concept of Baby Z being a 'protective factor' for mother, whilst a usual term within adult psychiatry relating to protection from the risk of suicide, this was regarded by most of the serious case review panel as an unhelpful concept, which could encourage staff to have a misunderstanding of the priority of the welfare of the child as opposed to the mother.

The lack of consistent completion of feed and stool/vomit charts for Baby Z whilst at the MBU in January are a major concern possibly indicating a lack of focus on Baby Z's health.

The open opposition of staff at the MBU to the planned specialist parenting assessment unit in favour of a mother and baby foster placement, is likely to have confirmed maternal opposition to the care plan. The fact this was promoted with mother and at court is an indication of the lack of understanding of Baby Z's needs as opposed to mother's needs.

The fact of mother taking Baby Z to Southampton hospital in a taxi has been the subject of much discussion within the panel. Whilst this should not have been considered for an ill baby, the view of those on duty that day was Baby Z was not ill, there were no longer restrictions on mother taking Baby Z out alone [although not clear if this change was agreed with SCS] and it was within her rights to take Baby Z to a hospital of her choice. Moreover, staff had no power themselves legally to stop the mother in this action, But SCS did have that power and if they had been consulted may have held a different view. This aspect of child Z's legal position was not appreciated by staff at the MBU throughout the placement.

4 FINDINGS & RECOMMENDATIONS

INTRODUCTION

With the benefit of hindsight, practitioners appear to have been slow to conclude that the mother at this time did not have the ability to provide Baby Z with sufficiently consistent care and nurturing, within a stable safe environment. However, this was not apparent to any of the professionals at the time, except for the Children's Guardian. The following findings explore why at the time professionals did not consider that any assessment of maternal parenting capability needed to commence with Baby Z being safe and secure with carers, whilst assessments took place. These would need to address first mother's ability to keep herself stable and physically well and to fully understand the nature of her ill health, mentally and physically.

4.1 INSUFFICIENT FOCUS ON BABY Z'S NEEDS AS A VULNERABLE PREMATURE BABY

4.1.1 Throughout the period under review, professionals were primarily focused on mother's needs to be assessed and given a chance to learn to care for Baby Z, as opposed to how best to meet the needs of a vulnerable premature baby, whilst assessing whether or not her mother would be able to provide her with the stability, consistency and care she needed at that time.

4.1.2 Whilst practitioners did not have a full understanding of mother's history, the available information on her past and on her level of functioning for much of the pregnancy, suggested that she was erratic, impulsive, constantly suffering from poor physical and mental health, subject to self-harming and the taking of overdoses. Critically, at the end of her pregnancy, she demonstrated an inability to follow professional advice to go immediately to hospital, so placing her unborn baby at immediate risk.

4.1.3 These concerns continued throughout the period under review. Whilst mother was able to care for her baby, practically and at times emotionally, for much of the time, there were frequent occasions when she was unable to prioritise 5-week premature Baby Z's needs e.g. for consistent 3 hourly feeding; feeding even when mother wanted to be asleep or smoking a cigarette. Moreover, the mother was not consistently well enough to care for Baby Z, because of being emotionally stressed and anxious, self-harming and taking overdoses requiring medical intervention. There were also a few occasions when her responses to nurses in hospital were verbally and physically aggressive – such inability to control her feelings and actions should have been identified as a risk to her baby. Most worryingly, there was a period when she felt unable to hold her daughter and spoke of hating her, albeit she did seek help at that point. Mother's volatility, unpredictability and recourse to physical aggression at times meant a high risk of harm for a baby in her care.

4.1.4 Given such a history, the priority needed to be to provide Baby Z with immediate secure and consistent quality care, whilst assessing if her mother could be emotionally stable enough over a prolonged period prior to be able to care for Baby Z.

4.1.5 Instead, whilst waiting for mother to be sufficiently stable to be able to undertake a parenting assessment in the first 4.5 months of her life Baby Z was constantly moved, had 4 different carers. At one point an unknown male (mother's partner) was known by some professionals to be staying in the household, but the impact of his presence was not assessed, despite a report of domestic abuse causing damage to property within the mother's home.

4.1.6 Baby Z was herself ill in this period and had 5 hospital admissions, including 2 near death events. In at least one of her hospital admissions she had no carer visiting as her mother was not well herself and staying with MGGM in London. She was therefore totally reliant on hospital staff.

4.1.7 Prior to moving to the MBU, Baby Z had spent 8 days being cared for by her mother alone [at 19 days old] and this had ended very badly, with her mother suddenly behaving erratically: self-harming, getting annoyed or irritated when Baby Z cried and saying she hated her baby. At this point Baby Z was at high risk of harm. She then returned to MGGM care and it is of note that at that point MGGM told the social worker she did not think mother would ever be able to care for her baby. Appropriately these events triggered the local authority to initiate legal proceedings, but the plan remained to return Baby Z to her mother so a parenting assessment could be undertaken.

4.1.8 By that time sufficient information was known about mother's erratic, impulsive behaviour and the focus should have been on stability for Baby Z, with a move to her mother if and when the mother was able to demonstrate she was emotionally stable and had the ability to put Baby Z's needs consistently above her own. Instead a placement was arranged which was considered to meet mother's mental health needs, where she could also learn how to care for her baby. This was not appropriate though to Baby Z's needs, as the Children's Guardian recognised [according to the chronology from Cafcass].

DELAYS IN PROVIDING BABY Z WITH CONSISTENT AND SAFE PLACEMENT

4.1.9 From the initial CPC in June 2016, the plan was for mother to have family support, involving mother and baby living with MGGM initially in London. The mother and baby unit was often mentioned to be put in place if things deteriorated, but this was about mother's mental health needs as opposed to the parenting assessment (see 4.4).

4.1.10 Whilst some professionals have during this review expressed doubts about the family plan, this was not articulated strongly at the time. It is possible the family plan could have worked if there had been a structure around it, with minimum timescales, agreement about roles and tasks and a parenting assessment started before birth and then continued at MGGM's home. Instead no parenting assessment was undertaken and it was the family decided when mother and baby moved to Hampshire.

4.1.11 The manager of the case at SCS in August and September 2016 referred in interview to the lack of evidence to commence the PLO and the need to have transferred the case to Hampshire prior or just after the birth. It may be that the plan to transfer the case was an obstacle to thinking about what measures needed to be in place for the birth of Baby Z, and what assessments needed to be undertaken prior to her birth. By not taking control earlier, the case drifted and Baby Z was subject to her mother's erratic lifestyle.

4.1.12 Once care proceedings were initiated, the local authority still did not take control, and relied on mother's mental health practitioners to identify and obtain a psychiatric placement for mother and baby. This may have been based on the hope that mental health treatment would be able to 'change' mother's emotional and mental health sufficiently to parent Baby Z, or alternatively to be able to say this was not possible. This is discussed further in 4.5.

4.1.13 The parenting assessment that was a critical component of the child protection plan and the subsequent care plan was never implemented, due to a misunderstanding about the role and function of the MBU (see 4.5). A child focused plan following the birth of Baby Z would have been to provide Baby Z with the nurturing, stability and care she desperately needed, whilst assessments of mother were first undertaken, and her ability to achieve sufficient stability and insight in her own life, look after herself adequately and establish her ability to prioritise her baby's needs.

SHOULD LEGAL INTERVENTION HAVE BEEN INITIATED EARLIER?

4.1.14 A dilemma in considering practice in this case is if legal intervention should have been decided upon earlier, and if so when that should have been.

4.1.15 It was evident from before Baby Z's birth that the risk for Baby Z of remaining with her mother alone, was too high, given mother's mental and emotional instability. Appropriately it was not considered safe for Baby Z to live in the sole care of her mother from birth without further support and a parenting assessment. The latter part of the plan developed from the initial conference was however never attempted. Had it been tried, it would have been evident that there was never sufficient stability within mother's life to accomplish such an assessment, with the possible exception of the 1st 3 weeks in the MBU (where such an assessment was not available).

4.1.16 The concerns about mother's parenting ability and the obstacles in her achieving sufficient stability to be able to assess her parenting viability in the long term should have been considered during July and August, before the birth in September. However, with SCS focusing on mother's move to Hampshire and the transfer of case responsibility, there was no attempt to do such an assessment. Without such an attempt it may have been difficult to have sufficient evidence to initiate legal intervention at birth, although that would have been the only way to provide security for Baby Z.

4.1.17 The position was the same at the first review CPC, a week after the birth. By this point the risks for Baby Z should have been identified as significantly high and consideration given to legal advice as to how to secure stability for Baby Z either within or outside of her family, whilst also providing mother with support so as to be able to participate in assessments of her ability to parent Baby Z.

4.1.18 Having failed to do this in September 2016, this should have happened in October 2016, when mother was in even more crisis than she had been earlier and MGGM articulated that mother would never be able to adequately parent Baby Z. The decision was taken shortly after this in October, but there was further unnecessary delay in starting the process, with it taking several weeks to hold a legal planning meeting.

4.1.19 This is likely to have been a systemic issue within Surrey at the time, consistent with the with a lack of management oversight and high thresholds for initiating legal action as described by the Surrey Ofsted inspection of 2018, i.e.:

> *'Managers at all levels, including child protection chairs, do not carefully and rigorously evaluate the progression of children's plans. While regular oversight is largely evident, it is not always responsive to escalating concerns or to a lack of progress, and it does not consistently ensure that actions are completed. This trend is particularly apparent where the level of professional concern for children is likely to warrant legal action to safeguard them.'*

FINDING 1:

The focus on mother's welfare, and her need to be given the chance to have her parenting assessed whilst living with Baby Z, meant that premature Baby Z's needs for an emotionally secure, stable and consistent care were not given sufficient priority in the first months of her life.

Following the Surrey 2018 Oftsed inspection there has been a programme of improvement taking place within Children's Services which are designed to address some of the weak practice noted in this serious case review. Surrey SCB should consider what actions are required to assure themselves of the necessary improvements in child focused practice in relation to:

a) **Plans relying heavily on family support** need to specify timescales, details of who does what in relation to the child, how progress is measured, what outcome is expected and a clear contingency plan if it fails

b) **Children's social care plans when there are parental ill health factors, including physical, mental and emotional ill health** need to be child focused, not primarily based on the needs of the 'ill' parent and routinely based on child and adult services joint planning.

c) That whenever a **looked after child is admitted to hospital,** the local authority ensures s/he is visited regularly in the absence of parents /carers presence in the hospital

d) That the **implementation and progress of child protection plans** are monitored rigorously, with contingency plans and legal planning meetings held when insufficient progress is not made

e) That **plans to transfer a case to** another local authority do not act as an obstacle in assessments and implementation of child protection plans.

4.2 IMPACT OF HIGH MOBILITY WITHIN THE SAFEGUARDING SYSTEM

4.2.1 One of the underlying obstacles for all professionals in this case was the difficulty in obtaining a full understanding of maternal physical and mental ill health and the impact this may have on the mother's ability to care for her baby due to:

- The mother having moved around prior to arriving in Surrey
- Living or staying at 4 different addresses during the period under review and
- Registered with 3 GPs and accessing at least 2 GPs and 14 acute health settings in this period – involving at least 47 hospital presentations during the period under review (including scheduled ante natal appointments)

4.2.2 Section 2.1 explains the extremely high number of agencies and practitioners involved with the mother and/or Baby Z during the period under review due to her living / staying in 4 different places in the 10-month time period and accessing a wide number of health services in even more places.

4.2.3 Such a level of mobility means information is spread over a wider geographical area and amongst a high number of practitioners, some of whom are only involved for a brief period of time. This makes it challenging at times for practitioners to have a comprehensive understanding of both the current situation as well as earlier history.

Impact on understanding family history

4.2.4 During the period under review the knowledge of mother's history was limited largely to what she chose to share of her history, along with the information sought and obtained by the social worker from London in the s.47 enquiry and the information given to mental health services via the referral from Lincolnshire mental health sevices.

4.2.5 This history was sufficient to confirm the need for a child protection conference, but was incomplete in terms of evidence regarding mother's ability to care for herself and a baby. Particularly concerning was the lack of detail about mother's health background, and the first social worker at the end of the s.47 enquiry noted mother's refusal to share any information around her mental health.

Specific problems associated with GP records and mobility

4.2.6 There is no record of the GP being approached to contribute information about mother's health history. However, neither of the GP practices with whom mother was registered had her medical records *at the time she was a patient*. This was due to systemic problems in relation to the transfer of patient records at that time, which sometimes took a few months to arrive at the new GP. This was compounded, in this case, by GP1 practice apparently delaying sending on the previous records which only arrived at GP1 practice after the patient had already changed GPs. In consequence GP2 practice only received the mother's records after she had moved to her next GP.

4.2.7 Discussions held with GP1 and GP2 as part of this process highlighted the difficulties individual GPs face. They are NHS Digital not informed of the identity of the next GPs so cannot telephone them to alert them of particular significant information.

4.2.8 Discussions with NHS Digital revealed that arrangements have changed since the period under review, with introduction of secure electronic transfer of information, allowing rapid transfer of records and identification of a patient's GP. There are also streamlined arrangements now for the transfer of non-electronic material, albeit this remains reliant on the individual GP surgery's response. The author was told that there are now systems to check that records have been obtained in these cases, albeit the effectiveness of this needs to be checked [see recommendation below] .

Information sharing

4.2.9 The high and changing numbers of professionals presented real problems in terms of any one individual having a holistic understanding of maternal capacity and needs. Information sharing is especially important in such circumstances. In this case much effort was made by most practitioners to liaise with others and ensure vital information was shared. At times this was particularly problematic because of confusion around which local authority held social work responsibility along with difficulties practitioners reported in contacting the social worker, SCS managers and the CPN.

4.2.10 Overall information sharing was variable.

4.2.11 Particularly commendable information sharing practice was demonstrated by:

- The Hampshire health visitor's [HV2] persistence in communicating with her colleagues in health and with CSC, even though Baby Z only lived in HV2's locality for 8 days. HV2 ensured health visitors in West London knew when Baby Z was staying with MGGM.
- The Frimley Hospital midwifery service communications, internal and external, along with the safeguarding service, which kept SW2 and the child protection conferences informed of the many hospital admissions and allied concerns.

4.2.12 There were though a large number of critical weaknesses in professional communications during this review period:

- Lack of SCS formal notification to both Hampshire and the London borough that a baby subject to a CPP was staying /living in their area [as required by Working Together 2015 – now 2018]
- Child protection conference [CPC] documents were not always received by practitioners– although SCS have told the SCR panel these documents were sent
- Several instances when professionals were not informed about Baby Z's movements – albeit usually this information was communicated
- The Surrey Designated Nurse for Looked After Children [LAC] was not informed about Baby Z's placements as a looked after child
- The MBU did not provide consistent and timely communications with the social worker (see 3.12) and did not inform either RHCH or UHS that Baby Z was subject to an interim care order
- RHCH did not liaise with either the MBU or SCS (in contrast with USH which understood the need to liaise with SCS)

- Delay in health visitor referral from midwife
- The health visitor was not provided with information on maternal mental ill health episodes

Systemic Improvements to health information sharing

4.2.13 Since the time period under review, the development of NHS Child Protection – Information Sharing (CP-IS)[vi] is a helpful tool in improving information sharing practice by connecting systems between local authorities and unscheduled health settings e.g. emergency departments, walk in centres, minor injury units and maternity units. This provides an alert accessible to the settings within the NHS Spine to indicate that the child is subject to a CPP or is a LAC. The CP-IS system also sends a notification to the Local Authority who have the responsibility for the child, to alert them to the unscheduled care setting attendance.

CSC case responsibility

4.2.14 From the time when mother moved to Hampshire (mid-August 2016), until the point the decision was taken to initiate care proceedings at the end of October 2016, SCS planned to transfer the case to Hampshire and told health colleagues of this imminent intention.

4.2.15 However, this had not yet been agreed with Hampshire and SCS did not complete the transfer process and did not formally start it till mid October 2016. There seem to be a variety of reasons for this including an initial misunderstanding at the time of the move, whereby the social worker thought that Hampshire would not accept the transfer until mother had lived there for a month. There is no evidence how this misunderstanding occurred, but SCS should have challenged and escalated it. This did not happen and the attempts to transfer the case were delayed till October. Unfortunately, the belief the case was about to transfer, contributed to the lack of implementation of the child protection plan and may have also contributed to the lack of effective monitoring of progress of the case.

4.2.16 Mother and Baby Z were only briefly living together in Hampshire for 8 days before Baby Z was ill and admitted to hospital. She never lived subsequently in the Hampshire flat. With uncertainty about her future care and the plan to initiate care proceedings, SCS appropriately maintained case responsibility.

[vi] digital.nhs.uk/services/child-protection-information-sharing-project/benefits-of-child-protection-information-sharing

4.2.17 The confusion within the professional network that case responsibility was /had transferred was unhelpful. Police, Frimley Park Hospital, midwifery and health visitors constantly contacted Hampshire MASH or children's services first, not Surrey children's services. The information shared reached the Surrey social worker, albeit this led to considerable time and frustration being taken up in communications, compounded by the perception [reported by a number of health staff in both Surrey and the MBU] that the social worker and manager were never available.

Measures taken to improve consistency so as to enable better assessment

4.2.18 Overall some practitioners made great efforts to improve communication and understanding of what was happening for mother and baby and overcome the problems posed by her mobility and accessing numerous health services. This was evidenced by:

- Oversight of the case in FPH by the safeguarding team
- Maintaining midwife practitioner case responsibility when the mother moved from Surrey, so as to provide better support and better-informed assessments – however, this appears to have had the unintended consequence of initial poor communication with health visiting, who did transfer case responsibility
- The midwife attended some psychiatric appointments with the mother to be better informed of her mental health problems
- The safeguarding midwife at FPH identified early on the need to collate a chronology, contacting colleagues in neighbouring hospitals – this was initiated as a substance misuse problem (of prescribed medication) was suspected originally.
- The safeguarding midwife asking the community midwife to check the GP records about mother's requests for pain relief from different health settings.

FINDING 2

There are systemic problems for practitioners having full access to historical and current information when working with mobile families and/or those accessing a multitude of services in different areas. The main risk in these cases is being able to undertake holistic assessments based on partial information.

Surrey SCB to consider how to minimise risks of communication weaknesses where there are a large number of practitioners involved with a mobile family. Particular issues to focus on are:

a) That social workers are routinely notifying other local authorities when a child subject to a child protection plan or a care order stays in their area and also that the Surrey Designated Nurse for Looked After Children is notified of the moves

b) To establish how well the child protection conference administration is working in terms of all relevant practitioners being sent and receiving conference invitations and records: this includes both the processes of sending the information and the process of circulation within receiving agencies, when not sent to the allocated practitioner

c) That GPs are now experiencing timely transfer of medical records

d) That adult mental health services inform health visitors as well as social workers of parental mental health episodes and the consequent ability of a parent to care for her/his child/ren

NHS England to consider how to be assured that changes implemented at the MBU have led to a staff group who now understand

e) the significance of child protection plans and shared parental responsibility in care proceedings in terms of the need to reliably communicate with other agencies, and in particular with social workers, around any circumstances affecting the welfare of the child.

4.3 HIGH USAGE OF HEALTH SERVICES

Mother's ill health

4.3.1 One of the features of this case was the high usage mother made of acute health services, in different geographical areas, for a variety of physical health issues. These were self-reported by mother and she received medication in line with her reported diagnosis.

4.3.2 There was some suspicion mother may have misused her medications and might be addicted to strong pain killers. There were incidents both at FPH and at the MBU of drugs suspected of going astray as well as reports by a friend of hers and a previous housing provider that mother 'hid' and stored medication. Partly this was perceived as being to enable her over doses.

4.3.3 At FPH in July 2016 a consultant tried to understand the mother's physical health and became doubtful of her gestational diabetes diagnosis. In conversation for this review the consultant explained the concerns at this point with the mother having had 2 diabetic hypos, with 3 different hospitals involved and some doubt about the diabetes diagnosis. The consultant asked the mother if she had taken extra insulin at one admission, but mother was adamant she had not. Mother presented again a few days later with 4 hypo episodes, but refused diabetic screening and discharged herself. On this occasion it was suspected she had taken insulin home with her from the ward, but she denied having done so. She continued to decline and/or avoid several attempts made in hospital, in the antenatal clinic and at home to provide diabetic screening.

4.3.4 The consultant wanted to discuss these observations with the GP and telephoned GP1 during 2 different hospital admissions in July 2016 but got no response. On each occasion the consultant subsequently wrote to the GP explaining these concerns and in particular the queries about the diagnosis. The 2nd letter stated clearly that blood checks 24 hours after admission of the last insulin dose suggested that mother, despite her denials, had taken a further dose of insulin whilst in hospital. The letter refers to calls to another hospital, no history of a formal glucose tolerance test and lack of clarity how the diagnosis of gestational diabetes mellitus [GDM] was made. Mother refused to have a glucose tolerance test or home glucose monitoring and was aware that untreated GDM presents risks to the baby. There was though no direct confirmation of GDM apart from a couple of high blood sugar readings by the patient in her monitoring booklet.

4.3.5 The consultant explained (as part of this review) of wanting to ensure the GP was used as a central point to verify medical conditions. However, GP1 (in a conversation as part of this case review) said that s/he perceived that the consultant was managing this aspect of mother's health. In fact, there was a vacuum and no professional actively managed the implication of the consultant's concerns that the mother may have been fabricating or inducing her own symptoms of ill health. The consultant did not articulate or identify this as a suspicion, because of the need first for further investigation. She identified it as a possible risk to the mother's health, but not for the unborn child.

4.3.6 The consultant referred to mother being monitored under the 'safeguarding' umbrella in the letter to GP1, but without any clarity about what this meant. From the GPs perspective it might suggest that all was in hand. In interview the consultant explained an assumption that colleagues in maternity would inform the safeguarding midwives of such concerns. In fact, the possibility of mother's s concern was never articulated and any potential risks of this to the unborn child were consequently not investigated further. Hospital midwifery were unaware that there was any doubts about mother's reported diabetes diagnosis. Whilst all were aware of the more general safeguarding concerns arising from mother's mental ill health, this potential issue and any possible implications for the (at that time) unborn baby was never discussed or investigated further.

Fabricated and induced illness

4.3.7 Fabricated or induced illness [FII] is a condition whereby a child has suffered, or is likely to suffer, significant harm through the deliberate action of their parent / carer and which is attributed by the parent to another cause.

4.3.8 There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history;
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid;
- Induction of illness by a variety of means.

4.3.9 Adults are also known to fabricate or induce illness in themselves. There are a number of different terms used to describe this, although FII is not usually used, even though it does describe the behaviour. Other terms used are, factitious disease[vii], factitious disorder imposed on self [viii], Munchausen syndrome[ix], parent fabricating own health[x],

4.3.10 The possible relevance in this case is in terms of the lack of understanding of mother's own health problems and the 2 near death experiences of Baby Z. It is not known if any illness to mother or baby was in fact fabricated or intentionally induced in either case, but the concern is based upon:

- The toxicology report that identified that Dihydrocodeine was present in Baby Z's urine on the day she was presented at Southampton University Hospital ED on the 28.01.17: this was a medication prescribed to the mother
- Mother presented at a large number of different health settings and reportedly suffered and was given medication for a variety of health conditions, including cardiac conditions and gestational diabetes

Baby Z's ill health

4.3.11 Baby Z suffered 2 life threatening illnesses, recovering quickly once in hospital. The cause of the first incident in early January, is unknown as the initial diagnosis of meningitis, was put aside subsequent to further testing showing there had been a false positive result. On the second occasion test results showed that that Dihydrocodeine was present in Baby Z's urine when she arrived at Southampton University Hospital [SUH] ED on the 28.01.17: this was a medication prescribed to the mother.

4.3.12 At no time in the period under review was there any suspicion that Baby Z had in any way been subject to having an illness fabricated or induced and there is no evidence that staff should have been aware of this risk.

Links between carer fabricating own ill health and fii by carer of child

4.3.13 Had there been any suspicion that mother may have been fabricating or inducing any of her own physical ill health symptoms, practitioners and panel members have all said that this would have alerted them to risks to Baby Z, along with the view that the risk of placing them together in the MBU in all likelihood would have been too high. Staff at the MBU have said if they had known about these suspicions it is doubtful they would have accepted mother as a patient.

[vii] http://sciencenordic.com/feigning-illness-gain-attention

[viii] The perpetrators of medical child abuse (Munchausen Syndrome byProxy) – A systematic review of 796 cases, Gregory Yates, Christopher Bass, Child Abuse & Neglect 72 (2017) 45-53

[ix] http://sciencenordic.com/feigning-illness-gain-attention

[x] http://www.thurrockccg.nhs.uk/about-us/document-library/safeguarding-children-key-documents/691-fabriciated-illness-final-report-nov-14-3/file

4.3.14 The literature on FII highlights that the carers of children who have suffered FII often '*as with many parents who abuse or neglect their children, specific aspects of their histories are likely to have been troubled.*' [xi] including being victims of childhood abuse, having experienced a number of physical health problems, which may or may not be substantiated by medical investigation, deliberate self-harm, complicated obstetric history and history of mental health problems with some being diagnosed with a personality disorder.

4.3.15 Recent research of perpetrators by Yates & Bass has provided a strong evidence base of the link between the 2 conditions[xii]. With the most common psychiatric diagnoses recorded as factitious disorder imposed on self (30.9%), personality disorder (18.6%), and depression (14.2%). The authors conclude that

> *' From the largest analysis of MCA perpetrators to date, we provide several clinical recommendations. In particular, we urge clinicians to consider mothers with a personal history of childhood maltreatment, obstetric complications, and/or factitious disorder at heightened risk for MCA. ……'*

4.3.16 The 2011 study by Bass & Jones[xiii] provides an even stronger link, with 64% of perpetrators of FII in children have previously fabricated symptoms.

Conclusion

4.3.17 Mother had a high level of acute health presentations for a variety of self-reported physical ill health conditions, including diabetes and cardiac disease. When the consultant at FPH tried to arrange further testing to obtain a better understanding of the causes of the symptoms, mother did not co-operate with such investigations.

4.3.18 It is not known if the mother in this case self-fabricated or induced the symptoms of any of her own reported illnesses. However, given the high level of health services attendance and reliance on self-reported diagnosis, further investigations were needed into the cause of these symptoms. To be able to do this requires medical information from a variety of health settings to be joined together. In this case, the consultant assumed the GP would do this, whilst GP1 assumed the consultant would.

[xi] Safeguarding Children in whom illness is fabricated or induced, DSCF 2008

[xii] The perpetrators of medical child abuse (Munchausen Syndrome byProxy) – A systematic review of 796 cases, Gregory Yates, Christopher Bass, Child Abuse & Neglect 72 (2017) 45-53

[xiii] Psychopathology of perpetrators of FII in children, Christopher Bass & David Jones BJPsych 2011

4.3.19 Another obstacle in establishing the nature of mother's physical ill health was the short time any individual health practitioner or service knew her; this highlights the increased risk with mobile families and those accessing a multitude of services, because the systems do not facilitate systems to easily obtain and analyse health histories. Whilst GPs may have access to the information [when the records have transferred], few are likely to have the time to do the research and analysis required.

4.3.20 When there are suspicions that a pregnant woman, or a parent or carer, is a high user of acute health services with self reported diagnosis of chronic health conditions there is a need for further investigation and verification of the cause of the symptoms, and consideration of the possibility that the symptoms could be being induced or fabricated, as this could not just be a risk to the health of the woman, but also a risk to the inborn child.

4.3.21 Current improvements in health information sharing via CP-IS (see 4.2.13) will help here if the individual has children linked to her/his records who are either looked after by the local authority or subject to a child protection plan. However, if this is not the case, CP-IS will be of limited help.

FINDING 3

When a pregnant woman or parent is a high user of health services, health practitioners should always consider any impact this may have on the unborn baby and/or children in the household.

Hampshire and Surrey SCBs to consider:

a) how to make practitioners more aware of the possible safeguarding risks to children when parents and/or pregnant women are high intensity users of health services, including the consideration of the potential for self-fabrication or induction of illness

b) does this have national systemic implications on the communication and analysis of patient health information, especially in relation to mobile families and those accessing a large number of different health providers?

Hampshire and Surrey SABs to consider:

c) how adult health practitioners are better able to analyse health information in the context of adults who are high users of health services, including the consideration of the potential for self-fabrication or induction of illness and the impact of the behaviour on the unborn baby and/or child

d) the need for a key health practitioner with responsibility to analyse medical and health information in the context of patients over or mis-using health services

4.4 SUPPORT AND TREATMENT OF MOTHER'S MENTAL ILL HEALTH

4.4.1 Throughout the period under review, and for a considerable period of the mother's life, she was in receipt of mental health services. She was diagnosed with having a borderline personality disorder (also known as Emotionally Unstable Personality Disorder).

4.4.2 During the period under review mother's behaviour was characterised by unstable and impulsive behaviour, self-harming and suicide attempts, aggression at times along with observations that she often was unable to prioritise her baby's needs over her own needs. This was highlighted by her refusal to go to hospital when advised by the midwife, resulting in an emergency caesarean birth, her difficulty on the ward waking to feed Baby Z and placing her need to go out for a cigarette above Baby Z's needs for a feed.

4.4.3 Throughout the period under review there seems to be an absence of analysis of mother's mental health issues and the real prospect of what this would mean in terms of her parenting capacity. The child protection plan did not specify exactly what assessments were required by the mental health practitioners involved, especially in the critical pre-birth period.

4.4.4 In general, mental health staff were supportive of what they felt was the progress the mother made when she was able to undertake the practical parenting tasks, without consideration of how well she would be able to sustain this. In particular if, without staff around, would mother always wake to feed Baby Z, give priority to feeding her when she wanted a cigarette and avoid self-harm and overdosing when upset.

4.4.5 Other health and social work professionals seemed to hope that psychiatric and mental health treatment would be able to help and support mother so that she would then be able to be a good enough parent. Given the long-standing nature of the maternal mental ill health it is likely that such progress would take considerable time and would involve the therapeutic interventions which mother largely avoided when offered in the community and in the MBU – ones that involved commitment and reflection. The CPN explained mother was offered 'dialectical behavioural therapy (DPT), a new form of CBT lasting 18 months, and needing full patient engagement and 3 hours per week commitment'. However, such commitment was not possible for mother. At the initial CPC mother was described as declining psychotherapy, opting only for seeing the psychiatrist and the independence worker. MBU, staff told the author that mother declined sessions that involved self-reflection.

4.4.6 One of the main challenges in child protection in relation to parental mental ill health in general and EUPD in particular, is evaluating the impact of the parental illness on the child and the likelihood of change. There is no evidence that this was done, with plans being based on hopes of mother becoming well enough, without any evidence at the time that she had the motivation, commitment and insight necessary for such change.

4.4.7 The Surrey adult services panel member suggested that the work of the Surrey psychiatric services in supporting and treating the mother would benefit from being subject to an adult review to learn lessons about the co-ordination of services in such cases.

FINDING 4

Practitioners working with Emotionally Unstable Personality Disorder parents need to have an understanding of the potential impact of this on parenting, associated risks to the child, what types of treatment are effective in enabling change and the challenges in doing so.

Surrey SCB to consider:

a) How to increase awareness of parental Emotionally Unstable Personality Disorder and the potential impact on children? ?

b) Whether child protection plans involving child/ren [or an unborn child] of parent/s with mental health difficulties need to specifically address the expectations of mental health practitioners to not just provide support to the parent, but to assess the potential for change of the parent, what steps will be involved and the likely timescale for these.

c) Referring this case to Surrey SAB for review of the lessons to be learnt in terms of the co-ordination of services.

4.5 MOTHER AND BABY UNIT PLACEMENT

How was decision made on this placement?

4.5.1 From the outset, there was a view amongst health staff, both at FPH and within the mental health service, that a mother and baby placement was the desired plan for the mother. Whilst the child protection plan was for family support with mother and baby to stay initially with MGGM, it was always part of the plan for mental health services to make a referral to a mother and baby unit [MBU] should mother's mental health deteriorate. This happened in October 2016, when mother was an inpatient. The referral (made from the psychiatric ward where mother was an in-patient) was for a unit within a psychiatric hospital, designed for women who have severe mental illness from 24 weeks of pregnancy until a child is one year old.

4.5.2 As discussed in 4.1, this plan was based on mother's mental health needs and the treatment she was thought to need so as to be able to parent, along with the perceived positive view that this would enable the development of bonds between mother and baby. But there were problems relating to the choice of placement and the admission process.

Admissions process

4.5.3 It is now evident that such a placement should never have been made and was based on insufficient knowledge of mother's mental illness. When the referral was made in October, it is possible she may have met the criteria, as she was acutely unwell, but by December this was no longer the case: mother had been discharged from hospital, therefore unlikely to still be suffering from an acute mental illness. It is not clear why any changes in mother's mental health since referral was not considered by the MBU prior to admission. Up to date assessments should have been obtained to check a patient satisfies the admission criteria, rather than risk a distressing process for mother and baby of being discharged immediately.

The wrong type of mother and baby unit?

4.5.4 Having been admitted to the MBU, the unit itself decided immediately that the mother did not fit the criteria for admission. The social worker also became aware that this was the entirely wrong placement for Baby Z as it was unable to provide the type of assessment needed in terms of making recommendations about whether or not the mother would be able to care for Baby Z in the long term.

4.5.5 It is hard to understand how such a misunderstanding occurred in the first place in the communications between the manager of the MBU and the manager in SCS. However, this discussion should have taken place earlier between Surrey mental health services and SCS, so as to ensure the placement met the needs of both mother and baby. There was also a fundamental misunderstanding about the purpose and functions of mental health provision based around the mother as a patient [with the baby termed at the time as a 'guest' on a hospital ward], as opposed to a setting focusing on the needs of the baby, providing mother with support to learn how to parent, but also assessing her capacity to become a good enough parent.

4.5.6 This does though raise the question as to where parents, such as this mother, should be placed with their babies. If psychiatric wards like the MBU cannot offer assessment, are the specialist assessment units able to cope with this type of parental mental disorders? It is significant that the alternative provision that was planned, specified that they could take mother and Baby Z if mother had no further incidents of self-harm or overdose. This needs to be recognised as an indicator of when such assessment is not feasible, and that changes are needed to be made by the parent prior to having care of her child.

4.5.7 It is also significant that when mother reported to the MBU she had an 'accidental' overdose in January whilst staying in London (see 3.14.4), this was not communicated to either the social worker, or the planned new placement. If this had happened, presumably the proposed placement would have turned down mother and Baby Z.

Should a psychiatric ward MBU have more understanding and provision for assessment as well as treatment and support?

4.5.8 In terms of this case, clearly the MBU was the wrong placement because its purpose was primarily around the mental health functioning of the patient, whilst giving her support to learn and improve parenting skills. Mother did not have the mental health needs for such a placement and the placement could not provide the assessment that was needed for Baby Z.

4.5.9 This does though raise the question whether or not a mental health unit such as this for mothers and their babies should be equipped to routinely undertake such assessments given the potential safeguarding risks that can be associated with parental mental illness.

4.5.10 The need for the MBU to be more involved in the multi-agency safeguarding network has been identified through this case. In talking with staff as part of the review it was evident that they did not fully understand the child protection process, the significance of care proceedings and that the local authority by virtue of the interim care order shared parental responsibility with mother for Baby Z.

4.5.11 This lack of appreciation of the wider safeguarding arena led to unit staff functioning mainly in the role of supporting and helping mother, whilst advocating on her behalf to the social worker. For example, one of mother's workers with responsibility to set the care plan for mother, understood that mother had 'gone off the rails' and the job was to build the bond between mother and baby, not specifically also to assess. She said that the working assumption was the baby was not at risk from the mother, as that was part of admission criteria. She described care plans being developed internally, not with other professionals. She also said she had not personally accessed any information sent by the social worker.

4.5.12 The lack of understanding of the MBU role within the multi-agency safeguarding arena was demonstrated by the lack of regular and detailed written records and communication with the social worker, despite repeated social work request for weekly reports and daily updates. The lack of immediate consultation about, and reporting of, concerns and health events again showed the lack of understanding of the role and function of the social worker in the child protection process. The open opposition to the care plan for the residential mother and baby assessment unit and the advocacy for a foster placement both undermined the care plan and demonstrated a lack of understanding about multi-agency working in such circumstances and the risks in this case in particular.

4.5.13 Staff at the MBU and comments received from managers to drafts of this report do point out that they experienced difficulty in getting hold of the social worker. Whilst such difficulties would make communication more difficult, it does not explain the lack of written emails, progress reports to social workers and timely notifications of medical concerns including hospital admissions.

Changes made

4.5.14 As a result of this case the Southern Health NHS Foundation Trust undertook its own Significant Incident investigation, which, along with much internal management and staff reflection. Staff and managers at the unit told the author that this has led to a considerable number of changes to improve safeguarding of babies on the ward including:

- Babies now have their own separate records – referred to as 'baby RIO' documenting feeding chart and general care
- Babies now classed as patients with their own care care plan [instead of guest] – although not all staff seen were aware of this change of terminology
- Increase in health visitor time to the MBU to 3 days per week – initially for a year but now confirmed as a permanent arrangement
- Health visitor now supervises the nursery nurses
- Separate baby handovers in addition to mother's handovers.
- A new policy in development around escorting unwell children to hospital – but in fact unlikely to apply in the circumstances of this case as staff did not identify Baby Z as unwell on 28.01.17 [NB the author was subsequently informed by a panel member that NHS 9England) is not aware of such developments]
- Where possible an increase of qualified staff on shift from 1 to 2
- Training provided on 'mother infant interaction' and 'babies in mind'
- Weekly weight and body maps for babies
- Mother and baby interactions to be included in recording and MDT discussions
- Group safeguarding supervision commenced

4.5.15 What is not clear though is if these improvements will change the underlying culture in terms of staff understanding their place in the multi-agency safeguarding arena, working together with social workers, developing care plans for mother and for baby jointly and being aware of and understanding the significance of social work information. This will require a shift from their role as supporters and advocates to one that includes their participation in the wider professional safeguarding network. If this is not possible the MBU may not be an appropriate placement for babies' subject to child protection plans or care proceedings.

4.5.16 Staff also spoke about other improvements that they would wish to see to improve their ability to safeguard babies more effectively including:

- Be able to discuss and reflect on what happened openly – after the initial period when it was subject to formal discussion, it has felt taboo to discuss what happened
- Training for those providing safeguarding supervision and consideration of the provision of such supervision being individual rather than group supervision
- Recording of safeguarding supervision

- Nursery nurses to work nights, so increasing capacity to 3 staff instead of 2, and including child care expertise

4.5.17 The first bullet point in 4.6.15, is particularly concerning as suggesting a closed culture, which after the initial responses, is not encouraging reflection and openness.

FINDING 5

There is insufficient professional understanding of the different types of 'mother and baby' resource available, and their different functions, leading to the potential for unrealistic plans being made for mothers with mental health problems and their babies.

NHS England to assure themselves that:

a) The MBU (in this case) has and follows clear admission criteria and processes, which involve obtaining sufficient current information on a prospective mother and baby so as to be able to offer beds only to those that fit the criteria

b) MBU staff have sufficient involvement in multi-agency training which includes information on child protection processes and care proceedings

c) That management and staff of the MBU understand the need to read and review the history of patients, including any reports provided by social workers

d) The MBU now provides adequate assessment of the mother and baby relationship and parenting, consistent with its functions – and that the level of assessment is clearly articulated in written information for professionals and includes risk assessments relating to the need, or not, for supervision of mother and baby both when in and when outside the unit

e) That SHFT and the MBU have a clear pathway for any unwell babies on the unit, including how unwell babies on the unit are managed, how external medical help is sought after for the babies, including when a parent will need an escort from the MBU and what communications need to be made with other agencies

f) The changes made in the MBU have been effective in changing the culture so it can work effectively, in partnership with other agencies and particularly social workers, as part of the wider safeguarding arena and also encourages and enables reflective discussions to take place which support staff in their everyday role on the unit.

g) There is continued quality oversight and improvements on this unit, to ensure there is a culture that embeds safeguarding as core business for all staff working on the unit (including medical staff)

Surrey SCB to consider:

a) How to facilitate those making referrals to mother and baby units understand the different types of units available and when psychiatric mother and baby wards are suitable to use if babies are subject to child protection plans and care proceedings? Do such wards have to provide minimum services in relation to care of the babies and assessments of the mother, and if so, what are these?

4.6 CARE PLANNING

4.6.1 Section 4.2 discusses the difficulties arising from the large number of professionals involved with the family, with Baby Z staying in 3 different geographical areas and her mother accessing health services in various London boroughs, Berkshire as well as Surrey and Hampshire.

4.6.2 Care planning and delivery will be more of a challenge with a high number of professionals; good co-ordination and planning in such circumstances is essential. A number of individual practitioners tried hard to make this happen, in particular the first community midwife, the Hampshire health visitor and the safeguarding team within FPH. Whilst Baby Z was subject to a child protection plan, the initial and review CPCs, and the core group meetings facilitated the multi-agency co-ordination and care planning.

4.6.3 Once the decision was taken to initiate care proceedings, such multi-agency co-ordination tailed off and with the ending of the child protection plan, following the making of the interim care order, care planning becomes the responsibility of the Looked After Children [LAC] system through the statutory reviews and placement planning arrangements. In this case no LAC review was held prior to the placement at the MBU as the move did not involve a change of LAC care plan. Whilst this is consistent with government guidance for LAC reviews, it had the unintended consequence, in this case, of leaving the details of care planning to the MBU, rather than being discussed at a formal meeting. Moreover, if a LAC review had occurred at the MBU, it would have led to further understanding by MBU staff of concerns, Baby Z's needs and what was required. It maybe that a SCS chaired planning meeting could have accomplished this task, but the onus here is on CSC to take such a lead when a child is subject to a care order.

FINDING 6

Whenever looked after children change placements, consideration needs to be given with the IRO to the need to hold a LAC review or other multi-agency planning meeting, even if the move was part of the care plan. This is particularly important in parent and child residential placements or when children are returned to parental care, to promote and facilitate joint understanding, development and ownership of the care plan. It is important that this is chaired by social care and not the residential unit, so clarifying the legal position with other agencies. When such placements meetings are held without the IRO, the IRO needs to retain oversight and challenge of the implementation of the care plan.

Surrey SCB to consider how to be assured:

a) that when a placement is changed that the local authority take responsibility for promoting and facilitating joint understanding, ownership and development of the care plan: this is best done by holding a LAC review or another form of planning meeting

b) that the IRO retains oversight and challenge of the implementation of plans when there has been a major change in circumstances e.g. change of placement, return to parental care and in the absence of any LAC review

4.7 FATHER AND PARTNERS

4.7.1 Practitioners at the time did ask the mother about the identity of the father. She consistently declined to disclose his identity, sometimes saying she was not sure which man he was, sometimes providing one name and at other times another. She spoke of the father variously not knowing of the pregnancy, of him being mentally ill, cheating on her and of having been violent. This information subsequently has turned out not to be true.

4.7.2 It is of note that sometimes practitioner records appear to take mother's word as fact in relation to the father having cheated on her or of being violent – in much the same way as her reported physical health conditions were accepted as fact. It is important that records distinguish between what is known facts and what is being alleged.

4.7.3 Conversely, when a man was seen at the hospital, staff assumed he was Baby Z's father without checking his name and identity. The GP also did not check his name nor record his presence in the family, albeit made no assumption about him being the father. When the hospital mentioned him to the social worker, records indicate she already knew who he was and that he should not have been with mother and Baby Z. However, this information had not been shared with the wider professional network.

4.7.4 Overall there appears to be insufficient focus and shared understanding on the role of the various men in the mother's life, despite the impact this could have on Baby Z.

FINDING 7

Staff in all agencies and settings do not always explore the household and relationships of parents when there are welfare concerns about children. Names and relationships need to be established wherever possible and records should not make assumptions [eg of paternity] and distinguish between known facts and what professionals have been told.

Hampshire and Surrey SCBs to consider:

a) How to change the culture and behaviour of staff in terms of always clarifying and recording the names of partners, being able to distinguish in records the source of information and therefore whether this is known fact or 'as told to them'. Moreover, they need to be able to understand that service users will not always tell the truth about the paternity of children and identity of partners, and therefore this needs careful and delicate probing.

GLOSSARY OF TERMS AND ABBREVIATIONS

CMHT / CMHRS	Community Mental Health Team/ Community Mental Health Recovery Service
CPC	Child protection conference
CP-IS	NHS Child Protection – Information Sharing
CPN	Community Psychiatric Nurse
CPP	Child protection plan
ED	Emergency Department at hospital, previously called Accident & Emergency
EUPD	Emotionally Unstable Personality Disorder [EUPD].
FPH	Frimley Park Hospital
Hants	Hampshire
HCSC	Hampshire Children's Social Care
HTT	CMHT home treatment team
ICO	Interim Care Order
LSCB	Local Safeguarding Children Board
MGGM	Maternal great grandmother
RSH	Royal Surrey Hospital
SCS	Surrey Children's Services
SCR	Serious case review
Surrey County Council	SCC

APPENDIX 1:

Terms of Reference for Serious Case Review into Child Z

Timescales for review;

24/06/2016 – 28/01/2017 (date of presentation to UHS where fractured rib was discovered)

Family members to be included in the Serious Case Review (SCR);

Child Z	Subject Child	DOB 16.09.2016
Child Z's mother	Mother	DOB 21.01.1994

Areas of focus

- Professional's understanding of the situation:
    - What information was available to agencies to inform strategic decisions and assessments of Mother particularly in relation to her mental health, and how this impacted on her parenting capacity?
    - Was this information accurate, timely and reviewed at key points?

- Working across multiple Local Authority boundaries:
    - Was there an understanding across all agencies that Child Z was subject to a Child Protection plan led by a local authority outside of the area where Child Z lived at the time? Was information from agencies in Hampshire, and elsewhere, shared with the local authority in a timely way to inform their care plans and risk assessments? Was information from that local authority shared with agencies in Hampshire who were working with Mother and Child Z?
    - Mother, and therefore Child Z, moved around a number of different areas during the timescales of this review, both to live and receive care. What challenges did this present in relation to cross border working and information sharing? Was there a clear picture of the whereabouts and movements of Mother and Child Z during the period of this review, particularly given that Child Z was on a Child

Protection Plan during this time? What assessment and consideration was given to the appropriateness of placements Baby Z had with friends and family?

- Quality of Professional Practice and Professional Challenge:

    - Was the quality, accuracy and timeliness of referrals / contacts between agencies appropriate?
    - Did the information included lead to robust and appropriate decision making, and, where appropriate, professional challenge?
    - What factors informed the decision making each time Mother and Baby Z were placed in an in patient unit? What oversight was given to decisions on placements? Were these decisions always made by professionals or was Mother able to self-refer herself into in patient placements?

- Professional understanding and awareness of vulnerability and risk factors:

    - What was professionals understanding of risk and vulnerability of the Mother in this case? Was consideration given to factors including;
        - Her mental health and her extensive engagement with known services including Adult Mental Health
        - Substance Misuse
        - The fact that she was in care for a period / previously known to Children's Social Care (out of area) when a child.
        - Her frequent moving locations / residences including staying with other family member
    - What was professionals understanding of the risk and vulnerability of Child Z during this time period? Was Child Z recognised as having safeguarding needs of her own in addition to those associated with her Mother? Was each incident risk assessed individually or was there a review of the whole case at key points to inform a cumulative assessment of risk?
    - What understanding did staff in the inpatient unit have in relation to caring for babies, including their general health and wellbeing? Were they sufficiently trained to understand and identify risk to babies and safeguarding concerns given that their primary focus was to care for the adults who were resident in the unit? Was there evidence that they understood the safeguarding risks to Child Z given Mother's mental health? What role did they play in caring for Child Z, and, was this separate to, or, part of their care Mother?

Methodology

Agencies will be asked to produce an agency report and chronology of events for each child using the current HSCB templates. A Reference Group will be formed to work with the Independent Reviewer.