chscb

Serious Case Review

Child H

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safeguarding
children board

Background

- Child H died at age six weeks in spring 2014.
- Medical advice indicated that she died as a result of inflicted injuries.
- Death of Child H could not have been anticipated by any of the services or professionals involved with the family.
- No-one has been held to account for her death.

Scope and Focus

- Reviewed at SCR Sub Group in July 2014.
- Independent Chair decided to initiate a SCR.
- Decision in line with Regulation 5 of the LSCB Regulations 2006.
- Process consistent with statutory guidance set out in Working Together to Safeguard Children (2013) (since revised in 2015).

Methodology

- Independent Reviewer & Review Team.
- Individual Management Reports.
- Multi-Agency Chronology.
- Interviews with staff.
- Interviews with parents and extended family.
- Final report produced.
- Feedback to parents and extended family.

Involved Agencies

Hackney Council

- Children's Centre
- Hackney CYPS (Children's Social Care)

Health

- City and Hackney Clinical Commissioning Group
- General Practitioners
- Homerton University Hospital NHS Foundation Trust
- East London NHS Foundation Trust
- London Ambulance Service NHS Trust

Metropolitan Police Service

Background

- Mother adopted in infancy.
- An older boy also adopted – (he died during the period under review)
- Both parents had specialist education provision as children.
- In a relationship for about 3 ½ years
- Lived together for 2 ½ years.
- There had been some difficulties between them, including a brief separation in 2011.
- Both parents lived with maternal grandparents.

Background

- Mother's GP had helped her with anger management / mental health issues believed to be linked to experiences in early years.
- However, prior to pregnancy no contact with specialist mental health services deemed necessary.
- In 2011 – mother said to have threatened boyfriend with knife.
- Taken to hospital by police – seen by psychiatrist – no evidence of mental disorder.
- No follow up with psychiatric services judged necessary.

Key events (Oct – December 2013)

October 2013

- Pregnancy Confirmed.
- Mother referred to maternity services and Perinatal Mental Health Service (PMHS).
- GP contacted a Learning Disability Liaison Nurse for advice.

Ante-natal booking assessment at 9 weeks

- Mother reported in good mood and feeling well.
- Nurse noted history of depression and ‘mild learning disability’.
- Mother engaged with ante-natal services

Key events (Oct – December 2013)

Initial assessment by PMHS

- No acute mental health problems / low risk.
- Partner knowledgeable/reliable in event of mental health deterioration.
- GP already prescribing medication for low mood.
- Follow-up appointment scheduled
- Nurse concluded mother had "*personality and anger management issues*".
- No evidence of severe or enduring mental illness.

Key events (Oct – December 2013)

Midwife completed a CAF

- Report considered by Children's Centre Multi-Agency Team (MAT)
- Invited mother to attend a parenting group.
- Mother did not engage with parenting group.
- Midwife subsequently referred to Hackney Children's Social Care (CSC) for an assessment of Ms M's overall situation and parenting capabilities.

Key events (Oct – December 2013)

Referral considered promptly by CSC - allocated for assessment to focus upon:

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

Key events (Oct – December 2013)

CSC assessment

- Two visits undertaken and checks with other agencies.
- Some evidence of Ms M having difficulties in managing her anger.
- CSC concluded that the situation overall was stable.
- Ms M was well supported and that there was probably no need for the continuing involvement of CSC.
- After second visit, CSC planned to close case once agency checks completed.

Key events (Oct – December 2013)

Before Xmas, the MAT review the case

- The MAT noted that CSC were now involved and suggested that they consider a “step down” referral.
- CSC subsequently considered this but decided that there was not sufficient indication of cause for concern to make such a referral.

Key events (Jan – April 2014)

Argument between mother and her parents

- Mother & Father left the home of the maternal grandparents and went to live in his home.
- Returned in early January 2014.
- The home situation then appears to have settled down although Mr F lost his job around that time.

Key events (Jan – April 2014)

Early February 2014

- CSC liaised with the “Learning Difficulties Team” (sic).
- Limited knowledge of mother.
- The Adult Learning Disabilities Team had never undertaken an assessment.

Mid February 2014

- CSC close the case.
- Support from extended families / Good engagement with maternity services / Mother compliant with medication regime.
- Decision explained to the family, but they were not given a copy of the assessment, as they should have been.
- All relevant agencies were informed of this decision.

Key events (Jan – April 2014)

Early April 2014, mother spoke with her GP

- Father diagnosed with a terminal illness.
- She was often tearful and irritated by her mother.
- She was worried about post-natal depression.
- She expressed anxiety about her ability to look after her baby in future.
- Declined re-referral to the PMHS but said would like counselling and support.

Key events (Jan – April 2014)

Urgent referral from GP to Primary Care Psychology Service (PCP)

- No contact number on referral form & PCP wrote to mother.
- Mother didn't respond and case closed by PCP.
- Around this time, mother's brother died after a long illness.

Midwife refers to Learning Disability Team

- Mother was eventually seen by this team after death of Child H.

Key events (May 2014)

Pre-birth visit by Midwife and HV

- Mother and father not in (at the hospital as they felt birth was imminent).
- Spoke with maternal grandmother who noted concerns.
- MGM concerned about Ms M's ability to care for the baby, describing her background, her immaturity and the problems of bereavement and illness currently facing the family.
- The HV decided to provide an enhanced level of input after the child was born.

Key events (May 2014)

- Baby born later that day at home and admitted to Special Care Baby Unit.
- Mother admitted to Postnatal ward.

Request for mental health assessment

- Mother seen by junior psychiatrist.
- Presented as stable.
- Discharged with advise on recognizing low mood, restlessness & relationship difficulties.
- Letter sent to PMHS for follow-up given history.

Key events (May 2014)

Child H in hospital for 12 days

- Discussed at psychosocial meeting and contact made with CSC.
- CSC advised of recent assessment, no concerns about discharge due to support and supervision of family members, and that continuing input from CSC was not necessary.
- CSC not made aware of the death of mother's brother and the terminal illness of MGF when giving this advice.

Key events (May 2014)

- Both parents visited Child H daily in hospital.
- good interaction / care noted.
- Joint Visit to family home by HV and Midwife post birth - no evidence of concern.
- Parents agreed to re-referral to CSC and Adult Learning Disabilities Service.
- Mother contacted by PMHS on the day of discharge, but she did not see need to see them.
- Was discharged to the care of her GP.

Key events (May 2014)

Over the next two weeks, mother seen 3 times by the HV and Midwives

- Observed good physical care of the baby, who was undressed by the midwife.
- HV discussed the family with the GP and it was agreed - no current concerns regarding the care of the baby.
- However - acknowledged the stresses of bereavement and terminal illness in the family.
- HV and GP agreed that the Midwife would re-refer to CSC.

Key events (May 2014)

Next day, Child H admitted to hospital with intra-cranial bleeding

- The parents and extended family members attended.
- Directly asked about the possibility of trauma and non-accidental injury
- All adamant that this could not be the cause of the problems.
- CSC and police were contacted and child protection investigations commenced.

Key events (May 2014)

Transferred to Great Ormond Street Hospital

- Further investigations revealed fracture to ankle.
- Child H remained unconscious for two weeks before death in May 2014.
- Parents arrested on suspicion of murder.
- Police investigation underway.
- Full review subsequently undertaken by The CPS.

Key events (May 2014)

On the basis of the evidence available the prosecution could not allege homicide against either parent, nor could they allege the other parent was an accomplice.

- No other/alternative charges were deemed suitable.
- In August 2015 both parents were informed that they would not be the subject of any further enquiries.

The family perspective

Mother and her family

- Spoke highly of health professionals.
- Mixed feelings around arrest however stressed support provided by the Family Liaison officer.
- MGM reflected they could have made better links with local community services.
- Child H was new experience for all as mother adopted as a toddler + she also thought that Mr F had little idea of how to care for a small baby, giving examples of him behaving inappropriately when handling the child, without due regard to the baby's safety.

The family perspective

Father and his family:

- Spoke highly of many services and professionals, particularly Public Health Midwife in Hackney, and some staff at Great Ormond St Hospital.
- Mr F's family felt that he had taken on most of the responsibility for the practical care of Child H.
- Agencies perhaps under-estimated the amount of help Ms M needed.
- They contrasted this with events after the injuries to Child H, when they felt some hospital staff did not liaise adequately with the paternal family.

The family perspective

Paternal family felt there was a failure of professionals to recognise the strain in a situation involving:

- two young new parents.
- terminal illness of maternal grandfather and support he provided.
- Mother's limited capability to parent.
- Concerns around sharing of information.

Conclusions

- Although there is no contact now, the two families got on well before the events leading to this review.

- Meeting Ms M, it is evident that she has what she calls “special needs”. However that is not the case with Mr F, whose presentation would not suggest any such conclusion.

- It is understandable that professionals meeting them before the injuries to Child H might have assumed that his presence would be supportive and reassuring, and indeed there is no evidence to the contrary.

Conclusions

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

- All those factors go some way to setting the context in which the family was seen by professionals, and the judgments made by those professionals.

- This was not an unhappy or troubled family situation where cause for concern was evident.

The Agencies - GPs

- Overall the way in which the GPs dealt with the family through these events was appropriate.
- The most significant learning point for the GPs, which they accept, relates to information sharing.
- During the pregnancy, the GPs became aware of the terminal illness of MGF.
- However they did not share that information appropriately, within their practice or across the network of agencies.

The Agencies - CSC

- The input from CSC was generally proportionate to the referral they received.
- There was no evidence to suggest any cause for serious concern.
- Assessment was generally thorough, although it could have given greater consideration to mother's intellectual impairment.
- No indication that continuing involvement from social workers was necessary or appropriate.

CSC

- In closing the case, the SCR notes that there was an expectation by CSC that a “psychosocial” meeting at the hospital would consider the case.
- Decision not to step down to MAT due to CSC’s judgement that extended family would provide support
- SCR concludes this was a reasonable assumption.

CSC

- The SCR identifies 3 weaknesses in this particular case - insufficient recording, drift in executing work plans and a failure to meet all the requirements of a plan
- The SCR makes commentary on the Hackney model stating there was "*no routine managerial process*" to identify and deal with these issues.
- However, the SCR is also clear that more conventional approaches to managing casework are not guaranteed to prevent them.

The Agencies - HUHFT

- Mother's contact with maternity services was largely unremarkable.
- She was entirely compliant with the requirements and expectations of the service.
- From her first contact her vulnerabilities were identified.
- Good handover from maternity to community health – but this approach was not similarly evidenced between maternity and psychology services.
- Maternity services were unaware of the GP's referral to PCP.
- PCP staff did not liaise with colleagues in maternity services when seeking to contact the family.

HUHFT

- As with all the agencies involved with the family there was confusion around the issue of learning disability, which HUHFT acknowledges in its IMR:

"There is a need for a greater understanding of the care and assessment pathway for learning disabilities in the context of parenting and appropriate support of vulnerable parents".

The Agencies - ELFT

- Assessments of mother by PMHS were generally thorough.
- LD “touched on”.
- The SCR concludes that the issue of mother’s learning needs should have been recognised and could have been given greater consideration.

Cross-cutting issues

Learning disabilities vs learning difficulties

- Eligibility for services provided by multi-agency Adult Learning Disability teams.
- Lack of clarity about what constitutes a learning disability.
- Inaccurate, interchangeable use of the terms “learning difficulty” and “learning disability”.
- Role of Learning Disability Liaison Nurse
- Confusion as to whether Child H’s mother had a learning disability, how that should be assessed and addressed and how the relevant specialist services were configured and accessed.

Cross-cutting issues

- Assessments could have given greater consideration to the mother's intellectual impairment.
- No referral to learning disability services until shortly before the death of Child H.

Psycho-social meetings

- Role of a psycho-social meetings requires clarity
- Terms of Reference to be reviewed and reissued to partnership

Conclusions and Key Learning

- The death of Child H could not have been anticipated by any of the services or professionals involved with the family.

- This sort of review with its close scrutiny of a complex set of multi-agency relationships and responsibilities will inevitably identify learning points.

- Even if those matters had been addressed, it is very unlikely that there would have been evidence suggesting that this baby would suffer serious inflicted injuries.

Conclusions and Key Learning

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

- Ms M and Mr F co-operated with specialist assessments by social care and mental health agencies. The assessments could have given greater consideration to mother's intellectual impairment.

- There was some avoidable drift and incomplete case recording within Children's Social Care services.

Conclusions and Key Learning

- There was confusion across the network of agencies as to whether Ms M had a learning disability, how that should be assessed and addressed and how the relevant specialist services were configured and accessed.

- Consequently there was no referral to learning disability services until shortly before the death of Child H.

- During the pregnancy there were some significant changes in the family's circumstances as a result of serious illness in the immediate family and the death of a relative.

Conclusions and Key Learning

- That information was not shared comprehensively across the network of agencies. Had it been shared there should have been a re-assessment by CSC - though this would not necessarily have led to any change in service provision.

- The review revealed some confusion across agencies in respect of the role and purpose of “psychosocial meetings” in maternity services.

- The family circumstances, in themselves, would not necessarily trigger a referral to psychosocial meetings, and those meetings do not provide continuing monitoring of a family situation.

Conclusions and Key Learning

- The family did not avoid contact with services. Ms M talked to her GPs about her fears and apprehensions about being a parent.

- The GPs made an appropriate referral to psychological services but the referral did not lead to any contact.

- Those services, aimed at adults, may not have been sufficiently alert to the child care implications of the GP's referral.

Recommendations

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

   (SEE CHSCB Response para 2.8 – 2.9)

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

   (SEE CHSCB Response para 2.10 – 2.11)

Recommendations

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

   (SEE CHSCB Response para 2.12 – 2.13)

Recommendations

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

   (SEE CHSCB Response paras 5 - 5.6)

Recommendations

5. The Board should require the Homerton University Hospital Foundation Trust, in the light of the issues identified in this review, to review their arrangements for:
    - psychosocial meetings
    - liaison between maternity services and the Primary Care Psychology Service.
    - promoting awareness of child safeguarding issues across adult mental health services (in partnership with East London NHS Foundation Trust).

    (SEE CHSCB Response paras 3 - 4.5)

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