



# **Baby F Serious Case Review**

**Author: Edi Carmi**

**11.10.15**

# EXECUTIVE SUMMARY

## Context

On 22.08.14 Baby F, aged 11 months, was found by his mother submerged in the bath, after she left him unsupervised. He was taken to hospital, but died in September 2014. Baby F and his two siblings had been subject to child protection plans under the category of neglect since the end of April 2014.

Baby F's mother pleaded guilty to manslaughter in March 2015 and received a six year custodial sentence.

## Summary of Case

Baby F's mother was well known to agencies in Harrow because of historic concerns about the neglect of her children due to her own lifestyle, which involved substance misuse, domestic violence and lack of engagement with services. Her eldest child (Sibling 1) moved to a relative when young and her next two children were the subject of child protection plans between 2010 and 2011. It was understood that these children are half siblings to each other and to Baby F.

The period under review began with the start of her pregnancy with Baby F in early 2013. Prior to the birth the midwifery service did not identify the risks of a vulnerable pregnant woman who had not booked in for antenatal care, did not attend appointments offered and was neglecting her own health needs and in consequence the needs of her unborn baby. Children's social care were unaware of the pregnancy so no pre-birth assessment was undertaken.

Baby F was born early, at a friend's home, delivered by the man understood to be his father. The paramedics thought they could smell alcohol on the mother's breath when they took mother and new born baby to hospital. Baby F remained in hospital (first in Brent and then in Buckinghamshire) until he was 23 days old, before joining his mother and two siblings in a refuge in Buckinghamshire; mother had moved there just before his birth. Despite intentions to hold a pre-discharge meeting at both hospitals baby F was discharged without such a meeting or any social work involvement.

During baby F's first five months of life, from the time he was discharged from hospital, he was seen twice by health visitors and once in a clinic. No social worker saw him or his siblings despite concerns around the circumstances of his birth, mother's current circumstances, the context of the family history and several referrals from members of the public. These referrals mentioned that Baby F's parents were smoking heroin in front of the children, whose health and nutritional needs were being neglected.

Despite initiating a child protection enquiry, Harrow children's social care did not see baby F and siblings or investigate the allegations that were made. This was due to confusion around the children's whereabouts, with Mother claiming to be travelling to different places. There

was initially a mistaken assumption that Buckinghamshire would investigate concerns, even though the family had returned to Harrow, or an acceptance that it was not possible to locate the family and that the mother did not want help. This ignored both the fact that this was clearly a Harrow family and the alleged risks to the children that needed to be investigated.

From February 2014 onwards there was a great deal of effort and tenacity displayed by the newly allocated social worker in constant attempts to locate the family and try to see the children. The health visitor at the time also put in a great deal of effort to support the family and ensure the children received the health resources they needed. However, despite this major individual and collaborative effort by the professionals, there was no progress made and the children did not receive the health and dental care they needed. Moreover, there was increasing suspicion that the mother had returned to misusing alcohol and drugs.

Whilst it took too long for the management in children's social care to progress the case firstly to child protection and then to legal intervention, by the end of June the need for such was identified and legal planning meetings were held in July and August 2014, with the mother advised of the imminent use of legal intervention unless she complied with the child protection plan.

A new social worker took over the case in July and initially there appeared to be some improvements made by the mother in response to the warning of legal intervention, but just before August Bank Holiday the social worker learnt from the Bed & Breakfast manager that a man was visiting the family every day, that the mother was borrowing money from the manager and other residents, and was overheard asking for heroin in a telephone conversation. Also Baby F's siblings were rescued by staff after they ran across the road unsupervised, dressed just in nappies.

The next day the management of children's social care took legal advice and agreed that proceedings would be initiated, with an application for an Interim Care Order to be made after the Bank Holiday.

Whilst consideration was given to the immediate removal of the children, a joint home visit by police and social worker that evening did not give grounds for the police to remove the children under Police Powers of Protection<sup>1</sup>, as there was no immediate risk: mother did not appear to be under the influence of substances and the children appeared well.

---

<sup>1</sup> The Police have powers under s. 46 of the Children Act 1989 to protect children. If a police officer believes that a child is at risk of immediate danger and there is insufficient time to seek an Emergency Protection Order, then s/he may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in police protection for more than 72 hours.

The next day consideration was given to the immediate removal of the children that day through the taking of an Emergency Protection Order<sup>2</sup> by children's social care. However, the understanding of legal advice was that there were insufficient grounds for such emergency action. Instead plans were made to provide support to the family over the Bank Holiday, with two visits daily. Legal intervention was planned to take place on the Tuesday with an application for an Interim Care Order. Tragically, between the support worker's visits on the Saturday, the mother left Baby F unsupervised in the bath and he suffered brain injury which led to his death some weeks later.

## Findings and recommendations

### **1) *Systemic weaknesses in ante-natal midwifery services contributed to the failure to identify and refer pre-birth safeguarding concerns to children's social care***

The provision of midwifery services demonstrated fundamental flaws in safeguarding practice involving the:

- inability to access historical records of patients who are not 'booked in' for services
- repeated lack of recognition of /or response to the vulnerability of a pregnant woman
- lack of fulfilment of the basic midwifery duty to ensure patients are 'booked' in (especially those who are vulnerable)

#### **Recommendation 1**

The LSCB to ask the CCG and the LNWHT to report to the LSCB how midwifery will be able to provide a safe service which:

- provides access to historical patient records for all midwives, regardless of which team is providing the current service and whether or not the patient is 'booked-in'
- ensures that all midwives are able to identify and work with vulnerable patients, recognise safeguarding risks and make child protection referrals when required
- does not apply a DNA policy of withdrawing services following 3 DNAs, without reference to the fact that such behaviour is likely to denote greater need and risk
- provides a safety net which ensures the 'booking in' process is not avoided by staff due to time constraints and which addresses the risk to baby and patient of women who have not made use of antenatal provision

---

<sup>2</sup> An emergency protection order or EPO is a court order granted under Section 44 of the Children Act 1989 on the grounds that a child will suffer immediate significant harm unless they are removed to council accommodation or moved from where they a current place of safety. Separation is only to be contemplated if immediate separation is essential to secure the child's safety: 'imminent danger' must be established (X Council v B (Emergency Protection Orders){2004}.

**2) *The belief that mother was a 'traveller' together with her effective avoidant behaviour contributed to a lack of effective follow up of concerns; this highlights the vulnerability of children in mobile families and the risk that children can become invisible***

Mother was understood to come from a travelling family, so when she missed appointments but explained she was staying in different places outside of London, practitioners accepted this as part of her culture, without further checking.

There was inadequate consideration given to the need for follow up of concerns (in the case of children's social care) or of checking the children's health and development (in the case of health visitors) when mother claimed to be elsewhere. On one occasion children's social care assumed that another authority would undertake the required assessment (despite having not agreed this with them) and at other times no contact was made with the 'host' authority where Mother claimed to be, even when there was a s.47 (child protection) enquiry in progress.

Even when Mother seemed to be staying in the B&B accommodation provided, she was skilful in avoiding professional contact, despite the tenacity of a social worker spending considerable time in trying to locate her. In such circumstances it is vital that intervention is taken at earlier points in order for practitioners to be able to see the children and assess their needs. Whilst in this case practitioners were threatening to take such action, this took too long. Mother explained to the author that the repeated warnings made to her, without immediate action, reassured her that no action would happen.

**Recommendation 2**

- a. The LSCB to consider how to develop practice so that:
  - children within mobile families do not become 'invisible' and that they receive continuity of health and social care involvement, and when necessary intervention, even when the family moves around
  - practitioners challenge avoidant parental behaviour and do not accept at face value explanations of the family travelling
  - managers recognise the immense time involved in such challenge, but that this is required whenever there are safeguarding concerns
  - no child protection case is ever closed because a parent claims to be living elsewhere, without an agreement by the next local authority to take over enquiries
- b. The LSCB to ask children's social care to report on quality assurance processes on the 'front door' of the service; in particular that children's needs within mobile families are met (including cases not being closed without assurance of them being picked up in other areas) and that decisions for no further action are consistent with the safety of children.

**3) *The case demonstrated a misunderstanding about the use of Police Powers of Protection instead of an Emergency Protection Order***

The senior manager within children's social care identified the risk to the children the need for their urgent removal following the information received from the manager of the B&B. However, subsequent decision making reflected a misunderstanding within children's social care about the use of an Emergency Protection Order as opposed to a reliance on Police Powers of Protection, which should only be used if there is evidence of immediate risk.

This case also demonstrated the need for social workers and managers to take account of legal advice, but when they feel that the risk is too high to leave children within the family whilst an Interim Care Order application is made, an EPO should be progressed and the matter put to the Court for a decision.

**Recommendation 3**

Children's social care to hold facilitated workshops for managers to explore the differing use of Police Powers of Protection and Emergency Protection Orders. This should also cover the role of lawyers to provide advice as opposed to social work managers in making the decisions

**4) *There was repeated misunderstanding within children's social care of the function of police welfare checks as opposed to the children's social care responsibility to investigate allegations and concerns***

Within children's social care in Harrow there was an assumption that when police visited a home and concluded that the children were safe and well, there was no need for further investigation of referrals. This demonstrated a basic misunderstanding of the police role to establish if the children were at immediate risk of harm at that point in time, as opposed to the role of children's social care to undertake the wider and in depth assessment of the allegations.

**Recommendation 4**

Children's social care to consider how best to disseminate to staff the distinction between police welfare checks and the role of children's social care, and how to establish if this is successful in changing practice. The LSCB to request a report from children's social care on the implementation and progress of this recommendation.

**5) *The repeated lack of investigation by children's social care of the referrals from members of the public may reflect underlying cultural attitudes and suspicions to non professional referrals; such an attitude is a serious weakness in a safe service***

Safeguarding is everybody's responsibility and referrals from members of the public need to be fully investigated. This needs to involve referrers being provided with the opportunity to meet with a social worker so as to provide more detail and evidence of concerns. This has been part of the London child protection procedures since the first edition in 2003.

**Recommendation 5**

- a. The LSCB to consider how best to promote cultural change so that professional practice fully values the involvement of members of the public in safeguarding children - such a cultural shift would see changes in practice which includes routine interviews of members of the public as part of follow up to referrals and assessment practice
- b. The LSCB to request agencies include the involvement of members of the public, friends and wider family in audits of response to referrals and of assessment practice - the results of such aspects of the audit to be provided to the LSCB and published as part of the promotion activities of the LSCB

**6) *The lack of individual supervision for social workers is likely to impact on cases that require a great deal of reflection and management oversight***

The allocated social workers in this case were part of the 'pods' within the children in need service. Staff within a pod are managed by a pod manager but do not necessarily receive individual supervision as this model of organisation predominantly uses group supervision for staff. Whilst group supervision can be a very helpful tool, it does not address the individual needs for reflection and management decision making that is typically needed in chronic neglect cases, especially in relation to avoiding delay in moving into child protection and legal proceedings.

The social workers within this pod were concerned that their concerns about this case were not being adequately 'heard' by management at the time. It is important that whatever structure is in place, senior managers are assured that systems are in place for practitioners to have their concerns heard and addressed by managers beyond the individual pods.

#### **Recommendation 6**

- a. Children's social care to review the use [or not] of individual reflective supervision within pods, and report to the LSCB on how the needs for reflective case supervision are met in complex cases, and particularly where there is chronic neglect.
- b. Children's social care to provide systems for social workers to be able to articulate concerns about case management or to seek consultation, outside of the individual pods; children's social care to report to the LSCB how this will be accomplished and review its effectiveness

#### **7) *There was little indication within midwifery services and children's social care 'front door' of practitioners understanding the need to take account of the family's known history***

A common finding in serious case reviews is the lack of practitioner understanding of the need to access and understand previous agency history of the family, in order to evaluate the risk to children. In this case the practice weakness was evident in both midwifery services and the children's social care teams involved between August 2013 and January 2014.

#### **Recommendation 7**

The LSCB to consider how to change cultural practice across all agencies so that practitioners routinely access the known agency history of families (including all carers), and that the history is taken into consideration in any responses

#### **8) *The father and wider family members were insufficiently involved in the assessments undertaken***

In common with findings from other serious case reviews nationally, there was insufficient involvement of the father in the assessments undertaken, although one social worker did initially try to engage him. Most critically the previous history of father was not accessed, although he was known to be the father of another child who had been adopted.

The assessments also did not involve other family members, despite it being known that both paternal grandparents, maternal grandfather, and other members of the extended family were involved in supporting the family.



### **Recommendation 8**

The LSCB to consider how to change professional practice in all agencies, but especially within children's social care, so that all carers and involved family members are routinely involved in assessments of children subject to child protection plans and that their history is accessed as part of the assessment.

***9) During the period of this review mother and children were homeless and moved many times, including eight different bed and breakfast placement: the constant moves and type of accommodation provided is likely to be detrimental to the children's welfare***

Whilst the reason for the frequent moves are not totally understood and were in part due to Mother's actions and inactions, such constant moves must have been disruptive and distressing for the children.

The use of B&B accommodation for families is recognised as being unsuitable, only to be used when there is no alternative provision available and that the family should not remain there in excess of six weeks. This family were in B&B accommodation for longer than six weeks.

### **Recommendation 9**

a) The LSCB to establish the use of B&B accommodation by Housing for Harrow families, the frequency of moves between B&B per family and the total amount of time families spend in such accommodation before being offered more suitable temporary accommodation such as a flat or house.

b) When the LSCB have this information, consideration to be given if there are systemic problems in the available provision and if further action is needed locally or in collaboration with other London boroughs.

**10) *There were examples of good practice by individual practitioners, despite an overall service characterised by 'too little, too late'***

- The first Harrow health visitor who persevered in trying to see mother and tried to get children's social care in both Buckinghamshire and Harrow to investigate the concerns; had she escalated the failure of both children's social care services to do so, her involvement would have been even more effective
- The team manager of the child in need service for ensuring in February 2014 that the case was allocated and that this time the mother and children must be assessed
- The persistence and tenacity of both allocated social workers after February 2014 enabled the risks to be identified, recognised by management and begin to be addressed
- The persistence of the Ealing health visitor to try to facilitate the health and development needs of the children and her continuing involvement after the children moved out of Ealing
- The escalation of concerns by the Ealing health visitor, leading to the safeguarding advisor communicating concerns to Harrow children's social care
- The willingness of police to do welfare checks in response to referrals from members of the public
- The good communication and partnership working between the two allocated social workers and their colleagues in health and in the police, involving a number of joint visits
- The attempts by staff in the refuge to find mother, identify the whereabouts of the children and maintain the placement whilst trying to facilitate the family's return

This case demonstrated some very good examples of safeguarding being everyone's business, with the last B&B manager and staff involved in trying to help the family, as well as reporting to the social worker the concerns about the children's care and mother's behaviour. This manager also contributed to this serious case review which has enhanced our learning.

Members of the public also tried to contribute to the children's welfare by expressing their concerns at the time to police and children's social care. Such responsibility towards children in our community is to be greatly commended.

**What will the LSCB do in response to this?**

At the end of each finding in section 6 recommendations have been made for the LSCB. The LSCB has prepared a separate document which describes the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.