LONDON BOROUGH OF BARKING & DAGENHAM SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

BABY M

10.05.10

Contents

1 INTRODUCTION 1

1.1 Background to serious case review 1
1.2 Report Construction 2

2 REVIEW PROCESS 3

2.1 Initiation of the serious case review 3
2.2 Involvement of local agencies 3
2.3 Independence 4
2.4 Scope of the review 5
2.5 Involvement of family 5
2.6 Staff contribution 5
2.7 Recommendations & action plan 5
2.8 Publication arrangements 6

3 SUMMARY OF EVENTS 7

3.1 Introduction 7
3.2 'Light touch' period: 1980 - 2005 7
3.3 Period under review: 2005 - 2009 8

4 KEY ISSUES ARISING FROM THE CASE 10

4.1 Introduction 10
4.2 Inter-generational neglect 10
4.3 Thresholds for referral 10
4.4 Co-sleeping 11
4.5 Learning difficulties 12
4.6 Transition to adult life 12
4.7 Assessment Issues 12
4.8 'Think Family' approach 13
4.9 Inter-agency working 13
4.10 Information sharing 14
4.11 Management & Resources 15

5 PRIORITIES FOR LEARNING & CHANGE 16

5.1 All agencies 16
5.2 Education Services 16
5.3 Health Services 17
5.4 Housing Services 18
5.5 London Probation 18
5.6 Safeguarding & Rights 18

6 RECOMMENDATIONS 20

6.1 Introduction 20
6.2 B&D Safeguarding Children Board 20
6.3 The Children's Trust 21
6.4 Child Death Overview Panel 21
6.5 Local agencies 21

1 INTRODUCTION

1.1 BACKGROUND TO SERIOUS CASE REVIEW

1.1.1 Baby M was a White English six week old baby girl, who lived in Barking & Dagenham with her elder sibling (Child T), her mother and members of the maternal family.

1.1.2 The London Ambulance Service received a 999 call early on a Sunday morning in October 2009, reporting that a baby at the family home was not breathing. On attending the home the ambulance crew found Baby M had no pulse, no respirations, her pupils were fixed and dilated and she was cyanosed (blue).

1.1.3 On arrival the ambulance crew took over the resuscitation of the baby from a neighbour and following assessment, they conveyed her to hospital where she was seen by a consultant paediatrician. The child showed no vital signs and was declared dead.

1.1.4 The family told the ambulance crew that Baby M had suffered with a cold. When the mother awoke that morning she said she found Baby M in bed with her, unresponsive, and assumed that Child T must have brought her to the bed sometime in the night.

1.1.5 The Metropolitan Police Service was contacted by the hospital and followed the standard reporting and recording process for sudden unexpected deaths of infants (SUDIs).

1.1.6 Both the ambulance crew and the police officers who attended the family home described the home conditions as poor, cramped and untidy. In liaison with the Children's Safeguarding & Rights Emergency Duty Team social worker the police exercised 'power of protection' under s.46 Children Act 1989 to ensure the two remaining children in the household stayed elsewhere. Arrangements were made for Child T and Baby M's mother's teenage sibling to stay with another relative.

1.1.7 Prior to this date there had been no concerns reported about the welfare of either Baby M or her sibling. However, there had been extensive historical multi-agency involvement with their mother and her siblings during their childhood, including periods when they were subject to child protection plans.

POST MORTEM & INQUEST

1.1.8 The post mortem carried out on Baby M found nothing to suggest anything other than sudden infant death. The child had rib fractures but the consultant paediatric pathologist confirmed the view of the consultant paediatrician who had examined the baby on arrival at hospital that these injuries were consistent with the resuscitation attempted by the neighbour.

1.1.9 Results of toxicology tests were subsequently made available but provided no further clarity as to cause of death. An Inquest was subsequently arranged.

1.1.10 There was no indication of abuse or neglect being a factor in baby M's death. In these circumstances Barking & Dagenham Safeguarding Children Board are to be commended for deciding to initiate a serious case review, so as to learn lessons

arising from the context of long term agency involvement with the family and potential inter generational neglect.

1.1.11 At the recent Inquest held on baby M, the Coroner accepted the cause of death as an ‘unexplained sudden unexpected death in infancy’ and returned a verdict of ‘accidental death’.

1.2 REPORT CONSTRUCTION

1.2.1 The remainder of this executive summary contains:

- An explanation of the review process
- A historical context of agencies involvement with the family
- An overview of agencies’ involvement during the period of this review
- Key issues arising from the case
- Priorities for learning and change
- Recommendations for action within prescribed time limits by Barking & Dagenham Safeguarding Children Board and its member agencies

2 REVIEW PROCESS

2.1 INITIATION OF THE SERIOUS CASE REVIEW

2.1.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of government's statutory guidance 'Working Together to Safeguard Children'[1].

2.1.2 A serious case review should be initiated if a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
- As a consequence, improved inter-agency working and better safeguard and promote the welfare of children'

2.1.3 There was no indication of abuse or neglect being a factor in baby M's death, but commendably the 'serious case review sub-committee' recommended to Simon Hart, the independent chair of the LSCB, that a serious case review be completed, so as to learn lessons arising from the context of long term agency involvement with the family and inter generational neglect.

2.1.4 This decision was subsequently ratified by the LSCB in November 2009.

2.2 INVOLVEMENT OF LOCAL AGENCIES

2.2.1 Discussion by panel members determined that the contribution of the following agencies had been of sufficient relevance to justify the formulation of a full individual management review (IMR):

- Community Health Services incorporating health visiting, school nursing and GP involvement
- Hospital Services providing midwifery and Accident & Emergency services
- London Ambulance Service
- Metropolitan Police Service
- Barking and Dagenham Children's Services, providing Safeguarding & Rights Services (S&R) and education services
- Barking & Dagenham Housing Advice Service
- London Probation Service

[1] *Working Together to Safeguard Children* HM Government (2010) London, The Stationery Office

2.3 INDEPENDENCE

PANEL MEMBERSHIP

2.3.1 Moira Murray was appointed as the serious case review panel chair. She is an independent social care professional with an extensive experience of safeguarding within the statutory and voluntary sectors and is currently on the Board of the Independent Safeguarding Authority.

2.3.2 Membership of the SCR panel, none of whom had any involvement with Baby M or her family, was as follows:

- Independent Chair: Moira Murray
- Assistant Chief Officer London Probation, Trust'
- Interim Group Manager Safeguarding, Quality & Reviews in Safeguarding & Rights, Children's Services
- Detective Inspector Metropolitan Police Service
- Divisional Director, Safeguarding & Rights, Children's Services
- Deputy Head-Safeguarding and Partnerships, Legal & Democratic Services, London Borough Barking and Dagenham Council
- Media and PR Officer, Marketing & Communications, London Borough Barking and Dagenham Council
- Group Manager Safeguarding Adults, London Borough Barking and Dagenham Council
- Nurse Consultant Child Protection, Barking, Havering & Redbridge University Hospitals NHS Trust [BHRUHT]
- Designated Nurse Safeguarding, NHS Barking and Dagenham
- Acting Principal Educational Psychologist, Children's Services
- Choice Assessment Manager, Housing Services, London Borough Barking and Dagenham Council

2.3.3 The Child Protection & Reviewing Service Business Support Manager provided administrative support to the process.

INDIVIDUAL MANAGEMENT REVIEWS

2.3.4 Local managers who had had no direct responsibility for Baby M or her family were identified and completed 'individual management reviews' of the involvement of their respective agencies, consisting of a chronology and report. The Metropolitan Police Service's (MPS) management review was authored by one of the MPS Specialist Crime Review Group.

2.3.5 To enhance objectivity and facilitate exchange of ideas, a separate 'authors' group was established consisting of the authors of the individual management reviews, meeting with the Panel chair, overview authors and Interim Group Manager Safeguarding, Quality & Reviews in Barking & Dagenham Safeguarding & Rights.

OVERVIEW AUTHORSHIP

2.3.6 The commissioned overview authors (Edina Carmi and Fergus Smith) have no connection with any of the individuals or agencies that provided services to Baby M's family and have extensive experience of SCRs, as overview and individual management review authors and as Panel chairpersons.

2.4 SCOPE OF THE REVIEW

2.4.1 In November 2009, the serious case review panel agreed that the serious case review would involve each agency undertaking:

- A 'light touch' chronology from each participating agency highlighting significant events only, in the period predating the period to be scrutinised in detail
- A detailed integrated chronology of all relevant services provided from the mother's 16th birthday to 24 hours after Baby M's untimely death
- Comprehensive and self critical analyses of the services provided by respective agencies
- An overview of all the individual management reviews that offered further analysis and challenge and identified key conclusions and recommendations for action by the LSCB, member agencies and if justified by the findings, national agencies

2.5 INVOLVEMENT OF FAMILY

2.5.1 The overview authors met first with Baby M's mother and then with her maternal grandparents. Baby M's mother felt that she coped well with her children and was receiving all the help that she needed from her family. Her parents supported this view. The views of the family are integrated into the body of the report.

2.6 STAFF CONTRIBUTION

2.6.1 All individual management reviews authors, as part of their respective management reviews, undertook interviews with relevant staff.

2.7 RECOMMENDATIONS & ACTION PLAN

2.7.1 Each agency individual management review agreed recommendations for improving its service delivery and developed action plans for implementation of those recommendations. Many recommendations have already been initiated and some have already been fully implemented.

2.7.2 The overview report, agreed by the Panel on 28.04.10 and the LSCB on 29.04.10, introduced some new recommendations and amendments to those within individual management reviews. The amendments:

- Changed individual management review recommendations to make them more specific or effective
- Replaced some individual management review recommendations with ones for the LSCB

2.7.3 An integrated action plan has been produced which details how each recommendation from the overview report has or will be implemented, identifying the responsible person, the progress made and the timescale for its achievement.

2.8 PUBLICATION ARRANGEMENTS

2.8.1 This executive summary will be available via Barking & Dagenham's Safeguarding Children Board.

3 SUMMARY OF EVENTS

3.1 INTRODUCTION

3.1.1 In accordance with the scope of the review agency involvement is divided into 2 periods, the 'light touch' period, of key events over twenty five years covering the childhood of Baby M's mother and her siblings and the five year period under review. Child T and Baby M were born during this latter period

3.2 'LIGHT TOUCH' PERIOD: 1980 - 2005

3.2.1 The family lived in Barking & Dagenham for most of this twenty five year period, with the exception of a year spent outside of London.

3.2.2 Family members were observed to have warm and loyal relationships with each other. However, the records show an ongoing history of concerns for the children in the family, predominantly around neglect. There was also some evidence of physical abuse to the children and isolated incidents of alleged or suspected sexual abuse by visitors to the home.

3.2.3 Baby M's maternal grandparents experienced problems themselves which would have impacted on the care of their children, including domestic violence incidents, misuse of alcohol and some mental health issues.

3.2.4 The family received the involvement of social workers and many other professionals over this 25 year period. The pattern of pervasive neglect of the children in the household continued with little sustained change over time.

3.2.5 Several family members (including Baby M's mother) were assessed as having learning difficulties, and one of Baby M's mother's siblings is learning disabled. Their parents were also thought to possibly have some learning difficulties.

3.2.6 Baby M's mother and her siblings hygiene and presentation tended to socially isolate them. Professionals reportedly considered them to be 'smelly'; it is likely that this would have been expressed much more forcefully by their peers.

3.2.7 The poor punctuality and school attendance of Baby M's mother and her siblings would have further distanced them from other pupils, leading to an ever increasing sense of exclusion from both the social and educational activities of their peers

3.2.8 Throughout Baby M's mother's childhood there were varying levels of multi-agency support provided. During three periods (in the 1980s, the 1990s and again in the 2000s) children in the household were subject to child protection plans.

3.2.9 During periods of intensive intervention under child protection procedures the carers in the family made minor changes, which were quickly recognised by professionals and facilitated the agreed ending of such intervention. As the children became older and perhaps less vulnerable to physical harm from the neglect issues, there was less recognition of their safeguarding needs.

3.3 PERIOD UNDER REVIEW: 2005 - 2009

January 2005 – August 2006

3.3.1 The mother of Baby M left school in 2005 and until she became pregnant with Child T in the latter part of 2006, had little contact with any agencies.

3.3.2 Connexions contacted her offering help and support to obtain training and education opportunities. The mother of Baby M occasionally responded, did agree to attend training, but reported being bullied by her peers (a recurrent theme of her life) and lost her place due to non attendance.

3.3.3 Baby M's mother had some limited contact with the police who raised concern having found her and a friend visiting a much older man, and later she made an allegation against him of indecent assault.

3.3.4 During 2005 and 2006 most of the professional contact with the family arose due to educational services contact with Baby M's mother's younger sibling 'D'. D ceased attending school in April 2005, following an incident when D was allegedly threatened with a knife and attacked outside school.

3.3.5 The attendance officers had regular contact with D, attempting to facilitate a return to school. During this process the focus of activity was on prosecuting D's parents and D remained without any educational provision.

3.3.6 The 'knife' incident was never adequately investigated, after D's parents declined the suggestions of informing the police or of D attempting to identify the alleged perpetrators through the use of photographs.

3.3.7 During a multi-agency meeting to negotiate D's return to school an allegation was made against a teacher which was not subject to any form of further enquiry.

3.3.8 A referral to Safeguarding & Rights was made in 2005 by the school about D's poor hygiene. This resulted in a core assessment and the offer of support from the Adolescent Resource Team. D did not respond to the offers of interviews.

September 2006 – March 2007

3.3.9 During the pregnancy with Child T, Baby M's mother ceased any attempts to undertake training, although maintained some contact with Connexions staff.

3.3.10 She attended ante-natal appointments regularly and no concerns were raised about her vulnerability by her GP (who was aware of her family history) or at the ante natal clinic. She was not referred to the teenage pregnancy service, because she was too old for the service. At that time this was for younger teenagers.

3.3.11 Probation offender managers were involved following the conviction of D's parents for failing to secure D's regular school attendance. The offender managers did recognise the risks to the unborn baby arising from the poor 'conditions of the property' and planned to make a referral to Safeguarding & Rights. Through an oversight, this did not occur.

3.3.12 D was receiving home tuition during this period, which largely took place in the library. D made good educational progress with this individual attention. The home

tuition staff remained concerned about hygiene issues within the family and a manager spoke to the parents a few times and referred the matter to the attendance officer.

April 2007 – August 2008

3.3.13 Child T and Baby M were born during this period, living with their mother and maternal family. Neither child had any contact with their fathers.

3.3.14 No concerns were raised by midwifery, health visitors, GPs or the hospital about either pregnancy or the welfare of either child.

3.3.15 Following the birth of Child T a health visitor undertook 2 home visits and noted the home was in need of decorating. Although informed by a colleague of the previous Safeguarding & Rights involvement with the family, no agency history was accessed.

3.3.16 Child T often missed immunisations and developmental checks, but these were eventually provided. At one point Child T's weight appeared to falter, but within a short space of time Child T had returned to a weight near the 50th centile. The reasons for the variation are not understood and appear not to have been explored.

3.3.17 Baby M was visited at home twice by the midwife, once by the health visitor and seen twice in the clinic. She was admitted to hospital on one day and discharged with a diagnosis of oral thrush.

3.3.18 The health visitor did note the home to be in a dangerous state, but was reassured by the maternal grandfather that he was in the process of undertaking repairs. The family were also in touch with housing at this time due to their imminent eviction from their home, as a result of financial problems.

3.3.19 The health visitor noted the family were welcoming and supportive, albeit the home was chaotic, with a large number of relations present during the visit.

3.3.20 D continued to make good progress during this period, attending a local college and achieving well enough to progress to a higher level course.

Death of Baby M

3.3.21 The London Ambulance Service was called by 999 to the family home early on a Sunday morning with a report that a baby was not breathing. The subsequent events that morning are described in 1.1 of this executive summary. Baby M was taken to hospital, where she was pronounced dead.

4 KEY ISSUES ARISING FROM THE CASE

4.1 INTRODUCTION

4.1.1 The full report provides various examples of good practice in this case, but the key issues arising from the case are around the shortcomings that emerge from consideration of the events over 30 years.

4.2 INTER-GENERATIONAL NEGLECT

4.2.1 The main issue arising from this case is the lack of change within the family, despite the provision of extensive multi-agency involvement over a thirty year period.

4.2.2 Historically, there appears to have been a lack of adequate assessment of the family, and in particular the ability of the parents to effect and sustain the changes required to provide their children with a reasonable standard of care.

4.2.3 Professional perceptions changed over time, with the risks for older children of such neglect less recognised, as they were viewed as less vulnerable. This minimises the impact on young people of the emotional components of neglect arising from, for example, social isolation as a result of poor hygiene, missing school and being unable to read and comprehend school work.

4.2.4 Past and recent research findings on neglect highlight:

- The severe harmful short and long term effects on children's cognitive, social, emotional and behavioural development and
- The challenges faced by professionals working with such families

4.2.5 The biennial analysis of serious case reviews have highlighted that in such circumstances of an 'overwhelmed, unsupported family'2 both the family and to a lesser extent professionals are overwhelmed with too many problems to face and a feeling of 'helplessness' to overcome the problems. Historically, this case provides an illustration of the difficulties professionals face in such circumstances.

4.3 THRESHOLDS FOR REFERRAL

4.3.1 Those professionals with any knowledge of the family background did not consider the potential impact of such experiences on Baby M's mother's parenting skills nor the potential risks for a new baby within the family home. This response is described by Brandon et al [2008] as the 'start-again syndrome'3 whereby:

- A 'common way of dealing with the overwhelming feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present in what we have called the 'start again syndrome'.....new pregnancy or a new baby would be seen to present a fresh start'

---

[2] *Understanding Serious Case Reviews and their Impact, A biennial Analysis of Serious Case Reviews 2005-07*, Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth, Warren and Black[2009]
[3] *Analysing child deaths and serious injury through abuse and neglect: what can we learn?, A biennial Analysis of Serious Case Reviews 2003 - 2005*, Brandon, Belderson, Warren, Howe, Gardner, Dodsworth, and Black [2008]

4.3.2 None of the professionals who saw the home following the birth of Child T and Baby M had an understanding of the family history. They also did not consider that the home environment was sufficiently of concern to warrant an assessment using the Common Assessment Framework or to make a referral to Safeguarding & Rights.

4.3.3 In contrast the ambulance crew and police officers, who attended the family home on the day of Baby M's death, clearly identified concerns for children living in such household conditions.

4.3.4 Such a difference in response may reflect deteriorating conditions, with the family packing their belongings in anticipation of eviction from their home. However, it is also likely to reflect:

- Differing standards of what constitutes suspected neglect
- Lack of knowledge of thresholds for undertaking a Common Assessment or for making a referral to Safeguarding & Rights

4.4 CO-SLEEPING

4.4.1 It is known that Baby M was found in her mother's bed on the morning she died. It is not clear exactly how she got to the bed or when she died.

4.4.2 The family believe Child T moved her from her crib to her mother's bed, on the basis this had happened before on at least one occasion and Child T liked to cuddle and tried to carry Baby M.

4.4.3 The police confirm this may have been possible in terms of the crib and bed heights being the same and the Coroner at the Inquest accepted that Child T would have been capable of picking up baby M, but there is no independent evidence to confirm if Child T was able and did do this.

4.4.4 The pathologist found no evidence of anything suspicious at post mortem and no features associated with asphyxia. The pathologist explained at the Inquest that about 60% of post mortems carried out at Great Ormond Street Hospital are co-sleeping related, although the mechanism is not clear.

4.4.5 The Coroner returned a verdict of 'accidental death' based on the view that the most likely explanation for Baby M's death was that 'something interfered' with her 'ability to breathe freely' and that given Baby M was found under her mother, 'on the balance of probabilities' 'there must have been an overlying component to this death'

4.4.6 The risks in this situation are highlighted by a recent study (by a team of researchers at the Universities of Warwick and Bristol) of all unexpected infant deaths from birth to two years in the South West region of England from January 2003 to December 2006[4]. This found that more than half occurred whilst the infant was sharing a bed or a sofa with a parent (co-sleeping) and may be related to parents drinking alcohol or taking drugs. There is however no evidence in this case of alcohol or drug that night.

[4] *Hazardous co-sleeping environments and risk factors amenable to change: case-control study of SIDS in South West England*, Blair, Sidebotham, Evason-Coombe, Edmonds, Heckstall-Smith and Fleming, published online at BMJ.com (BMJ 2009; 39:b3666)

4.5 LEARNING DIFFICULTIES

4.5.1 Learning difficulties and disabilities are a feature of family members, but there has been inadequate assessment and support provided throughout the 30 years.

4.5.2 Historically there was a lack of information on and understanding of any level of parental learning difficulties and the impact of such on the parenting capacity. Without such knowledge it is not possible to make informed decisions on the types of support and intervention that will be effective for the children in the family.

4.5.3 Within the household is an adult with learning disabilities, whose presence has been largely 'invisible' to professionals, both as a child and currently. There is no evidence of the individual being provided with an assessment of need, either during childhood or as an adult.

4.5.4 Other family members have progressed through a sequence of educational psychological testing and statementing, but with little evidence of any effective understanding of their educational problems or how to provide them with any effective intervention or support.

4.5.5 The strategy taken for one child in the family, to repeat an academic year did not adequately consider exactly how this would help the child concerned. Subsequently the decision to put the child back into the correct age group at secondary school seems to have ignored the potential impact on that child's emotional and educational development.

4.5.6 The use of the home tuition service appears to be the sole example of an individualised and effective response to the needs of the children in this household. The staff at the local college also attempted to provide more individual attention for this child.

4.6 TRANSITION TO ADULT LIFE

4.6.1 In the context of ongoing pervasive neglect and the learning difficulties of children in this family, family members would have been likely to experience problems in obtaining and sustaining further education, training or employment.

4.6.2 This serious case review has found weaknesses in the transition service provided to Baby M's mother from education services and more generally the lack of ongoing family support once the children ceased to be subject to child protection plans.

4.6.3 Both the Safeguarding & Rights and the Education Services individual management reviews outline the improvements to such 'transition' and 'step down' services in recent years through the development of the Connexions service and the community support facilities. However, it is not clear how this would assist in circumstances when the individuals decline to accept such support.

4.7 ASSESSMENT ISSUES

4.7.1 The lack of adequate assessment is a feature historically of this case in terms of obtaining a holistic understanding of the needs of all the individuals within the family and their abilities and relationships.

4.7.2 The focus on individual agency assessment processes without adequate consideration and knowledge of the past and of other needs within the family limited the ability of professionals to provide effective support and intervention.

4.7.3 Such lack of comprehensive assessment meant there was little understanding of the capacity of parents (now the grandparents) to change and how to best support them. There was little understanding of the learning difficulties and consequently how to communicate with each individual, according to their individual capacity and comprehension.

4.7.4 In recent years there was a lack of any assessment about the abilities of Baby M's mother to parent her children and the types of support she would need.

4.7.5 Specifically no Common Assessment Framework was undertaken with regard to Baby M and Child T. Partly this was due to the lack of training of staff who saw Baby M's mother, but also due to the lack of perceived concerns by those professionals.

4.7.6 Had such an assessment been undertaken, it is likely this would have led to the identification of additional needs and the involvement of a multi-agency team working with mother and her children.

4.7.7 Moreover, the use of a Common Assessment Framework would have made a referral to Safeguarding & Rights more likely. Given the description of the family home, such a referral should have been considered even *without* the use of a Common Assessment Framework.

4.8 'THINK FAMILY' APPROACH

4.8.1 The 'think family' policy initiative launched in January 2008 would only have been relevant near the end of this period. It encourages local services to consider the whole family to provide 'joined up' support across services for adults and for children.

4.8.2 The information provided to the authors indicates that if a 'Think Family' approach had been in place Baby M's mother would have been offered additional support within the current arrangements involving a Common Assessment Framework and support via multi-agency locality teams.

4.8.3 It is understood there have been changes to improve the links between GPs, midwives, health visitors, Connexions and Children's Centres and facilitate such a 'Think Family' approach. Such changes need to be evaluated in order to be confident of any real change.

4.8.4 Given the potential reluctance of Baby M's mother and her family to accept support it is not clear if this approach would have made a difference in these circumstances, unless each professional understood the importance of communicating, accessing and considering the family history.

4.9 INTER-AGENCY WORKING

4.9.1 Historically, over the 30 years, there was some evidence of inadequate inter-agency work but it is anticipated that current methods of working and procedures would minimise the possibility of such shortcomings in professional practice being

repeated. An example of this is the lack of education follow through when the family moved and their whereabouts were unknown to the school. Since that time Children Missing Education has become a national issue and Barking & Dagenham have dedicated staff employed to manage this issue.

4.9.2 In the period under review there remains some evidence of weaknesses in inter-agency working with:

- Education services identifying as 'bullying' a potential crime which should have been shared with Police and Safeguarding & Rights
- Lack of consultation about a vague allegation against a teacher: the details of the allegation were not clarified and no consideration given to the relevant procedures [5]
- Education Services not recognising the need for consultation and possible enquiries into a vague allegation about the conduct of a member of staff
- A delay in Police attending a reported domestic abuse incident in 2006 and lack of full enquiries at the time [the Police Individual Management Review considers recent training will have addressed these issues]
- Following an initial period of proactive engagement with other agencies, the engagement dissipated and Probation staff did not make the intended referral to Safeguarding & Rights during the pregnancy with Child T
- Safeguarding & Rights, in its responses to referrals during this period, demonstrated a lack of proactive consideration of the safeguarding needs of older teenagers
- A lack of Housing involvement in inter-agency working
- An assumption by health staff that Safeguarding & Rights would not act on basis of poor domestic hygiene alone, without checking this out with the service concerned

4.10 INFORMATION SHARING

4.10.1 In line with all serious case reviews, there were examples of poor information transmission both within and between agencies.

4.10.2 The communication shortcomings within agencies was primarily around the lack of provision of known family history to the:

- Midwife and health visitor, despite the family having been registered with the same General Practitioner practice for most of the last 30 years
- Home tuition service

4.10.3 Within health, the lack of communication was exacerbated by the practice of patient's self completion of referral forms to midwifery, as opposed to their doctor making the referral, the lack of verbal communication between midwifery and health visiting and the lack of discussion between the case holding health visitor and the agency health visitor who was undertaking the visits.

4.10.4 The communication shortcomings between agencies included:

[5] A LADO [Local Authority Designated Officer] was in place within Barking & Dagenham in 2006 and should have been consulted in these circumstances. Prior to this the 2003 London Child protection procedures and 'Safeguarding Children in Education' DfES 2004 involve procedures for reporting allegations.

- Lack of consultation with Safeguarding &Rights by education professionals who recognised hygiene issues
- Connexions' mistaken assumption that there was a support worker allocated to mother and Child T at the Family Centre, without having considered who was responsible to ensure this occurred
- Lack of provision of MERLIN[6] reports by the Police [see next paragraph]

4.10.5 The Police within their Individual Management Review provide a detailed explanation of the changes that have been made to ensure MERLINS are now consistently provided when a child comes to the attention of Police.

4.11 MANAGEMENT & RESOURCES

4.11.1 The main issues around management and resources were within health services.

4.11.2 The health overview report for this serious case review refers to the possibility that the 'overwhelmed family situation' was mirrored in each of the professionals own situation' of high caseloads and, staff shortages. These may have compromised the ability of midwife and health visitor to pursue a thorough assessment of parenting capacity and of the impact on the children's welfare of their environment.

4.11.3 The health visiting team was stretched at times because of staff illness, so that it did not always have a full complement of health visitors and staff had high caseloads. During a period in 2008 the health visitors raised their concerns with management and involved the trade union. These concerns to some extent remain ongoing.

4.11.4 That ongoing use of supply health visitors was an issue in this case, with the onus placed on the worker to access training and supervision themselves, despite working for the Trust for a period exceeding 2 years.

4.11.5 The lack of such training on the Assessment Framework and the Common Assessment Framework was thought to be a contributory factor in the lack of recognition of risk in this case.

[6] MERLIN: Notification forms of Children and Young Persons coming to notice of Police. MERLIN is the system for recording child protection information and Missing Person investigation.

5 PRIORITIES FOR LEARNING & CHANGE

5.1 ALL AGENCIES

5.1.1 There is a need to establish the extent to which practice concerns identified in this serious case review *actually* reflect current support and intervention, especially with regard to the need for:

- Early assessment e.g. the use of Common Assessment Framework
- Adequate Safeguarding & Rights assessment and if necessary intervention in the context of long standing neglect, including the use of assessments of parent's abilities and capacity to change
- Information transmission of relevant historical information by GPs to midwives and health visitors
- Information transmission within Education services
- Universal support provision to teenage parents and the need to take into account their own experience of being parented
- The provision of *effective* educational support in school for those children identified as having learning needs associated with neglect: this should consider carefully the value of moving children to different chronological age classes

5.1.2 There is a need for *multi-agency* training and guidance on responses to pervasive neglect, to cover:

- Impact on children
- Intergenerational issues and early intervention
- Parental and child learning disability / difficulty
- Minimum standards of care
- Thresholds for different assessments: single and multi-agency
- Models of intervention: single and multi- agency
- Professional role in the face of peer bullying of child victims of neglect

5.1.3 Such multi-agency training should involve relevant staff from adult services and from Housing, so as to promote a 'Think Family' approach.

5.1.4 The serious case review process has highlighted the need for written guidance and training to be provided to future individual management review authors and for the Education service to have adequate organisational expertise to undertake this role.

5.2 EDUCATION SERVICES

5.2.1 There is a need for Education agencies to review file recording systems so as to ensure that they are fit for purpose, coherent across educational provision and with clarity around archiving arrangements.

5.2.2 Consideration should be given to the development of a system whereby the academic progress and safeguarding needs of those students who are or have been subject to a child protection plan are routinely considered in schools' planning and review meetings with Connexions, education psychologists and attendance officers.

5.2.3 Consideration should be given to identifying a new system for prioritising the attendance of education psychologists at Annual Reviews (for students with Statements of Special Educational Needs) that is not mainly dependent on the internal processes of the school. This could have a significant impact on the allocation of resources (namely education psychologists time).

5.2.4 The review has highlighted some areas where staff need further understanding of safeguarding procedures, roles and responsibilities in relation to:

- Consultation with the Local Authority Designated Officer (LADO) about any allegations against those working with children
- Informing police and/or Safeguarding & Rights when behaviour identified as 'bullying' may in fact constitute a crime or abuse

5.2.5 When children leave school there needs to be an effective mechanism to ensure that relevant information held by schools, education psychologists and attendance officers is made available to other agencies if the young person is at risk of:

- Not participating in education, employment or training and /or
- Becoming a pregnant teenager

5.2.6 Each education service's child protection lead needs to have knowledge of the serious case review process and some will need expertise in undertaking individual management reviews

5.2.7 Where students make the transition between educational establishments the welfare of the child would be improved if any case holding education psychologist formally hand over the case file to the education psychologist allocated to the new school.

5.3 HEALTH SERVICES

5.3.1 The lack of recognition of the neglectful impact of the home environment on the children meant that the casework fell short of best practice.

5.3.2 There was a lack of understanding by the General Practitioner of the need to provide relevant information on the family background of Baby M's mother to midwifery and to health visiting services. This indicates a lack of understanding of the impact of neglect on children's welfare and development.

5.3.3 The lack of awareness of the history of Baby M's mother meant that health staff caring for Baby M at home or in hospital may well have assessed that there was insufficient grounds to warrant a referral to Children's Services, but a pre Common Assessment Framework [CAF] check should have been completed as a minimum and the family offered a CAF.

5.3.4 The midwife accepted at face value what was presented to her, applying the 'rule of optimism' that what was not presented / known was presumed to be satisfactory. A minimum of information gathering would have revealed that Baby M's care environment was as fragile and insecure as the structure of the home.

5.3.5 There is a need to ensure that health visitors seek out agency history of the families they visit and for the agency to ensure that staff receive appropriate safeguarding supervision and training.

5.3.6 The health professionals who had contact with the family should have ensured that an assessment was undertaken of the needs of the adult learning disabled family member and the impact of such needs on the capacity of the family to support Baby M's mother and her 2 young children.

5.4 HOUSING SERVICES

5.4.1 The initial assessment form needs to include a question on the condition of the applicant's current property.

5.4.2 Whilst focusing on homeless prevention, the service should also consider the need to explore with applicants wider welfare issues to ensure the need for information requests or referrals to other agencies occurs. This case highlighted the potential use for a 'Think Family' approach to obtain a fuller understanding of family members' disabilities or possible capacity issues.

5.4.3 There is a need to ensure that senior managers carry out quality assurance checks on supervision notes, to confirm the quality and frequency of these.

5.4.4 This review has highlighted the need for officers to provide comprehensive and accurate records.

5.5 LONDON PROBATION

5.5.1 London Probation need to ensure that the London Probation Going for Gold action plan is implemented in Barking/Dagenham and Havering so as to improve the quality of risk of harm assessments and management including greater management oversight and influence over case decision making. This action plan covers key activities to be delivered which include:

- The implementation of a London-wide risk of harm audit programme
- The introduction of case discussion workshops within operational team meetings
- The identification of local risk of harm specialist leads
- The dissemination of regular risk of harm top tips, guidance and training
- A skills audit of staff
- Delivery of mandatory risk of harm, victim empathy and multi-agency public protection arrangements training and
- More collaborative work between London Probation and other agencies to maximise the protection of the public.

5.6 SAFEGUARDING & RIGHTS

5.6.1 Planning with families must be robust and focussed with agreed clear outcomes and clearly articulated contingency plans. These need to be understood by all stakeholders, including most importantly the family.

5.6.2 The implementation of these plans should be monitored over a significant period of time. Reviews need to link not only to the actions listed but into outcomes, so as to avoid drift or premature closure of a case.

5.6.3 The relevant officer from housing was not present at any of the significant meetings in relation to this family. As a result there appears to have been limited information sharing and action planning around accommodation issues.

5.6.4 When children are re-referred as teenagers following previous significant agency involvement, social workers should identify services within the multi-agency network which support those young people who remain vulnerable.

6 RECOMMENDATIONS

6.1 INTRODUCTION

6.1.1 Recommendations emerging from this serious case review have been divided into those requiring action by:

- The Barking & Dagenham's Safeguarding Children Board [B&DSCB]
- The Children's Trust
- The Child Death Overview Panel
- Individual member agencies

6.1.2 These recommendations include, but are not restricted to, those contained in the individual management reviews.

6.1.3 Action plans have been drawn up by respective agencies to identify the post responsible for the implementation of the recommendation, the timescale for achievement and provide the criteria for success. A composite action plan has been completed.

6.1.4 There are no specific recommendations for the London Ambulance Service that arise from this serious case review.

6.2 B&D SAFEGUARDING CHILDREN BOARD

6.2.1 The B&DSCB should provide multi-agency sessions to disseminate the learning from this serious case review. [By 31.10.10]

6.2.2 The B&DSCB should commission a *multi-agency* audit of a sample of current secondary school age children who have statements of SEN, and about whom there are or have been concerns about neglect to ensure that they are in receipt of adequate multi-agency support. [By 31.05.10]

6.2.3 The B&DSCB should commission a *multi-agency* policy, practice guidance and training for practitioners and managers on pervasive neglect and learning difficulties which addresses the likely needs of some families for ongoing and effective support over extended periods, considers methods of effective communication and provides clarity around thresholds for different interventions.[By 30.09.10]

6.2.4 The B&DSCB should commission policy and practice audits to ensure that the *multi-agency* work currently being undertaken before and after the birth of a baby to a teenage parent is now able to provide effective assessment of the parent's history and parenting skills. This should consider the role and use of Children's Centres, Common Assessment Frameworks , Team Around the Child, Team around the Family, teenage midwifery arrangements; the work of GPs and health visitors. [By 30.09.10]

6.2.5 The B&DSCB should request that the Safeguarding Adult Board ensures that Baby M's eldest uncle has been the subject of recent assessments of his needs as a vulnerable person, and that he is in receipt of services to meet any identified needs. [By 30.04.10]

6.2.6 The B&DSCB should ensure staff likely to undertake the authoring of Internal Management Reviews in any future serious case reviews are provided with written guidance and training. [Ongoing from 30.04.10]

6.2.7 The B&DSCB should support the introduction of a multi agency professional panel, to be convened to consider cases which have had a Child Protection Plan for a period of 18 months, which should seek to make explicit steps to be taken by all parties to facilitate achieving sustainable positive progress and outcomes for the children. The panel should be chaired by an Independent Reviewing Officer within the Child Protection and Reviewing Service. [By 30.04.10]

6.3 THE CHILDREN'S TRUST

6.3.1 All teenagers who become pregnant should be identified, fully supported and referred to appropriate services through the Common Assessment Framework process. Compliance and performance should be reviewed by the Sexual Health and Reproductive Board. This process should commence by 31.05.10.

6.3.2 The Children's Trust need to ensure that agreed multi agency protocols are in place to support cases moving up and down between levels 2 and 3 of the Continuum of Needs and Services Model, that all agencies are aware of these and that multi agency audit processes address compliance and quality issues regarding this process. [By 31.05.10]

6.4 CHILD DEATH OVERVIEW PANEL

6.4.1 In the light of the Coroner's verdict, the Child Death Overview Panel should review the content and delivery of local public health advice provided regarding co-sleeping, taking into consideration the communication needs of the diverse population in Barking & Dagenham. [By 30.09.10]

6.5 LOCAL AGENCIES

EDUCATION SERVICES

6.5.1 Education Services to revise safeguarding training in the light of the findings from this serious case review so as to increase education awareness and understanding of individual roles and responsibilities, as well as personal responsibility for safeguarding. This to include:

- Allegations against staff & the role of the LADO
- Responses to bullying arising from neglect issues
- Intergenerational neglect: use of Common Assessment Framework and Pathway processes
- Role of Annual Reviews in safeguarding [By 31.05.10]

6.5.2 Education Services to consult the LADO about the outstanding allegation made against a member of staff in June 2006 and a decision made regarding any further investigations required [By 30.04.10]

6.5.3 Education services should update recording and archiving advice for all education agencies. [By 30.04.10]

6.5.4 Education Services to update local Children Missing Education protocols and re-publicise this amongst staff and other agencies. [By 31.07.10]

6.5.5 When EPs & attendance & welfare officers attend any planning or review meetings convened by a school about a pupil currently or previously subject of a CP plan, they should make an explicit request that the school present all relevant information on the pupil's progress. [By 30.04.10]

6.5.6 So as to improve the quality of 'transitions' information exchange, local guidance and an information transfer protocol should be produced for use by schools and lead professionals. [By 30.09.10]

6.5.7 The current inter agency protocol for alerting Adult Services of the transition of vulnerable young people should be reviewed to ensure:

- A clear record on all education services files at the point of transition
- Identification by lead and other involved professionals of any outstanding issues for short, medium and long term action
- Confirmation of the recipient of this information [By 31.07.10]

6.5.8 DCS should issue guidance to all relevant schools on the implications of a child moving into a year group that does not reflect her/his chronological age [By 30.06.10]

HEALTH AGENCIES:

6.5.9 CHS/NELFT should ensure that their staff, including agency staff are clear about local child protection procedures and have received safeguarding training appropriate to their role. [By 30.06.10]

6.5.10 CHS / NELFT and BHRUHT should schedule an annual audit to demonstrate application and compliance around Information Sharing across the health economy. [By 30.06.10]

6.5.11 NHS Barking and Dagenham should ensure that the audit of standards and records currently only undertaken within Training GP Practices is expanded to include all GP practices. [By 30.04.11]

6.5.12 CHS / NELFT and BHRUHT to undertake an annual supervisee feedback audit to monitor the quality of supervision delivered and identify ongoing needs, including staff not accessing supervision. [By 31.07.10].

6.5.13 CHS / NELFT to ensure that all Agency staff working with children, young people and their families are allocated a Child Protection Supervisor to ensure compliance with uptake in line with the Supervision Policy of the organisation. [By 30.04.10]

6.5.14 BHRUHT to ensure that the antenatal referral letter is amended immediately to include mental health / family and social history and the GP's should be requested to complete the referral forms themselves. [By 30.04.10]

6.5.15 BHRUHT should ensure that there is an urgent review of the provision and uptake of Common Assessment Framework training for midwives. [By 31.05.10]

6.5.16 BHRUHT to ensure that community midwifery services are reviewed in order to improve continuity of carer, adequate time for booking histories to be obtained and to ensure that the DNA policy is consistently used. [By 30.06.10]

6.5.17 BHRUHT to ensure that whenever a woman has had previous obstetric care with the Trust, her records must be available for review at the booking appointment. [By 30.04.10]

HOUSING SERVICES

6.5.18 The Housing Services should be review the Initial Assessment Form so as to ensure it captures information relating to the condition of the current property of prospective homeless households. If information obtained indicates a concern in relation to the property condition, appropriate referrals to be made.[By 30.06.10]

6.5.19 The Housing Services to identify key staff for Common Assessment Framework and 'Think Family' training. [By 31.03.10]

6.5.20 All staff to be reminded during supervision sessions, casework reviews and team meetings of the need for accuracy in recording information, paying particular attention to detail when recording significant events and to ensure that notes reflect all key items discussed, thus highlighting the importance of timely referral procedures with other agencies as appropriate.[Immediate and ongoing]

LONDON PROBATION

6.5.21 London Probation to undertake an audit of safeguarding training attended by operational probation staff in Barking, Dagenham & Havering. [By 31.03.10]

6.5.22 London Probation to use the results of this audit to develop an action plan to ensure that all staff complete appropriate internal and external safeguarding training. [By 01.06.10]

6.5.23 London Probation to ensure that the London Probation Going for Gold action plan is implemented in Barking/Dagenham and Havering so as to improve the quality of risk of harm assessments and management including greater management oversight and influence over case decision making. [Ongoing from 01.04.10]

METROPOLITAN POLICE SERVICE

6.5.24 The MPS should implement the planned training programme currently being prepared by the Violent Crime Directorate. [By 30.06.10]

6.5.25 The MPS ensure that officers acting as 'Initiating Officer' and 'Designated Officer' are reminded of their powers under s.46, The Children Act 1989 [police protection] and their responsibility to ensure the creation of accurate and complete records when these powers are used. [By 30.04.10]

SAFEGUARDING AND RIGHTS

6.5.26 All contacts to Safeguarding and Rights on closed cases must be individually evaluated and a decision recorded stating whether a referral needs to be opened or if not, why not. [Commenced January 2010]

6.5.27 Safeguarding & Rights to ensure that the Integrated Children's System provides an alert system for staff and managers, informing them of out of timescales for Initial and Core Assessments. [By 30.06.10]

6.5.28 Safeguarding & Rights to ensure that within 3 months of a case being made subject to a Child Protection Plan for neglect for a second time, it must be subject to a qualitative independent audit as part of the Safeguarding and Rights Quality Assurance Strategy. The audit must clearly detail the case is moving towards positive sustainable outcomes for the children and make explicit recommendations to address any concerns. [By 31.03.10]