

Brent
Local Safeguarding Children Board

SERIOUS CASE REVIEW

Executive Summary

Re Child D

August 27th 2009

Introduction

- 1.1** This Serious Case Review was commissioned by Brent Local Safeguarding Children Board (LSCB) due to the circumstances of an infant (who will be referred to as Child D in this report) who was admitted to hospital in 2008 and was critically ill due to suspected salt poisoning. The conclusion of the Court within the care proceedings was that Child D's condition was due to salt poisoning and that the overwhelming likelihood was that another young mother in the same foster placement was responsible for contaminating his feed.
- 1.2** At the time of Child D's hospitalisation, he was residing with his mother(Child E) in a foster home, where she had already been living for 1 ½ years, and they had been placed back there together soon after his birth. There was another young mother (Child G) and her baby (Child F) also resident in the same foster placement at this time. They had arrived there approximately 6 months previously following her own baby's birth. Both of these mothers were "looked after children", at the time of Child D's hospitalisation, and were in receipt of services from Brent Leaving Care Team.
- 1.3** At the time of the submission of this report, as an outcome of care proceedings, Child D had been returned to the care of his mother, and Child F is now placed under an interim care order.
- 1.4** In order to meet its commitment to safeguarding children in Brent and to learn lessons when necessary about the ways that agencies work together to safeguard and promote the welfare of children and young people, then Brent LSCB made the decision to commission this Serious Case Review. Child D had suffered significant harm, potentially as a result of abuse, whilst residing in foster care. The analysis within this Serious Case Review therefore reflects the services provided to both of these young mothers and their babies.

Case Review Process

- 2.1** The purpose of a serious case review as set out in 8.3 of Working Together to Safeguard Children (2006) is to:
- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations worked together to safeguard and promote the welfare of children;
 - identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result;
 - as a consequence, improve inter-agency working and better safeguarding and promote the welfare of children
- 2.2** Each agency that had some direct involvement with these young mothers and their babies was required to undertake an Individual Management Review, to look openly and critically at individual and organisational practice as it related to their involvement with the family. In undertaking this, each agency was required to produce a chronology of its contact with the family. It was required that those managers conducting the Individual Management Reviews were not directly concerned with the services provided for the children or family, or the immediate line manager of the practitioners involved.
- 2.3** Selected representatives of the Brent LSCB were brought together to form a Serious Case Review Panel to collate the information provided from the Individual Management Reviews and then to analyse the professional practice and inter agency working as it related to this family. This Panel was chaired by the Independent Chair of the LSCB, and the Overview Report and Executive Summary was written by another independent person who had expertise in safeguarding children and young people.

The composition of the Serious Case Review Panel was:

Donald McPhail	– Independent Chair/Independent Chair of Brent LSCB
Graham Genoni	– Assistant Director, Children & Families – Social Care
Louise Cherrington	- Detective Inspector Brent & Harrow CAIT, Met Police
Jean Cooper	– Education Child Protection Adviser
Bernadette Halford	– Designated Nurse NHS Brent
Catherine Knight	– Associate Director of Operations – Central and North West London Foundation NHS Trust

2.4 The agencies required to provide Individual Management Reviews were:-

Brent Children and Families
NHS Brent
North West London Hospitals NHS Trust
Metropolitan Police
The National Fostering Association
CNWL Foundation NHS Trust

Destiny House, Residential Unit supplied a report to support the serious case review process

Case Details

- 3.1** The two young mothers had resided together in the same foster placement for 9 months but because Child D was born prematurely and remained in hospital, there was only a period of approximately 6 weeks when the babies were simultaneously in the foster placement with their young mothers. It was at this stage that Child D sustained life-threatening harm when given a large dose of salt. It was later found that a considerable amount of salt had been put into Child D's feed.
- 3.2** The background of both of these young mothers included abuse by adults, and as they grew up, their separate lives followed similar courses, with low self esteem leading to periods of self harming and challenging behaviours. It was these circumstances that brought them into care as young adolescents, and meant that with this background, they would inevitably find it challenging to parent their own babies as single parents. Neither of the two fathers played any part in the care of their respective baby. Whilst the mother of Child D had always resided in the same foster placement, the other young mother had a longer history in care with a number of disrupted placements.

Key Findings

- 4.1** It was apparent that the final foster placement had the ability to provide much needed security and support to either of these young people, and eventually their babies, but it was questionable whether this was possible within the circumstances of both young women residing there at the same time. The lack of any consideration of the joint placement by the relevant social workers and other professionals was a significant omission.
- 4.2** Assessment opportunities, particularly in respect of pre birth circumstances, were missed in both cases. In this way safeguarding procedures were not followed in respect of the need for pre birth assessments and there was a failure on one occasion to recognise when child protection procedures needed to be instigated.
- 4.3** There were examples of good practice in this case, and it was no doubt the level of professional support offered which contributed to both of these young mothers being able to demonstrate some good parenting skills when their babies were born. Both young mothers were vulnerable and required considerable professional support as adolescents and the difficulties that were presented, particularly from one of the young mothers by her risk taking behaviours, cannot be underestimated.

- 4.4 Professional communication was not always as effective as it should have been, and at the ante natal stages, there should have been more purposeful collection and collation of background information to inform knowledge about the parenting capacity of these young women. At the time there was too much attention paid to the current presenting situation, which was generally positive in terms of child care skills. This was in respect of both mothers. Whilst there were no doubt some benefits in trying not to stigmatise a young parent, and particularly a care leaver, there was nevertheless a danger in focusing on the present and not taking past history into account.
- 4.5 The foster carer had an inconsistent level of support from Children's Social Care and at times was left much to her own devices. The Fostering Agency worker however provided consistent input and support. Although the foster carer was experienced, she should have been given more formal assistance in addressing the needs of the two young mothers and their babies. In a busy local authority where demands on social workers' time are high, it can nevertheless be understood how an experienced foster carer, who was achieving successes with both young women, would not present a high priority for their attention. As difficulties began to emerge in the placement, requests by the foster carer were made for one of the mothers to be placed elsewhere, but although the intention by Children's Social Care was to organise a transfer, the complexities of the situation meant that this could not be quickly resolved to everyone's expectation.
- 4.6 There was mounting evidence of the placement becoming dysfunctional and relationships became tense, whilst at the same time both mothers wished to remain, and so how to address the need for a placement change whilst still being supportive to both mothers and reflecting their's and their baby's needs, was clearly highly complex. Potentially this could have been helped by a clear separation of the roles of social workers for both mother and child, and whilst this was successfully utilised on occasions, unfortunately this was not consistent.
- 4.7 The decision reached to find another placement for one mother and her baby, and to leave Child D and mother, Child E, in the foster placement, was primarily based on the positive parenting that had been witnessed, and therefore promoted as a positive move for the young mother, Child G. This did appear to be an appropriate decision in the circumstances, but the mother in fact experienced it in a negative way, feeling that she was not ready for more independent living. This young mother's stance in these circumstances continued to make it difficult to make decisions that would meet all of the needs being presented. The harm that occurred to Child D by the excessive salt intake, occurred at a time when professionals were still trying to resolve the need to organise and promote separate placements for these two young mothers and their infants.
- 4.8 Overall, this Serious Case Review has reflected a complex set of inter weaving factors involving two separate families, which inevitably generated many challenges for the range of involved professionals to manage. This was particularly so at the latter stages of the joint foster placement in trying to make the most appropriate decisions that would meet the different, and to some extent conflicting sets of needs of two different, but vulnerable mothers and their children.

Summary of Key Recommendations

- 5.1 The procedural requirement for all Looked After Young People who become pregnant, to have a pre birth risk assessment undertaken, should be actively promoted via the experiences in this case, to relevant social care and health service managers, to ensure understanding and compliance.
- 5.2 An audit of the most recent cases when a Looked After Young Person has become a parent whilst in care or in receipt of leaving care services, should be undertaken, to monitor and evaluate the use of pre birth risk assessments. The outcome of such an

audit would need to be presented to relevant managers and practitioners, in order to enforce learning.

- 5.3** An additional process should be developed in respect of the Looked After Child Review system, to ensure that when young people who are Looked After become parents, that the Looked After Child Reviews remain effective in addressing their specific needs, whilst the issues of parenting can also be appropriately and separately addressed. Key professionals for inclusion in the Looked After Child process would be in respect of midwifery services
- 5.4** A process must be established which will ensure that opportunities are created for formal exchanges of information between social workers and other professionals, including foster carers, when children and young people from different families, are separately placed in the same foster home.
- 5.5** The processes for Legal Planning Meetings need to be able to reflect a clear audit trail in respect of the recommendations made, or the decisions reached, and how the eventual outcomes from such meetings are agreed and implemented.
- 5.6** Psycho-social meetings within the hospital which are utilised to share information and plan interventions in respect of child care issues, must have agreed purposes, terms of reference, with outcomes which are minuted and accepted by the professionals in attendance at such meetings.

Recommendations from Internal Management Review Reports

In addition to these recommendations, each of the Individual Management Reviews have compiled their own set of recommendations for their agency to address. The action plans generated from these and from the recommendations above will be overseen and monitored by Brent LSCB.

Police

- 1** It is recommended that the Senior Management Team at Brent Borough Operational Command Unit review their interview policy in respect of children returning from periods of being missing to ensure they comply with the London Procedure for Safeguarding Children Missing from Care and Home.
- 2** It is recommended that the SCD5 Child Abuse Investigation Command (CAIC) should review the working practices, capacity and capability of the Referrals Desk staff, including the manager's resilience at the Brent and Harrow CAIT to ensure that staffing levels are correct.
- 3** It is recommended that Brent CAIT officers be reminded of their responsibility to ensure accurate and complete records are created at the initial point of contact when allegations of crime are made in line with the Home Office crime reporting systems.

Health (NHS Brent, NWLH & CNWL)

- 1 Midwives need to recognise the significance of a child being a Looked After Child when assessing and planning for a child (including unborn children) and ensure this takes place. Their 'Looked After' Status is to be included in all their Health records.
- 2 Maternity notes should include a checklist of what written information or advice a pregnant woman is given.
- 3 The role of father in a pregnancy and baby's life should be considered.
- 4 If a decision made at a child protection conference is changed, then a discussion should take place to share and agree information as to why this has happened and challenged if necessary.
- 5 All administrative staff to be reminded to check the clients home address and their GP at all attendances of each child/woman
- 6 All unborn and newborn babies with a child protection plan should have their social background detailed in the babies notes
- 7 When assessments are completed for child abuse cases, copies need to be sent to all partner agencies.
- 8 When a strategy meeting is held; following an injury to a baby child relating to a domestic violence incident; and the health professional is not invited; this should be followed up by health professional.
- 9 Staff to be updated on implementation and responsibilities when a child is subject of a child protection plan
- 10 GP's and primary care practitioners should consider the need for additional mental health support for young pregnant mothers with a history of sexual abuse, suicide attempts and mental health issues
- 11 GP Practices should highlight all 'Looked After Children' using existing IT coding systems
- 12 Health Visitors and Paediatric Nurses should receive an updated training session on the nutritional needs of premature babies
- 13 All Looked After Mothers and their babies who share the same accommodation/foster placement should be allocated a separate Health Visitor.
- 14 When Looked After Children who are former Child and Adolescent Mental Health patients are known to be pregnant, there should be consultation with the former Child and Adolescent Mental Health service.
- 15 The 'Looked After Children' Team should invite a contribution from the former Child and Adolescent Mental Health Service to a professionals meeting to discuss the pregnancy.
- 16 Pregnant 'Looked After Children' who are former Child and Adolescent Mental Health patients should be offered re-referral to the Child and Adolescent Mental Health Service.
- 17 A mother with a history of mental health problems and instability and difficulties with their own mothers should be considered for referral to an appropriate service prior to the birth of their baby. The development of a Peri-natal Mental Health Service locally should ensure that this is addressed.

- 18 Early identification of problems and early referral to CAMHS increases likelihood of compliance with treatment
- 19 CAHMS should discuss all their 'Looked After Children' who are pregnant with their named professionals for safeguarding children
- 20 All referrals into a CAHMS team should include a check of all the systems to include all information known on the patient and collated into a single record

National Fostering Agency

- 1 NFA to devise its own Risk Assessment template for Duty officers.
- 2 NFA to revisit its matching Policy, particular attention paid to Mother and baby Placements
- 3 Revisit template for duty team to ensure that NFA has where possible relevant/sufficient information to enable its SSW and carers to make informed decisions in relation to possible placements
- 4 Quality Assurance team to develop guidelines, procedures and recording materials for NFA SSW and carers to use with mother and baby placements.
- 5 Additional guidance to Social Workers in relation to assessing carers for mother and baby placements
- 6 Training for Senior Social Workers in assessment and recording
- 7 National Fostering Agency to produce guidance and a tool kit for foster carers considering mother and baby placements
- 8 Continued foster carer training for parent and child placements
- 9 On-going training in relation to matching, safeguarding and recording
- 10 Senior Social Workers to be assertive in ensuring receipt of appropriate minutes from statutory meetings.

Social Care

- 1 All looked after children who become pregnant must have a pre birth assessment with a support plan formulated to meet both the young parent and the baby's needs.
- 2 When two social workers are allocated to work with a looked after young mother and her child, regular meetings should take place between the workers to ensure that both children's needs are addressed within the care planning process.
- 3 Any diversion from recommendations from legal planning meetings must be agreed by the Head of Service for Care Planning.
- 4 Brent Children's Placement Panel ensures that any placement of a child takes into account the needs of any children already placed.
- 5 Brent Independent Reviewing Officers ensure that any consideration of other children's needs are taken into account at each review.
- 6 Supervisors should be reminded of their responsibility track activity against plan at each supervision meeting. Supervisors must leave a record of outstanding actions after each supervision meeting.

- 7 Risk assessments must be regularly updated in cases where young people are engaged in risk taking behaviour, are suspected of being sexually exploited, are regularly absconding from placement.
- 8 The action plan agreed by Independent Reviewing Officers should include firm timescales for actions and the professional responsible for the task.
- 9 Assessments undertaken by the Leaving Care Team must take account of and demonstrate an understanding of the young person's history.
- 10 Supervisors must ensure that the action plan from Looked After Child reviews is specifically addressed in supervision.
- 11 Brent's Looked After guidance and procedures should be reviewed to ensure that they:
 - a. Have sufficient regard to safeguarding children guidance and child protection procedures and include relevant information and/or links where appropriate.
 - b. Include the need for impact/risk assessments to be carried out in respect of proposed changes that may affect a Looked After Child.
 - c. Provide guidance on the number of Looked After Children in any one placement - this guidance should also have regard to all other children in the placement who may not be Looked After.
 - d. Provide guidance on the status and responsibility of foster carers in respect of babies of Looked After Mothers where the babies are not themselves Looked After - this should include the need for a written agreement with the foster carer when a mother and baby is placed in these circumstances.

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