Lambeth Safeguarding Children Partnership

Learning Lessons Summary
Baby N

Completed: November 2019
Summary published: August 2020
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Overview

Baby N was born in Lambeth during in the spring of 2018. Prior to birth, Baby N had been the subject of a Child in Need plan (Section 17 Children's Act). Baby N's mother, Ms X, was a young woman in her early twenties when she became pregnant with Baby N. She identifies herself as black and British, having been born in the UK. Mr Y, Baby N's father, was in his late twenties at the time of the pregnancy. He identifies himself as black and British.

Ms X was adopted aged two. She described this relationship as having broken down, leading to foster home placements. Prior to coming to London from another city she had been living with her adopted father. However, by summer 2017 she had fallen out with him and moved out. In May 2017, Ms X reported to Lambeth Housing that she and Mr Y wanted a fresh start in a new area. She declared that was homeless.

During the pregnancy, significant health and social care concerns had been raised with regard to Ms X. These had serious implications for the unborn child. Although initially co-operative with ante-natal services, Baby N's Mother withdrew from services.

Following the birth, it became increasingly difficult for professionals to work with Baby N's mother and father. Whilst not limited to concerns about weight gain, issues crystallised around the feeding regime for Baby N. Baby N had lost weight and had never regained their birth weight. In early June, Baby N was taken to hospital by paramedics under police protection. Because Baby N had gained some weight, it was felt there was no medical reason to admit Baby N, who was then discharged. Later that month, Baby N was admitted to hospital, and required high dependency care. These concerns led to care proceedings and Baby N was placed in foster care, aged four weeks.

Themed Findings

There was limited effective corroboration of information and who knew what

Ms X appeared to be cooperative and open about her past to the social worker who carried out the Initial Assessment of Need (S17). Therefore, much of what she reported was accepted without further attempts to check if Ms X's view coincided with that of others. For example, health and probation services were aware that Ms X did not have a diagnosis of Bipolar disorder. The Initial Assessment process as completed in this case, is somewhat skewed to the self-reporting of Ms X with no real scrutiny exerted.

The same observation could be applied to healthcare assessments; the contact from the Early Intervention Health Visitor (EIHV) in the city she had originally come from suggested that Ms X had been pregnant before, but no clarity was established in relation to her obstetric history beyond her self-reporting.

An Oasys assessment[1] had been completed in May 2017. This contained a detailed objective view of Ms X's engagement with services. It noted that it had been extremely difficult to engage with her. This information was available to inform the assessment process and help to focus on the most effective way to learn from other professionals when working with Ms X, but beyond what appear to be superficial enquiries, the information was not used.

The report of a diagnosis of a personality disorder is similarly not pursued. The perinatal psychiatric team established that Ms X did not display any signs of a serious and enduring mental health problem. There was no clarity around a diagnosis of personality disorder and therefore no advice on how to support and manage Ms X.

The record of the professionals meeting of the 1st June was not available until the 13th, so it is difficult to know how the duty social care staff could have been informed. Much of the healthcare information relating to Ms X was held in diaries or on WhatsApp messages and this did not facilitate universal awareness of any situation. When the social care team manager became involved when Baby N was first taken to hospital under Police Protection, she does not appear aware of either the detail of the care Initial Assessment or of the views of her colleagues who had been present at Ms X's home that morning.

The impact of past experience and behaviour

Even without seeking corroboration of events and incidents, if Ms X was correctly representing her past, she was at significant risk herself, along with her unborn child, of coming to harm. This should have indicated that a clear and closely monitored supportive plan was developed, one which made clear to Ms X what expectations were placed on her and one which offered a consistent approach across staff and disciplines.

Ms X had considerable practical challenges to face as a first-time mother, in a new city, living in one room. She was making a fresh start, but this meant that she had few friends and no family support mechanisms. As a pregnant woman she had particular physical challenges and risks including extreme obesity, smoking and a volatile relationship.

Her previous behaviour had led her into conflict with those around her. These issues were not only significant risks for her but must be seen as potential risks to an unborn child. However, the focus of the care antenatally does not consider this in a manner which considered all of the risks and which led to an agreed and settled approach.

Different information to different people

There is considerable evidence to show that Ms X was sharing her different health beliefs with an audience who offered no challenge to them. For example, the social work assessment notes:

1 http://nomsintranet.org.uk/roh/roh/2-basic_riskassessment/02_02.htm

"Ms X is said to be putting her unborn baby at risk by not attending the relevant appointments to help manage her high BMI and she has not engaged with recommendations . Mr Y has however informed that this is in relation to her beliefs about not taking man made drugs. The couple are observed to believe in natural herbs and remedies, and this is not currently viewed as an intentional attempt to harm her child. The couple appear to do a lot of research and take great interest in ensuring they know what natural remedies are good for them. I would argue they are showing great interest and precautions in the pregnancy."

These views had not been shared with healthcare staff, either by Ms X, Mr Y or the social worker. They have significant potential impact on an unborn child, and it is unclear why they were not shared more directly. For example, if Ms X's objection to heparin (used for thinning the blood to prevent clots) was that it is essentially an animal product, alternatives might have been proffered. All health care staff seemed to know, was that Ms X would not have heparin injections; this information offers a possible reason why.

In the UK, parents have the right to bring up their children according to their own beliefs and preferences. Whilst the right to private family life and choice must be respected, a judgment has to be made about the potential of those beliefs leading to significant harm.

The concern is that such views offered significantly more risk for Ms X and her unborn child than they might have held for others. She was morbidly obese and continued to smoke. Neither of these things were objectively "good for" Ms X or her unborn child.

There are several points where the social work view of Ms X's, such as on the day Baby N was born, when she was seen on the ward is radically different to that of the midwives. For example, midwives' concerns included Ms X refusing routine protective treatment for Baby N, including Vitamin K (which plays an important part in blood clotting) and allowing the baby to be examined. Equally, there are major inconsistencies in the views of the midwives and breast-feeding supporters to Ms X's approach.

One of the most apparent facets of this case is that there is copious communication at times, then little action and even less analysis of what some information might mean.

Lack of co-operation, declining engagement and over optimism

Ms X's co-operation and engagement with health and social services was initially focussed on her needs. She saw the GP for a letter for housing. She did not return with her antenatal book, but she did engage with midwifery services.

From the 31st week of her pregnancy when she was advised that she could not have a home birth or use a birthing pool, there is a decline in her engagement with health services. Whilst noting that this must have been disappointing, it seems to mark the start of Ms X's focus on what she desires rather than a focus on what will be best for both her and her unborn child.
There is a discernible disengagement as the pregnancy progresses.

The same pattern is repeated after the birth of Baby N: Ms X declines basic health protection measures for Baby N, such as Vitamin K and screening for metabolic disorders.
Her engagement with social services is similarly marked by declining engagement when she meets challenge.

Focus on Baby N's weight gain when there were other concerns

Concerns about Ms X's ability to consider the needs of her unborn child were recognised antenatally. This culminated in plans which were heading towards a pre-birth Child Protection Conference in March 2018, but this was changed, and a Child in Need plan was set out.

It is apparent that the concerns about Ms X escalated as the care Initial assessment was completed and differing views came into focus. Although it was the original social worker who completed the assessment, a new social worker took over and the focus moved to trying to let that person develop a relationship with Ms X.

The plans to manage Ms X's postnatal discharge and care are not as precise as they needed to be and do not appear to take account of the impact of the death of Ms X's estranged birth mother on the very day that Baby N was born. Despite this additional factor, Ms X was discharged from hospital, following the birth of Baby N, late on a Friday night. She had been keen to leave, but had also presented a different view to the social worker of a woman who was fearful of managing her baby.

There is considerable focus on Baby N's weight gain. This is a significant issue and was ultimately the reason for readmission to hospital. However, it is also a proxy for the wider concerns felt by the majority of health care professionals who encountered her, that Ms X was struggling to look after her baby.

Whilst Ms X argued that she was better left alone and she would manage adequately without help, there is nothing to support her view beyond her own assertion. However, the focus on weight meant that whenever there was even a slight gain, there was considerable over optimism that counterbalanced all other concerns. The level of medical and social analysis of risk and need for this vulnerable baby and mother was not proactive.

Individual approaches rather than following an agreed plan

Many of those involved with Ms X's care tried hard to keep her "onside" by trying to accommodate her requests. For example, the safeguarding midwife carried out the post-natal check. This is highly unusual. Taxis were sent for Ms X to try to get her to attend appointments. The aim of continuing with a CIN plan rather than formalising a Child Protection Plan was to try to continue to engage Ms X.

Whilst offering personalised care is admirable and something to which all aspire, this went well beyond this and in doing so appears to have blurred the boundaries of responsibility. The other concern is that even on the same day different individuals have different experience and responses. For example, in early June, one health care professional has what they believed to be a very positive encounter whilst another has a very negative one.

The lack of adherence to guidelines, such as the Lambeth standards for pre-birth assessment, the hospital guidelines for record keeping, and wider information sharing guidelines all contributed to the confusion in this case.

There is little doubt that Ms X appeared intimidating and difficult to staff. Dealing with such individuals is extremely challenging; staff are required to keep at the forefront of their approach what life is like for the child and to consider if they are unintentionally colluding with the parent/s by avoiding conflict; filtering out or minimising negative information; or placing undue weight on positive information (the 'rule of optimism') and only looking for positive information.

Missed opportunity and aftermath

When there were significant concerns which led to the need for police protection on in early June 2018, these were not limited to Baby N's weight gain. As noted above, the weight gain was something which could be measured but it was not by any means the only issue.

Ms X's response was perhaps predictably aggressive. The social care notes for that date record concerns about her behaviour and about the inability of Mr Y to challenge and be considered a protective factor. Ms X redefines what happened when speaking to the social worker's manager and her version of events is accepted uncritically, to the point that the manager notes "I had no concerns about mother's presentation".

The social worker's manager was met with agreement from the clinicians who carried out the physical assessment of Baby N on the 8th June; he had gained a little weight and by the time they were assessed, had been fed at least twice since the assessment by the paramedics. However, this was not the full story of the risk and they record no evaluation of it.

The safeguarding midwife had been able to establish something of a relationship with Ms X. There is a sense when reading some of the records relating to the 8th June, that some staff thought that there had been an overreaction to events and that Ms X would engage with an informal plan. The rules surrounding the end of police protection are clear: a strategy meeting must be held, and agreement achieved. This did not occur in this case.

This did not prove to be an accurate reading of events. Ms X withdrew even further from services. Baby N was not seen at all from the 12th June until the 26th June, by which time, the baby was extremely unwell.

What should have happened?

The focus of this review is to identify what lessons single agencies, as well as the multiagency partners can learn, to ensure action is taken to inform practice with the aim of avoiding similar issues in the future. This learning review has identified a number of multi-agency issues: working with hostile and resistant families, information sharing, record keeping, compliance with child protection procedures and professional curiosity.

1. There should have been an agreed plan of action which, if breached, would be formalised to give clarity to all, including Ms X and Mr Y.
2. Meeting notes and agreed actions from multiagency meetings should have been taken and circulated in a timely manner to ensure transparent communication and to hold individuals to account.
3. Emails and other forms of electronic communication regarding patients should be linked to patient files to ensure full transparency and continuity in the changeover of staff.
4. The pre-birth assessment should have resulted in a Section 47, putting Baby N on a Child Protection Plan. While there is no evidence that this would have improved Ms X's engagement with Healthcare and other authorities, it would have given her a very clear indication about the level of concern, as well as providing more options to professionals working with the family.
5. Baby N and Ms X should not have been discharged at 10pm on a Friday night. This

decision may have contributed to Healthcare professionals' inability to gain subsequent access to Baby N. While Ms X may have self-discharged, this would again have provided clear evidence of further intervention needed for Baby N.

6. When Baby N was taken to Hospital 1 under Police Protection three things should have happened:
    a. The Registrar and Consultant should have taken into account the presence of Police Protection, Social Worker and a parent with noted erratic behaviour, and not have discharged Baby N
    b. The Social Worker manager should have been apprised of the background history and details of the case
    c. A Strategy Meeting should have been called to reassess the risk to Baby N and put together a clear plan of action.

Recommendations

These recommendations are focussed on tangible actions for single agencies to take, as well as the LSCP to ensure that multiagency work is well coordinated:

1. Every multiagency meeting should agree on a note-taker who should record key decisions and actions and then email them to all participants, and non-attendees to ensure transparent communication, decision-making and accountability against specific actions against a specific timescale
2. All services should improve patient/client record keeping by linking emails or other electronic messaging involving patients to their personal records
3. Professionals involved in Strategy meetings may require training to empower them to challenge decisions they don't agree with. For example, there is no record that Healthcare professionals who felt that the Strategy meeting should have resulted in a Section 47, made their views known or escalated any concerns.
4. CSC should continue to quality assure outcomes from Strategy meetings, through Management Supervision and audit activities.
5. All agencies need to continue to ensure that the training they provide for their staff ensures clarity and support in how to balance building relationships with clients, in tandem to ensuring clear boundaries, which may lead to increased statutory intervention are in place. This is especially important in cases which involve confrontational or aggressive parents or family members which professionals attempt to get "on side".
6. All clinical services should review their patient discharge processes and decisions, to ensure that the patient is seen holistically and not simply from the perspective of one medical question (in this case, weight gain).
7. The clinical service involved should ensure that clinical supervision and reflection is sufficiently robust to enable staff to challenge effectively.
8. CSC should develop and communicate a clear protocol of action where a child is taken to hospital under police protection, and then discharged. This should include convening a timely multi-agency strategy meeting.