Swindon Safeguarding Partnership

Serious Case Review
Child G

August 2019

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Swindon Safeguarding Partnership
4th Floor Wat Tyler West
Beckhampton Street
Swindon
SN1 2JG

Tel: 01793 463803
Email: safeguardingpartnership@swindon.gov.uk
Website: https://safeguardingpartnership.swindon.gov.uk

1. Introduction

1.1 This Serious Case Review (SCR) was commissioned by the Swindon Safeguarding Children Board (SSCB) to consider the sudden and unexplained death of a ten-week-old baby to be referred to as Child G[1].

1.2 Child G was a twin. The babies were born prematurely and spent the first six weeks of their lives in hospital. When discharged they lived with their mother, their father, their older half sibling (to be referred to as Child I), and Child I's father, who reportedly owned the home where they lived.

1.3 Mother had another child who was removed from her care by a different local authority prior to 2012 and that child was placed for adoption. There were no known on-going safeguarding concerns about any of the children in the household at the time of Child G's death.

1.4 The father of Child I (Mr. B), who the family lived with, was arrested following the death of Child G. In May 2019 he pleaded guilty to manslaughter. The siblings were appropriately safeguarded by agencies in Swindon following the death of Child G.

1.5 This review has identified learning in relation to the following:
- The need to use unambiguous terminology
- The vulnerability of premature babies
- The importance of applying professional curiosity
- That family members may not always tell the truth
- The need to consult with GPs if there are low level mental health risk or if the family has not always lived in the area

1.6 The following family members are relevant to this review:

Name	To be referred to as
Subject child	Child G
Subject child's twin sibling	Child H
Subject child's older sibling	Child I
Subject child's Mother	Ms. A
Child I's Father	Mr. B
Subject child's Father	Mr. C

2. Process

2.1 An Independent Lead Reviewer[2] was appointed to undertake the review initially. A further Independent Lead Reviewer[3] was appointed in 2019 to complete the published report.

2.2 It was agreed that the SCR would cover the period from **27th July 2016** (when Ms. A attended her booking in appointment with the community midwife) **to 30th March 2017** (the date Child G died).

2.3 The methodology used for this SCR is based on the Welsh Model, a nationally recognised model that ensures that all the core elements of a high quality learning review are in place and

[1] In July 2017 it was agreed that the criteria for conducting a SCR as specified in Working Together 2015, had been met, namely, *'Abuse or neglect of a child is known or suspected. (Regulation 5(2)(a)), and the baby has died'. (Regulation 5(2)(b))*. Ofsted and the National Panel were notified on 1st August 2017.
[2] **Ghislaine Miller**, a Children's Safeguarding Consultant.
[3] Nicki Pettitt is an experienced chair and author of serious case reviews and safeguarding adult reviews. Both Ms Miller and Ms Pettitt are independent of the SSCB and its partner agencies.

that the SCR is proportionate in its approach. The principles of an Appreciative Enquiry[4] were also held in mind.

2.4 Agencies involved in the case were asked to provide an Independent Management Review Report (IMR). They included a detailed chronology for the period under review and an analysis of good practice and emerging issues for learning and improvement of practice. Single agency recommendations were made as required.

2.5 All practitioners and IMR authors were invited to a learning event which provided the opportunity for multi-agency discussion of the issues raised in the terms of reference and further discussion on the identified learning and action points.

2.6 The LSCB Strategic Manager wrote to the parents of Child G and the father of Child I inviting them to meet with the Independent Author. There has been no response, despite various additional attempts to contact them by letter, telephone and an unannounced home visit. A further attempt to speak to them will be made prior to publication of this report.

3. The case

3.1 A neighbouring authority Children's Social Care (CSC) was involved with Ms. A and her oldest child and then later with Child I, this included issuing care proceedings. When the family moved to Swindon, Child I was on a Supervision Order[1] to the neighbouring authority. The order was not transferred to Swindon Council, despite an attempt to do so by the neighbouring authority. There had been concerns about Mother's parenting of the child/ren, and that Mother had been a victim of exploitation herself. There were said to have been improvements and both the neighbouring authority CSC and the court were satisfied that Child I could remain in her parent's care. By the time the care proceedings had concluded Mother was with Mr. B and although he was significantly older than her, it appears he was seen as a protective factor. There was no information of concern held by any agency regarding Mr B.

3.2 Ms. A told the community midwife about the family history when she booked in at the GP Maternity Clinic. This included her previous depression and self-harming, and the involvement of the neighbouring authority CSC with her first two children. She stated that there had been no involvement with CSC since her move to Swindon around three years previously. Mother was adamant that she did not wish to give birth in her local hospital as this was where her eldest child was born, and this decision was respected. The community midwife was not specifically worried but was aware of potential historic risk factors, and completed a Safeguarding Notification Form due to this history and sent it to the Safeguarding Midwife.

3.3 The specialist midwife for mental health and substance misuse was alerted, due to Ms. A's self-reported mental health issues. They reviewed Ms. A's records and recommended she be monitored by her midwife and referred back to her GP if necessary.

3.4 A referral was made to Baby Steps[5] by the community midwife (to provide early help and support to parents) who visited Ms. A at home to introduce her to the programme, then assigned her to a group. Ms. A attended one session with Mr. C, who she introduced as a 'friend'. Following the session, which they left early, Ms. A texted the group to state she would not be returning. The community midwife was informed.

[4] Appreciative Enquiry: Cooperrider, D.L. and Srivastva, S. (1987) Appreciative inquiry in organisational life.
[5] Baby Steps is a perinatal educational programme, designed to help prepare people for becoming parents.

3.5 At 14 weeks gestation it was confirmed that Ms. A was pregnant with twins. The Safeguarding Midwife reviewed the Safeguarding Notification Form, and e-mailed Swindon CSC Family Contact Centre / MASH to ask if there was any current involvement with Child I. She also asked for information about when the case closed if it had been open previously, and stated that Ms. A had said she had a previous child adopted. The request was included in an e-mail that contained queries about a number of different cases. A timely response was received the same day, stating that Child I 'has never been open.' It did not mention the known historic child protection involvement in the neighbouring authority.

3.6 Child G and Child H twin were born by breech delivery at 32 weeks at a regional hospital and transferred to the neonatal intensive care unit (NICU). Ms. A was discharged the following day. Child G and Child H were later transferred to the special care baby unit (SCBU) at the hospital local to the family home. The discharge summary from the first hospital stated there were no safeguarding concerns.

3.7 The second hospital noted that there had been previous pregnancy concerns and contacted CSC. A message was left but the call was not returned. It was documented at the first routine hospital safeguarding round that there had been risk factors from previous pregnancies. The community midwife had visited mother on the SCBU and she informed SCBU staff of the history that was known to her. She was clear that mother was not a 'patient of note' however and that it had been agreed with CSC that health professionals were to monitor the children.

3.7 While the babies were in hospital they were visited by Ms. A, Mr. B and Mr. C. Child I also regularly attended with family members. Mr. C was described as their father and Mr. B as their paternal grandfather.

3.8 During a safeguarding ward round[6] Ms. A's medical and known social history was discussed[7] and it was noted that there were concerns about 'late night and haphazard' visiting at SCBU. It was agreed to discuss this with the parents. A Clinical Discharge Planning Meeting[8] (which was routine practice because of the gestation of the twins) would take place prior to discharge from SCBU. This meeting took place on 27th January 2017. Ms. A and Mr. C, attended and the twins were discharged home on 29th January 2017 following 2 days of the parents living in at the hospital. It was noted on discharge that Child G was more difficult to feed than Child H.

3.9 Prior to Child G being admitted to hospital in respiratory arrest when10 weeks old, Child G was seen at home by the health visitor on one occasion post birth. She had not been able to deliver the planned antenatal visit due to the premature birth, but had done a home visit while the babies were in hospital as well as seeing them after discharge. Child G was also seen by the nursery nurses from the SCBU at home on three occasions, and by the GP once in the surgery. No concerns were identified during the 4 weeks Child G lived at home with his family.

3.10 A number of strategy discussions[9] took place following Child G's presentation on 25 March 2017. Both Child H and Child I were admitted to hospital and had child protection medicals within 24 hours of Child G's presentation, which is good practice. (Although it has been identified that the ambulance service did not check on the well-being of the two children in the home prior to transporting a very unwell Child G to hospital.) The strategy meetings considered all three children and Ms. A's background history. It was noted that there had been no CSC involvement in Swindon and checks with the health visitor and Child I's school were not of concern.

[6] These Safeguarding Ward Rounds were established as a consequence of the Child S SCR published on 14th December 2016.
[7] The named nurse for safeguarding and the consultant of the week were present
[8] Discharge Planning Meetings were established as a consequence of the Child D SCR published on 14th December 2016.
[9] S47 Children Act 1989

3.11 The other children were safeguarded through care proceedings when it emerged that Child G had suffered a severe brain injury that was likely to be non-accidental. Child G died four days after being admitted to hospital.

4. Analysis and Appraisal of practice: identifying key learning issues.

4.1 The analysis section of the report highlights examples of good practice from the agencies involved and also identifies the learning, including if systemic issues impacted on practice.

4.2 Most of the professional involvement with the family during the 8-month timescale of the SCR was with health professionals. The only time another agency was involved **prior** to the presentation of Child G to the hospital prior to Child G's death was when the Safeguarding Midwife emailed the CSC Family Contact Point (MASH) and they responded, and the brief involvement from Baby Steps.

4.3 Following the hospital presentation there was a multi-agency response to the child protection concerns. This included three Strategy Discussions and a S47 investigation.

4.4 The learning from this review is identified by analysing practice in the following areas:

Unborn baby processes:

4.5 The Unborn Baby Protocol was first introduced in Swindon in 2007. Lessons learned from two SCRs involving baby deaths, published in December 2016, resulted in the Unborn Baby Protocol being updated and endorsed by the LSCB. The protocol states its purpose, which includes providing 'all practitioners with guidance to assist with decision making when undertaking pre-birth assessments and when making a safeguarding referral to Children's Social Care.' [10]

4.6 During the booking in appointment Ms. A, who was 8 weeks pregnant, shared information with the community midwife about her past, including having been in the care of the local authority herself and having her first child removed and placed for adoption in the neighbouring authority when she was 18 years old. She divulged that Child I was also the subject of care proceedings but remained with her following an assessment in a Mother and Baby placement. She was made the subject of a Supervision Order in the neighbouring authority for a year. Ms. A said she had suffered from depression in the past and had self-harmed. She said that there had been no involvement with CSC for the past three years and she felt she did not require any additional support. Ms. A told the community midwife that her past experiences had made her concerned about social work involvement and she worried that her new baby would be taken away from her.

4.7 On the basis of all this information, the community midwife completed a Safeguarding Mother and Baby Notification Form (also known as the Safeguarding Risk Assessment Form), which she sent to the Safeguarding Midwife, which was the correct pathway. The purpose of the form was to alert the Safeguarding Midwife, whose task it would be to make checks with the children's social care Family Contact Point (FCP) and to support and advise the midwife if a referral to CSC was needed. In this case the information provided by FCP stated that Child I had never been open to CSC. No further action was therefore taken other than routine monitoring, and as no concerns arose during pregnancy there was deemed no reason for the midwife to make a referral for a social work assessment.

4.8 The midwifery service believe that **had** they put in a formal referral to the FCP, the fact that Swindon CSC had no involvement with Child I means that the referral would have been rejected. The review was told that this was confirmed by the relevant social work managers at a

[10] SSCB unborn baby Protocol, August 2017, paragraph 1.

meeting held following Child G's death. Even with the extent of the past involvement in the neighbouring authority and the fact that the new pregnancy was twins, it was believed that the threshold for a pre-birth social work assessment would not have been met.

4.9 The hospital IMR completed for this review states that there is confusion about the term 'referral' and often midwives use this term for the notification form which goes to the safeguarding midwife. It is possible that Mother also believed that the form she completed with the midwife would lead to a social work assessment, as she asked her midwife what was happening in regards to this. The midwife was aware that there would be no social work involvement following her supervision with the safeguarding midwife. As she was asked by Mother at clinic however, which can be very busy, she did not recall this and while she did tell Mother not to worry, she did not share that no referral had been made. The GP records also state that the midwife had made a referral for a pre-birth social work assessment, although this was not the case. This could be due to the confusion about the status of the notification form, or because Mother had reported this to the GP.

4.10 The Safeguarding Midwife received and reviewed the form in this case. There was a delay of around six weeks due to capacity issues for the Safeguarding Midwife. However at the time CSC were clear that they did not want referrals on unborn babies before 12 weeks, so the delay was not particularly significant. When the matter was considered by the Safeguarding Midwife, she e-mailed the Family Contact Point in CSC / Multi-Agency Safeguarding Hub (MASH). An e-mail response was received by the Safeguarding Midwife the same day that 'Child I has never been open'. This was factually correct, but CSC had information available from the neighbouring authority CSC which should have been shared. The CSC IMR completed for this review states that a discussion could have taken place in relation to the reasons behind midwifery's query in this case, and that this dialogue would have provided an opportunity for more informed information sharing. It appears that the request for information was seen as informal by the FCP and there was a lack of professional curiosity regarding the new pregnancy from those receiving the request for information.

4.11 The Safeguarding Midwife understood that this was not a referral, but a check about the information Mother had shared with the community midwife about her past involvement with CSC. They were following the correct pathway outlined in the Unborn Baby Protocol that states 'the health professional should make an enquiry to the Swindon FCP/MASH to ascertain whether there are any children in the family who are subject to a child protection plan'. The Safeguarding Midwife was reassured that there did not appear to have been any concerns about Child I for a number of years.

4.12 The review was told that there are two types of Discharge Planning Meetings (DPMs) from the hospital SCBU. They are Safeguarding DPMs and Clinical DPMs. In this case because CSC had confirmed in a conversation with the ward manager that they were not involved they were not invited, and the DPM was a clinical rather than safeguarding meeting. There is evidence on the hospital safeguarding ward round form regarding the potential risks and two calls were made to CSC to confirm the children were not open to them.

4.13 Concerns about the 'haphazard' visiting pattern were discussed and recorded prior to the DPM. The parents often visited very late at night, and appeared to be lacking in routine. There were also times when they did not visit, due to having colds, headaches, and so on. They were challenged about this and they explained that Ms. A was still working as she was self-employed, that they did not have a car, and that they had to consider child care for Child I. The reasonswere accepted as there was no reason to believe otherwise. There were also concerns because the baby clothes they had provided smelled of cigarette smoke. None of this was felt

to meet the threshold for a referral to CSC. The ward staff were clear that the concerns would not have met the threshold for social work involvement, but the health visitor was informed.

4.14 There was liaison between the ward and the health visitor who had taken over the case from the community midwife while the babies were in hospital, as is usual practice. During the ward safeguarding round it was agreed that the DPM be postponed because the health visitor had not yet completed the home visit which the Named Nurse felt was essential. The health visitor reported capacity issues, but after challenge from the ward and information being shared about the low level concerns from SCBU she agreed to undertake the home visit before the DPM.

4.15 The DPM was well attended by health professionals, and it was recommended that the parents 'room in.' They were reluctant but did so for two nights, which meant that they did all the care giving for the twins. They were discharged the following day.

Learning Point 1: Professionals need to be clear about the terminology they use, particularly with parents, and be aware that some words like 'referral' may be used for different processes. It is noted that the Unborn Baby Protocol has since been revised

Information Sharing:

4.16 The e-mail exchange that took place between the Safeguarding Midwife and CSC referred to above was an opportunity to clarify the history and consider if there were any on-going concerns bearing in mind the previous risks and vulnerabilities. Instead a simple question was asked and answered, which did not allow for the information held to be shared and considered. CSC had a significant amount of information on Ms. A. It was historic information provided by the neighbouring authority in 2012 when Child I was subject to a Supervision Order. The neighbouring authority had requested that Swindon CSC take over the supervision of the case as the family had moved to the town. This transfer of responsibility did not take place, the neighbouring authority continued working with the family until the Supervision Order expired in December 2013. Child I later started school in Swindon and the school were not aware of the previous history.

4.17 When considering why this information was not shared with the Safeguarding Midwife in order for them to consider any potential risks and decide whether there was a need to provide additional support or safeguard the unborn children, it has been found that the question asked was short and closed and this appears to have elicited a short and closed response. The MASH team did not enquire why the information was being sought and did not share the information they had on record. Without the right question being asked, without asking for the reason for the question, and without the effective sharing of known information regardless of the question, there was limited opportunity for any of those involved to consider if the matter met the threshold for a pre-birth assessment. Midwives and other professionals request information and expect that they will receive all the information that is relevant to an unborn baby, and the system in place at the time does not appear to have been effective in regards to this case.

4.18 Previously a monthly meeting was held in the hospital which was attended by the hospital social work team, the liaison health visitor and the Safeguarding Midwife, to discuss patients of note, including those where there may be safeguarding concerns. The decision was made in 2015 to stop these meetings as they were becoming onerous and because the liaison health visitor post was removed by the local authority. The process that replaced the meetings was that the Safeguarding Midwife would call CSC for information and discuss the cases, however CSC then said they could not manage this process as it was resulting in tying up a member of their staff for long periods of time, so they said the Safeguarding Midwife should e-mail a list of

any requests for information direct to the Family Contact Point/MASH. This is what happened in this case.

Learning Point 2: There is evidence from this case that there was a potential systemic weakness in the way that information about unborn babies is sought and shared.

Professional curiosity

4.19 The community midwife had contact with Ms. A before and twice after the birth of the twins. She had been introduced to Ms. A's husband (Mr. B) as the father of the unborn babies. He attended a number of appointments with Ms. A and she told the midwife that he had been a positive factor in helping her to be a good parent to Child I. Although it wasn't confirmed, it was presented by the parents that the decision made by the court and the neighbouring authority CSC that Child I should remain in her parents care was in large part to do with the positive presence of Mr. B. While the midwife noted that Mr. B was significantly older then Ms. A, she had no reason to doubt the family situation as presented.

4.20 Ms. A was adamant that she did not wish to give birth in her local hospital, as she identified it as the place that had been involved in the removal of her first child. A home birth was not possible, due to the expected babies being twins, but Ms. A's wish was respected and her obstetric antenatal care was transferred to a different hospital. Her community midwifery care remained with her local hospital. Engaging with Ms. A about this issue and respecting her wishes demonstrates good practice.

4.21 Ms. A, Mr. B, and Mr. C were all known to a number of hospital staff in the two locations following the premature birth of the twins, who spent six weeks in hospital. After giving birth some issues were identified with Ms. A's unusual behaviour. She 'went missing' on several occasions, was absent from ward rounds, and self-discharged herself against medical advice. This information was not shared with staff responsible for the twins.

4.22 On the SCBU Ms. A presented Mr. C as the twin's father and Mr. B as their paternal grandfather. The ward staff had no reason to be suspicious and were not aware that the community midwife had been told a different story or that the birth certificate stated that Mr. B was the father of the boys.

4.23 Baby Steps involvement with Ms. A during her pregnancy was limited. They visited her at home but she attended just one group session. She attended with Mr. C who she described as a good friend. She said her husband and the twin's father was Mr. B, who was working.

4.24 Two SCBU nursery nurses undertook follow up home visits to Ms. A and the twins. This is routine practice for babies of such prematurity. They identified no concerns.

4.25 It is clear now that the family misled professionals regarding their family composition. They gave different information to different groups of professionals. This was not evident at the time however, and as a case where support is universal there is no expectation of extensive information sharing. Even though there was a visit from the community midwife to the SCBU, Ms. A appears to have ensured this was when neither Mr. B nor Mr. C was around.

4.26 In 2014 the NSPCC published a summary of learning from SCRs about disguised compliance. This involves parents giving the appearance of co-operating with agencies to avoid raising suspicions and to allay concerns. This can be an effective way of ensuring that professionals delay or avoid interventions, and to ensure that professionals are not aware of any concerning issues within the family. Professionals need to ensure they triangulate what parents are saying by establishing the facts, gathering evidence about what is actually happening, and communicating well with all involved.

4.27 The SCBU nurses did show curiosity about the erratic visiting and asked the parents on several occasions why they were not spending more time at the hospital. They also liaised with the health visitor and asked her to encourage more regular visiting. The health visitor spoke to the parents and found that Ms. A's upset at the recent death of her father and some health issues were a plausible reason and gave this feedback to SCBU.

Learning Point 3: None of the professionals involved had any reason to question the information given by the family regarding who the father of the children was. The adults in this case convincingly lied to professionals without raising any suspicion. Professionals should always be alert to the possibility that family members may not always tell the truth, and triangulation of information between professionals is good practice in cases where there have been previous concerns.

Mental Health Support

4.28 The Specialist Midwife for mental health and substance misuse reviewed the notification form from the community midwife during Ms. A's pregnancy. The outcome was that her moods were to be monitored at each antenatal appointment and the GP was to be notified of any problems. Ms. A was not seen by the specialist midwife for mental health at any point in the timescale as she did not meet the threshold for this intervention.

4.29 Mother had self-disclosed mental health difficulties. There is no evidence that confirmation from any professional regarding the extent of the mental health issues was sought or provided. The specialist midwife checks the hospital records for any mental health attendances, and there is an expectation that if there are current mental health concerns then the GP would notify the community midwife. Mother's mental health was monitored during the pregnancy by the community midwife and no significant issues emerged that required specialist input.

4.30 In regards to the health visitor who took on the case following the birth of Child G and Child H, they would have received the Mother and Baby Safeguarding Notification as it was sent to child health by the Safeguarding Midwife and this form had the risk factors stipulated on it. The SCBU also shared this information with the health visitor. The majority of parents who suffer mental ill-health are able to care for and safeguard their children and/or unborn child, however it is important that professionals understand the extent of the issue and consider what additional support may be required.

4.31 There is no evidence of any communication between the GP and the community midwife. If there had been there would have been the opportunity to discuss the extent of Ms. A's self reported previous mental health issues, and an opportunity to clarify that a referral to the FCP had not been made. The GP records from previous addresses would have been available to the GP.

Learning Point 4: When an expectant mother discloses a history of mental health concerns and adverse childhood experiences, as was the case here, consideration should be given to consulting with their GP.

5 Conclusions

5.1 Despite the parents actively deceiving professionals in order to avoid scrutiny, which would have been difficult for professionals to identify at the time, lessons have been learned about the way that partner agencies of the SSCB worked together in this case.

5.2 The Unborn Baby Protocol at the time outlines how agencies should work together to safeguard vulnerable babies where risk factors relating to the parents have been identified. The community midwife followed the process by completing a Safeguarding Notification Form and sending this to

the Safeguarding Midwife. They then followed the protocol by reviewing the form and checking with CSC if there was any involvement with the family. However systemic weaknesses have been identified in regards to the expected way that information is sought and provided from the FCP.

5.3 There is no certainty that the case would have met the threshold for an assessment by CSC as there had been no concerns about Child I since she moved to the area, even with the family history, Ms. A's reported historical mental health issues, and the added stress of new born premature twins. The provision of early help may have been suitable, but this is only possible with parental consent, and Ms A had stopped going to Baby Steps after one meeting.

6 Recommendations.

6.1 The lessons from this case have been highlighted within the analysis section above. The SSCB along with the SCR author have considered these lessons and have identified recommendations for the SSCB.

6.2 Each participating agency was required, as part of their IMR, to identify any single agency learning and make recommendations for service improvement where appropriate. The SSCB will seek assurances from agency leads that the recommendations have been addressed.

6.3 In some cases there are actions in place from other case reviews, or processes such as improvement plans, that address the learning identified. There have also been changes to processes, such as the way that information is sought from the FCP by the midwifery service. These actions or changes will be outlined in the published response to this review.

6.4 While this review has identified issues regarding the seeking and sharing of information between the MASH and the Hospital Trust, this is an issue that could apply to all partner agencies. Recommendation 2 acknowledges this.

Recommendation 1:
The SSCB to seek reassurance from partner agencies regarding how it will ensure that staff use the correct unambiguous terminology.

Recommendation 2:
That the SSCB request assurance from partner agencies that the new system put in place in 2017 for requesting and sharing of information on the families of unborn babies is making a positive difference for children in Swindon. (This should include a dip sample audit.)

Recommendation 3:
The CCG to provide information and assurance to the SSCB on the role and capacity of the Safeguarding Midwife.

Recommendation 4:
The SSCB to ask its partner agencies how they will ensure that professionals robustly test out information provided by service users.

Recommendation 5:
Recommendations in relation to Learning Point 4 have been made in other recent serious case reviews in Swindon. The SSCB should seek assurance from partner agencies that the required improvements are embedded.