V A L E O F G L A M O R G A N
B R O M O R G A N N W G

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

BABY GIRL

BORN 9/3/04

DIED 29/3/04

AGED 3 WEEKS

EXECUTIVE SUMMARY

Introduction

This Overview Report concerns a baby (Child 1) who died on 29th March 2004. The Area Child Protection Committee asked for a Serious Case Review to be undertaken as an opportunity to examine practice and make recommendations for changes. The parents of the baby have been interviewed by the police and are currently on police bail but they have not appeared in court. A new baby, Child 2 was born on 13th August 2005. He is the subject of care proceedings by the Local Authority.

Child 1, a baby girl was born on 9/3/2004, a healthy baby. She lived with her parents in a local authority homelessness hostel. There had been considerable involvement with her mother by local agencies. Her mother was only 17 when Child 1 was born and had many problems. Child 1 was found dead by her parents on 29th March 2004. Although the emergency services tried to revive her, she was pronounced dead shortly after her arrival at the hospital. A post mortem was carried out by a Home Office Pathologist and whilst the cause of death is indeterminate, there were a number of injuries present which gave cause for concern. Further post mortem tests continue to establish a cause of death.

Members of the Vale of Glamorgan Area Child Protection Committee (ACPC) discussed Child1's case. The ACPC decided to undertake a Serious Case Review, which is described in Working Together, Welsh Assembly Government guidance. A Serious Cases Review Panel was convened and it was agreed to undertake full management reviews of the involvement of Health, Police, the Social Services Departments involved, with other agencies to be asked to contribute as appropriate.

Child 2 is well and healthy and living with foster carers.

Summary of key events

To protect confidentiality, the names of the people involved are referred to by initials. The child's mother is MO1, the child's father is MP, the first child is Child1 and the second child is Child2.

C1's mother, MO1 was born 1/12/1986. She is the eldest of five children. Her family had considerable difficulties and she and her brothers and sisters were on the Child Protection Register until 2001. She was a promising pupil at school but she developed emotional and mental health problems. At the age of fifteen, she became involved with a much older man, MP. In 2003, there were many difficulties. She was referred to a child psychiatrist because of her emotional problems, drug use, low self esteem, eating disorders and depression. She attended Accident and Emergency because MP had assaulted her, possibly in the early stages of pregnancy. It was alleged she had assaulted her younger sister. She and MP said that they were homeless and at the end of 2003, and the couple were re housed by the Vale of Glamorgan in a hostel. In February 2004, she took an overdose just before the baby was born and spent time in hospital. The baby was born on 9th March 2004. She was a healthy baby. Mother and baby were discharged to the homelessness hostel and the family seemed to make good progress. The baby died on 29th March 2004. Various explanations were given by the parents for the death of the baby. The couple admit to using drugs and alcohol on the night before the baby died. A number of post mortems have been undertaken. Some injuries were found giving cause for concern. The couple remain on police bail.

Another child was born on 13th August 2005. He is a healthy baby and is in local authority care and there are ongoing care proceedings.

Involvement of individual agencies

There were a large number of staff involved with the family about approximately 72 contacts between the family and staff between March 2003 and the death of the baby in March 2004. The agencies include her General Practitioner, Mental Health Services, the Police, District General Hospitals, Children's Services, the Midwifery Service, Housing, Sure Start, a Hospital Social Worker, the Ambulance Service and Health Visitors.

MO1 visited her General Practitioner with depression in March 2003 and was referred to the Child and Adolescent Mental Health Service but failed to attend appointments so she was referred again and was finally assessed by a psychiatrist in June 2003. Unfortunately she had to wait for 3 months for treatment and when it was offered in September 2003, she failed to attend. In June 2003, she attended Accident and Emergency with an injury. She said that she has been assaulted by her partner and thought she was pregnant. The hospital did not think she was pregnant and she was discharged. The Police were involved, who interviewed her partner. He was interviewed and admitted the offence but MO1 did not want him to be charged. The police discussed the matter with Children's Services and offered MO1 further help, which she declined. The Police were involved again in August 2003 when they were called to the house because MO1 had allegedly assaulted her sister. A Community Midwife became involved with MO1 and when she looked at the situation, she was concerned and asked Children's Services to become involved. Children's Services agreed to undertake an Initial assessment but then decided not to do this but to ask health to continue to support MO1.

In November 2003, MO1 and her partner MP asked the Vale of Glamorgan to house them. They were placed in a homelessness hostel. Additional help was provided through the Supporting People initiative by a Voluntary Housing Support Agency and through the Sure Start programme. The family had a Sure Start Midwife, who specialised in the care of very young mothers. The homelessness assessment continued. Housing had some concerns about domestic violence and asked the Police whether they were aware of any incidents and were told about the earlier incident of domestic violence. MO1 took an overdose of prescribed medication in February 2004, just before the birth of her child. Whilst in hospital, she was assessed by another psychiatrist. The Hospital Social Worker made another referral to Children's Services, but this was not taken up. Some of the staff involved with the family met together to try and plan support for her after the baby was born.

The baby was born on 9th March 2004. MO1 and her baby were discharged from hospital on 11th March to the homelessness hostel and received intensive support for the first two weeks from midwives, Sure Start and the Health Visitor. The baby appeared to make good progress and gain weight and staff were optimistic. Support was reduced by the third week of the baby's life. On 29th March 2004, in the early hours of the morning, MO1 rang the Ambulance Service to say that MO1 had woken up and the baby was not breathing. Following the baby's death, there were a number of meetings between the Police, Health, Children's Services

Opportunities for a different outcome

A key part of the Serious Case Review process is to consider what opportunities agencies and individual staff had to make a difference. These opportunities are as follows:

- **Domestic violence incident in June 2003** This was not treated as a Child Protection referral by the Accident and Emergency Department despite a pattern of repeated presentations with minor injuries and MO1's age . Although the Police were involved and there was discussion with Children's Services, little action was taken and there was poor communication. If an assessment had been undertaken at this stage, later developments might have been interpreted differently.
- **Attendance at MO1's house by a Police Officer in August 2003** A Police Officer attended an incident at MO1's house where she was accused of assaulting her younger sister. MO1 was pregnant and the Police Officer expressed concerns about the baby. MO1's attitude should have been included in subsequent assessments.
- **Appointments with the Mental Health Services between June and October 2003** MO1 finally attended an appointment with a psychiatrist in June 2003. She had multiple difficulties and was referred for treatment. The waiting time was 3 months and she failed to attend despite being offered further appointments. If treatment had been offered sooner, she may have attended.
- **Referral to Children's Services October 2003** A referral was made by the Community Midwife but it was not allocated for assessment. If an assessment had taken place, the full extent of MO1 and MP's difficulties might have been recognised and plans made about the baby.
- **Housing Assessment between November 2003 and March 2004** MO1 and MP were housed in a homelessness hostel. Housing had some concerns and supported them through a specialist project. Housing were made aware of the domestic violence incident by the Police but did not pass this information on to the specialist project. Their housing situation after the baby was born probably exacerbated their difficult relationship. There were a number of opportunities for Housing to work with Children's Services which were not taken up.
- **Overdose in February 2004** MO1 took an overdose in February 2004 immediately before the birth of the baby. Whilst she was seen by a psychiatrist in hospital, it is unclear what her after care arrangements would be or whether there was a full understanding of how her problems would affect the ability to care for her child. A further referral was also made to Children's Services. If assessment had looked at all the circumstances, action could have been taken at this stage before the baby was born. Because Sure Start and the specialist housing project were involved, Children's Services did not become involved.
- **Birth of Child1** MO1 and her child were discharged from hospital very quickly and there are debates about whether they should have stayed in hospital or not and the arguments are finely balanced. After discharge, the family received a high level of support for two weeks but because the baby was developing well, this tailed off and there is some evidence that the family was avoiding contact by the third week of the baby's life. If previous opportunities to assess had been taken up, action may have been taken.

Good Practice

There were examples of good work by a number of staff involved in this case. This includes the General Practitioner, the Police, Mental Health Services, the Community Midwife, the Sure Start Team and the Voluntary Housing Support Agency.

Lessons to be learnt.

There are a large number of key lessons to be learnt from this Serious Case Review. These include:

- recognising the presence of risk factors
- listening to the voice of the child
- communication, information sharing, recording, supervision and following the Child Protection procedures
- Giving due weight to the role or the Assessment Framework in determining need and risk and underpinning its application in mandatory procedures
- Giving due weight to the role of joint assessment, strategy meetings and case conferences as the key tools for making decisions based on a shared and comprehensive understanding of all available information
- recognising the particular vulnerability of babies and very young mother
- ensuring that there are sufficient resources especially in Children's Services to meet demand
- looking at issues in an analytical way especially where accounts by parents of injuries do not fit the circumstances
- assessing situations properly before the baby is born
- understanding more about the impact of parental mental health problems on parenting
- recognising how domestic violence and pregnancy interact
- working with male partners
- recognising and dealing with aggressive parents
- understanding the significance of substance abuse in parenting
- making sure that there is a clear relationship between Child Protection and Family Support Services especially new services funded by initiatives
- making sure temporary housing is appropriate to the needs of the family
- looking at social inclusion as part of assessment.

Recommendations

1 The Area Child Protection Committee to ensure that all members are aware of the All Wales Child Protection Procedures and make appropriate referrals. This could be achieved through:
Regular auditing of referral sources
Identification of those agencies not passing on referrals
Targeted discussion and training
Protocol about referrals from Accident and Emergency Departments to Children's Services in respect of repeated presentation of children and young people to A and E Departments.

2 The Vale of Glamorgan of Glamorgan Children's Services reviews the staffing levels, and eligibility criteria for services in the First Contact Team to ensure that sufficient numbers of qualified social workers and managers are available to meet peaks in demand based on analysis of referral patterns.

3 The Vale of Glamorgan Local Health Board (with Cardiff and the Vale NHS Trust) reviews the waiting times for services for young people for therapy.

4 The ACPC urgently reviews protocols for undertaking assessments of parents including pre birth assessments. The protocol must include the availability of specialist assessments from mental health professionals including clinical psychologists. This work might be undertaken in partnership with other Area Child Protection Committees in South Wales and could also be undertaken with the help of a voluntary organisation and / or a university or research institution. New protocols must be supported by targeted training for front line practitioners and clear systems for monitoring and evaluation.

5 The Area Child Protection Committee considers how training is provided in mental health for front line practitioners and how this impacts on the assessment of parental capacity.

6 The Area Child Protection Committee reviews resources for domestic violence within the Vale of Glamorgan including the assessment of referrals and treatment programmes for perpetrators.

7 The Area Child Protection Committee in partnership with the Vale of Glamorgan, the Local Health Board and Cardiff and the Vale NHS Trust ensure that all current preventative and family support programmes have a clear care pathway, which takes into account child protection issues for:
Assessment of new referrals
Engagement of child protection services
Monitoring of cases

8 The Social Services Department in partnership with the Area Child Protection Committee and voluntary organisations should develop a Family Support Strategy for children and families in need for the Vale of Glamorgan. This Family Support Strategy should encompass services for families affected by domestic violence, and work with male perpetrators of domestic violence.

9 The Vale of Glamorgan Housing and Community Safety Directorate review staff understanding, awareness, training, assessments and systems in ensuring that children are safe within it's provision.

10 The ACPC should review the recording systems of each of its member agencies in relation to child protection and develop standards to ensure that each agency records the information, which is necessary to safeguard and promote the welfare of vulnerable children.

11 The Area Child Protection Committee in partnership with the Vale of Glamorgan should ensure that the content and recommendations of the Serious Case Review are disseminated to practitioners through a series of multi agency seminars.

12 The ACPC should review systems to audit compliance with child protection procedures, which should include:
individual agency auditing,
auditing of the multi-agency aspects of child protection.