Serious Case Review
Overview Report

Re: Child Z

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April 2019

1. Introduction

1.1.1 The subject of this Serious Case Review, Child Z, died at home in April 2018, aged 2 years and four months; neglect was believed to be a contributory factor in Child Z's death. Child Z had significant, additional health needs following premature birth, and resulting complications. Child Z lived in a household with two siblings and mother Ms A. Mr B, their father, was heavily involved in the children's lives.

Initiation of the Serious Case Review

1.2.1 This case was referred to the Local Safeguarding Children Board (LSCB) Learning from Cases Panel on the 6th April 2018, two days after the death of Child Z.

1.2.2 Following review of the facts of the case it was agreed that there was prima facie evidence that this case met the criteria for an SCR in accordance with Working Together (2015)[1] as:

- Abuse or neglect of a child is known or suspected and
- Either a child has died; or the child has been seriously harmed and there is cause for concerns as to the way in which the authority, the board partners or other relevant persons have worked together to safeguard the child

1.2.3 A recommendation was made to the LSCB chair on this basis. The LSCB chair endorsed the panel's recommendation.

1.2.4 The National Panel and Ofsted were notified on 8th May 2018.

Methodology

1.3.1 The methodology made use of the Welsh Model adapted version of the Child Practice Review process,[2] underpinned by a systemic approach. The review sought to understand:

- precisely who did what through development of agency timelines, and
- the underlying reasons that led individuals and organisations to act as they did through analysis of information held within each agency and conversations with practitioners involved in the case

1.3.2 Following notification of the circumstances of Child Z's case, and agreement by the chair of the Local Safeguarding Children Board to undertake a Serious Case Review, the Review Panel was established in accordance with guidance. This was chaired by an independently appointed chair, Sophie Humphreys, a child protection specialist, and lead by Nicki Walker-Hall, an experienced Serious Case Review author from a health background.

[1] Working Together to Safeguard Children, 2015 Chapter 4

[2] Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012

1.3.3 Each agency reviewed their records drew up timelines and produced single agency analysis reports (SAARs). Each SAAR contains recommendations. Where issues have been identified and recommendations made, these will not be repeated within this report.

1.3.4 The single agency timelines were merged and used to produce an interagency timeline. This was analysed by the reviewer and the panel members who developed hypotheses, further informing the key focus areas for exploration and consideration.

1.3.5 Key practitioners were identified and asked to attend a learning event in order to understand the detail of the single and interagency practice in this case, and crucially gain insight into their perceptions of the family and how the different agencies related to them.

1.3.6 The reviewer and panel chair met Child Z's mother to gain an understanding of the family's experiences of the services provided. Account was taken of mother's views when writing the report and making recommendations. The reviewer is grateful for her contribution.

1.3.7 Child Z's father was contacted and invited to be involved in the review but declined. The reviewer respects his decision but acknowledges this may limit the learning.

1.3.8 The practitioner event was held in October 2018 and was attended by professionals who had direct involvement with Child Z or other members of the household. The Reviewer was mindful of the issue of hindsight bias[3] and sought to mitigate this through discussions with the practitioners involved. Not all those invited could attend; some were spoken to at a later date. The practitioner's learning event was organised in line with Welsh Government guidance.[4]

1.3.9 Following the learning event, the Reviewer collated and analysed the learning and developed a draft report. The draft report was provided to the panel in advance of a panel meeting in December 2018 for input and reflections. Further panel meetings took place in January 2019 to considered the revised report. These panel meetings provided opportunity for organisations to conduct further analyses and draw up recommendations to address the learning points.

1.3.10 The Reviewer and Chair offered to meet again with Child Z's parents to provide an opportunity to see a copy of the report when agreed by the LSCB. Learning from the full report will only be made available to the public after consideration by the LSCB.

Time Period for the Review

1.3.2 The review covers the timeframe from just prior to the pregnancy of Child Z– 01.01.2015 until Child Z's death 04.04.2018.

[3] Hindsight bias is a term used in psychology to explain the tendency of people to overestimate their ability to have predicted an outcome that could not possibly have been predicted

[4] Child Practice Reviews: Organising and Facilitating Learning Events, December 2012

Family Members

Term used	Relationship to subject	Age in April 2018
Child Z	Subject	2 years 4 months
Ms A	Mother	34
Mr B	Father	36
Child C	Sibling	5 years 5 months
Child D	Sibling	3 years 7 months
Child E	Half-Sibling	16
Child F	Sibling	Died at 22 weeks gestation
Child G	Half-Sibling	Died aged 4 months

2. Brief Outline of the Circumstances Resulting in the Review

2.1.1 Child Z was 2 years and 4 months old at the time of death. Child Z had complex health needs and a complex family history.

2.1.2 At the start of the review period Ms A was pregnant with Child Z who was the 10th of 11 children born to mother (Ms A) and the fourth child of father (Mr B). Ms A did not attend all her midwifery appointments, particularly in the latter stages of the pregnancy.

2.1.3 Ms A was well known to Children's Social Care (CSC). CSC had been involved with Ms A's older children. Concerns centred around Ms A's capacity to parent the children, Ms A's mental health, overuse of prescribed medication and historically, substance misuse. Most of Ms A's living children had been subject to child protection plans under the category of neglect, at some point in their lives. Three older half siblings had been placed with their biological father in a separate location a number of years prior to the birth of Child Z and Child Z's siblings.

2.1.4 Ms A had an extensive history of CSC involvement having been placed in care as a baby and then again from the age of 9. Ms A had several adverse childhood experiences including a parent in prison, parental alcohol issues and domestic abuse. Ms A experienced frequent placement breakdowns and had at least 17 different placements. Ms A reported she experienced abuse in care.

2.1.5 Ms A also had longstanding mental health issues with a diagnosis of borderline personality disorder (BPD) (which she disputed) and post-traumatic stress disorder (PTSD).

2.1.6 Ms A had a number of premature births, resulting in 3 preterm neonatal deaths, 1 stillbirth at twenty weeks 1 ectopic pregnancy and a sudden infant death of a child aged 4 months. Ms A's three eldest children had been placed in the care of their father a number of years previously. Ms A and Mr B came to the attention of CSC following the birth of Child C. Following a positive assessment and a short period on a Child Protection Plan Child C remained in her parent's care. A further assessment was carried out when Ms A became pregnant with Child D; no concerns were raised and the family remained together.

2.1.7 Child Z was born at 24 weeks gestation with extremely low birth weight and respiratory distress. Child Z had significant health and developmental problems as a result of premature birth. Child Z had an intraventricular haemorrhage, grade 3[5], with an abnormal brain MRI, retinopathy of prematurity which resulted in visual impairment, a degree of hearing loss, communication and gross motor developmental delay. Child Z developed necrotising enterocolitis (NEC) a condition of prematurity and, as a result of surgery to remove the affected bowel, short bowel syndrome(SBS).

[5] Intraventricular haemorrhage is bleeding inside or around the ventricles, the spaces in the brain containing cerebral spinal fluid

2.1.8 Child Z spent the first fifteen months of life as an inpatient in three different hospitals. Child Z was initially transferred from the local maternity hospital to a specialist neonatal unit, then a ward within the same hospital best placed to meet Child Z's care needs, before being transferred to a tertiary hospital where parents were trained to meet Child Z's long term nutritional needs.

2.1.9 Child Z went through a number of surgical procedures some of which were life threatening, Ms A and Mr B were aware Child Z may not survive some of these procedures which caused understandable anxiety and distress. In addition, Child Z received care from Children's Speech and Language, Physiotherapy, Occupational therapy, medical and nursing teams.

2.1.10 Whilst Ms A, Mr B, Child C, and Child D (aged 3 and 1 at the time of Child Z's birth) visited Child Z in hospital; the amount of contact fluctuated. Initially visiting was almost daily by one or other of the couple and sometimes Child C and Child D, however latterly in one 4-month period it is recorded Child Z received 23 visits only.

2.1.11 Child Z's health and basic needs were largely met on a day to day basis by hospital staff. Life for Child Z was anything but normal. The impact of separation on the family and the child through prolonged hospitalisation and reduced contact, have been well researched and are known to be a factor in attachment issues, and increase stress, fear and anxiety. Ms A expressed concern she was not bonding with Child Z. Involvement of support services to mitigate some of these issues can be helpful. Child Z was emotionally supported by hospital staff whilst Ms A was offered support via the neonatal psychology service; this was not taken up. The psychology service initiated contact with Ms A's community mental health team to ensure support was being provided in the community. Child C and Child D received no psychological support during Child Z's hospitalisation.

2.1.12 Life for Ms A, Mr B, Child C and Child D was also anything but normal during Child Z's hospitalisation. Normal routines were interrupted for both adults and children. There were a number of missed health appointment for both children. Ms A in particular found Child Z's illness and hospitalisation difficult due to her previous experiences and mental health issues. Ms A experienced a significant number of mental health crises during this period. Hospital staff caring for Child Z, school and nursery staff were not fully aware of these crises.

2.1.13 At times of crisis Ms A engaged with MHS 1 and when a crisis was over, transfer to MHS 2 (a longer term team) was arranged. Ms A did not engage with MHS 2, a service best placed to reduce crises and provide longer term therapeutic support. This cycle was repeated again and again. Ms A struggled to build a trusting relationship with the staff and wanted to receive care from her trusted MHS 1 worker.

2.1.14 Mr B understandably struggled to manage the competing needs of the children and Ms A at times. Mr B received some short term support via psychology services and was prescribed medication by his GP. The couple were now both on medication that might make it difficult for them to rouse to respond to the children's needs, once asleep.

2.1.15 Child Z had been known to CSC, firstly through the Children with Disabilities Team (CWD) and then the Safeguarding Service. Child Z was initially referred for additional support and services in February 2017, just prior to discharge from hospital. In addition to Child Z's allocated social worker, Child Z also received a service from the CWD occupational therapists.

2.1.16 Child Z was dependent on two complementary forms of feeding, total parenteral nutrition (PN) via a Hickman line into the blood stream through the chest and milk feeds into the stomach via a gastrostomy (PEG). These lines made Child Z vulnerable to infection or other complications of the feeding lines. Ms A and Mr B were taught how to safely administer feeds, receiving tuition via a clinical nurse specialist at a tertiary hospital. Whilst Mr B's training went relatively smoothly, Ms A did not attend as frequently as agreed, meaning a two-week process took three weeks. Hospital 3 ward staff were largely unaware how mentally unwell Ms A was during this period.

2.1.17 Ultimately the couple were deemed competent and Child Z was sent home. Ms A's mental health appeared to MHS 1 staff to stabilise and improve however as time went on Ms A had further crises.

2.1.18 Following discharge Child Z was awarded a substantial care package to help with overnight feeds, which was never taken up by Ms A and Mr B. Ms A did not want carers in the house overnight indicating there wasn't room upstairs and a downstairs bathroom was also seen by Ms A as problematic.

2.1.19 Child D's attendance at nursery halted, the couple indicated Child D would commence nursery again when it was a legal requirement.

2.1.20 Child Z was re-admitted to Hospital 2 and Hospital 3 on a number of occasions for suspected/actual line infections and received appropriate treatment.

2.1.21 On one occasion in July 2017 a referral was made to CSC by Hospital 2 and the London Ambulance Service (LAS) following a suicide attempt by Ms A, this resulted in a Section 47 enquiry and an Initial Child Protection Conference (ICPC). A decision was made to make all the children subject to Child in Need (CIN) plans.

2.1.22 Ms A became pregnant and in November 2017 Ms A gave birth to a girl (Child F) at 22 weeks, the baby lived for 18 minutes. Four days later Area 2 relayed an allegation of historical physical, emotional and sexual abuse by Ms A against Child E, her eldest child. The allegation met the criteria for Section 47 enquiries but in view of Ms A's recent bereavement enquiries were delayed by a week.

2.1.23 During this period Child C's attendance at school dropped, there was a noticeable deterioration in Ms A and Mr B's self-care, and a decline in Ms A's mental wellbeing.

2.1.24 A further referral was made by Hospital 3 during another admission for a line infection in December 2017; they were concerned about neglect and poor hygiene. The day after Child Z's discharge a delivery driver raised concerns regarding the condition of the house and a young child who was undressed and looked cold. The driver was also concerned about the aggressive tone of the man who answered the door.

2.1.25 A second ICPC resulted in Child Z and siblings being made the subject of child protection (CP) plans on 8th January 2018. The majority decision of the conference was that no CP plan was required. This decision was overturned by the CP chair who felt the evidence presented met that required for the children to be placed on CP plans.

2.1.26 Subsequently Child Z's parents made a complaint about the children being placed on CP plans. The couple's complaint was partially upheld and a recommendation made for the evidence and decision to be reconsidered at review conference.

2.1.27 During this period access to the family home was limited to all but those professionals trusted by Ms A.

2.1.28 At Review Child Protection Conference (RCPC) on 20th March 2018 CP plans ended. Child Z was stepped down to Child in Need (CIN) and Child C and Child D were stepped down to Team Around the Child (TAC) plans.

2.1.29 Two weeks later Child Z died. At the time of death, the ambulance staff and the police who attended the home indicated the house was in a neglectful state, not suitable for a child with Child Z's level of medical need, nor a suitable place for Child Z's siblings to remain.

3. Practice and Organisational Learning

3.1 Introduction

3.1.1 The following focus points were agreed by the panel following review of the timeline:

1. Professional understanding of Ms A's mental health and the impact on the family
2. Patterns of behaviour associated with pregnancy, miscarriages and losses
3. How was history used by agencies within safeguarding practice?
4. Managing Complexity
5. Remaining child focused when parental need is high
6. Recognising and responding to indicators of neglect and abuse
7. Expert parents[6]
8. Effective Communication within and between agencies
9. Impact of fear on professional practice

3.1.2 Each focus point will now be discussed in depth.

3.2 Professional understanding of Ms A's mental health and its impact on the family

3.2.1 Understanding parent's mental health and functioning is key to understanding how that person may parent their children, and to tailoring support around the family's needs. In this case professional records describe Ms A's mental health using a number of different terms; low mood, depression, psychotic; but few records consistently acknowledge Ms A's diagnosis of Personality Disorder(PD) and none make clear how this manifests or affects Ms A and her parenting. Opportunities for mental health professionals to clarify this for other professionals, e.g. within multi-agency safeguarding forums, were not taken.

3.2.2 The PD diagnosis is disputed by Ms A because diagnosis was made at age 11. Whilst it is rare to diagnose under 13, within the new Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) (2013), there is provision for this. What is most important for professionals is Ms A's symptoms and functioning, and professional understanding of them. These act as a backdrop to all professional involvement and interactions with Ms A during the review period, and are therefore a significant part of this review.

Finding: None of the professionals demonstrated they had full understanding of the interface between Personality Disorder and how this might impact on functioning and parenting.

[6] 'Expert' parents are parents involved in providing care of a highly technical and intensive nature that would previously have been considered to be the domain of professionals

3.2.3 The way the family and professional network functioned around Ms A was unusual. Mr B was viewed by professionals as a protective factor for the children and often the main carer, however, except for the local hospital, professional interactions were mainly with Ms A who was described as "*in charge and controlling*". Mr B was not fully included in assessments and there is little evidence he was asked about his opinions or if he was coping. On occasion Ms A openly prevented him from offering an opinion. Professionals should have challenged Ms A when this occurred in order that Mr B had a voice and a more balanced picture of the family could be obtained.

3.2.4 There is little evidence that the children's lived experiences were sought and little understanding of how they were affected by Ms A's fluctuating mental health. What is known is the children missed many health appointments. Child Z missed 1 intestinal, rehabilitation and transplant clinic, 4 ophthalmic and 1 hospital 3 paediatric appointments as well as a number of physiotherapy and soft play appointments, and three neurodevelopmental assessment appointments meaning development was never assessed. Child C had missed 14 out of 17 paediatric, speech and language therapy and audiology appointments. Child D missed some speech and language therapy appointments and attendance at nursery was stopped when Child Z was discharged home.

Finding: Child C and Child D, in particular, became near invisible to professionals.

3.2.5 In order to take a proactive approach, it was important to recognise the likely triggers for a decline in Ms A's mental illness and how Ms A functioned during acute episodes. Stress is known to exacerbate problematic behaviours in people with PD. Ms A found situations which heightened stress and anxiety overwhelming, leading to oscillating mood and arousal, sometimes accompanied by suicidal ideation and crisis. At these times, Ms A's behaviour would become unpredictable, sometimes over using prescribed medication, self-medicating with alcohol, threatening suicide and self-harming through cutting the skin.

3.2.6 Ms A struggled with relationships with some professionals; this was viewed by some as Ms A being controlling and choosing who she wanted to work with. Ms A informed the lead reviewer that she found it difficult to trust professionals. Ms A reported this was due to her own experience of professionals not believing her allegations of abuse whilst in care, and her experiences with her older children being placed in their father's care.

3.2.7 Ms A makes swift judgements as to whether she likes or dislikes, trusts or mistrusts, individuals. Ms A made intense attachments to some practitioners, demonstrating behaviours associated with abandonment when they were not available. Alternately, if Ms A didn't relate to or trust a professional she displayed hostility and was immovable from her initial judgement. Rejection of an individual could lead to rejection of a whole service.

3.2.8 Ms A's strong attachments to some professionals led to her being cared for within services not best placed to offer proactive therapeutic treatment, for example, the MHS 1.

3.2.9 MHS 1 recognised their service was not best placed to manage Ms A long term. However, MHS 1 justified on-going involvement on the basis that they knew Ms A well, and did not want to abandon her when she would not work with MHS 2. MHS 1 acted as advocates.

3.2.10 Dr Adshead noted that 'special' treatment is a common issue in the treatment of PD, often reflecting professional inability to manage patient distress, anger or hostility, causing tension between professionals and interfering with effective treatment. As a result, professionals took up polarised positions about whether Ms A was making progress or not.

3.2.11 It is recognised that change can be difficult for people with PD as it increases stress and anxiety. The change and transition between workers and services needed to be handled sensitively however, both within health visiting and mental health services, this was not managed well. Whilst the need for a well-managed transition was recognised and plans were made for joint visits, those plans were not well executed. Plans for joint visits by the old and new Health Visitor and joint working between Ms A's trusted MHS 1 workers and a new worker within MHS 2, were not followed in July 2016. There followed a period of non-engagement with all the services and professionals during which time Ms A stopped her medication which induced an acute episode. The lead reviewer learned that over stretched teams and lack of capacity impacted on transitions.

Finding: Transitions between workers and between services was not well managed. Transitioning of patients with mental health issues needs careful management and practitioners should be allowed the flexibility to offer a phased transition.

3.2.12 Lack of recognition of the underlying significance of Ms A's PD within maternity services meant she was not cared for by a specialist mental health team in either pregnancy during the review period. Ms A was also not cared for by a specialist mental health team at the beginning of Child F's pregnancy as she was not engaging with MHS 2. Ms A informed professionals she had miscarried so professionals were not anticipating engagement with maternity services. Ms A booked late with midwifery when she was 16 weeks and 6 days pregnant. Ms A was immediately referred to the Specialist Midwifery Service. There was no Perinatal Mental Health Service during her pregnancies with either Child Z or Child F.

Finding: Service design meant pregnant women with mental health diagnoses, who were not engaging with the appropriate mental health service, might not be receiving optimal maternity care from the correct specialist team during pregnancy. Pathways are being reviewed, and it is anticipated that a specialist Perinatal Mental Health Service will be available to provide this service in the future.

3.2.13 Ms A, as someone who had extensive experience of social care, had significant knowledge of the social care system. This coupled with her PD, which has been associated with an ambivalent attitude to care providers, meant she was averse to anyone other than herself and Mr B caring for the children. Ms A wanted to prove she

could care for her children on her own. Prior to Child Z's birth, when well, she demonstrated herself to be a loving, caring mother. However, with increased stress and in the midst of crisis, Ms A was not averse to disguising her own issues by avoiding professional contact and denying problems. This presented a false image of the situation. Challenge, anger and complaint by Ms A often resulted in a change of view by the professional. This will be looked at further in section 3.8. When Mr B reported he was struggling with the unpredictable nature of Ms A's mental health, and had expressed concerns about the impact on the children of witnessing Ms A's behaviours, this should have served as a red flag to professionals that the children required safeguarding.

3.2.14 The children were rarely spoken to alone. Ms A did not want the children to be seen alone and actively prevented some professionals from seeing the children's bedrooms, it is difficult to establish who was advocating for the children.

Finding: The voices of the children were not heard above their parents. Adult mental health services did not fully recognise how Ms A's mental disorder was impacting on her parenting. When the case was being managed in multi-agency forums, greater understanding of who in the children's workforce was best placed to consider the children, would have helped professionals maintain focus on the children. Professionals in this case required a greater understanding of personality disorder, PTSD and Short Bowel Syndrome, in order to understand how best to structure the support and services to the family.

3.2.15 Post-delivery of Child Z and Child F, Ms A discharged herself against medical advice. Following Child Z's birth, the reasons for this are unclear although she indicated to the HV she felt the neonatal staff were judging her and that they kept asking her questions. In response to Ms A distress hospital staff were requested not to ask questions, this likely inhibited professional curiosity. Post the birth of Child F Ms A cited a traumatic delivery with no midwife present, and unhappiness with her treatment, as reasons for self-discharge. On both occasions Ms A put herself at considerable risk as she had high blood pressure, and on the second occasion, significant blood loss.

Finding: There was insufficient curiosity regarding the reasons for self-discharge and consideration of the risks to maternal health and Ms A's dependents.

3.3 Patterns of behaviour associated with pregnancy, miscarriages and losses

3.3.1 Ms A has one of the most complex and poor obstetric histories the reviewer has experienced. At the time of Child Z's death Ms A had experienced:

- 1 ectopic pregnancy,
- 4 miscarriages,
- preterm neonatal deaths,
- 1 stillbirth at 20 weeks,
- preterm vaginal deliveries

- 1 preterm emergency caesarean section
- One of her children, died aged 4 months of Sudden Infant Death Syndrome associated with lung immaturity as a result of pre-term birth

At time of writing Ms A has had 16 pregnancies in total.

3.3.2 It can be difficult for professionals to broach the subject of why a woman would continue to get pregnant with such a poor obstetric history. Professional focus was on Ms A's high blood pressure, which precluded many forms of contraception. There was great empathy for Ms A. Professionals, including the GP, tried to steer Ms A to appropriate contraceptive services but when Ms A did not engage this was viewed as personal choice and no additional efforts were made. When asked about pregnancy and loss as part of this review Ms A indicated removal of her older children and her desire to be a mother were motivators for getting pregnant although pregnancies were often unplanned.

3.3.3 Following the death of Child G, Ms A was diagnosed with PTSD. Ms A was experiencing nightmares. There is no evidence that Ms A was receiving any additional treatment for this diagnosis other than medication for anxiety.

3.3.4 It is not unusual for women with personality disorder (PD) to have complex pregnancies and labours; they are also at increased risk of experiencing anxiety and depression after birth. Normal practice would mean a woman with Ms A's obstetric history would be referred to have an obstetric review in order to establish any preventable cause for premature births and to plan support for subsequent pregnancies and reduce complications of prematurity. This was considered, however Ms A refused an obstetric review. Ms A's refusal might be explained by her PD which has been associated with ambivalence to pregnancy and having children. Ms A's mental health worker indicated Ms A's attitude in relation to her pregnancies was '*what will be will be'*; this thwarted professional's attempts to support Ms A's pregnancies and reduce complications of prematurity. Increased joint working between maternity, obstetric and mental health workers may have proved fruitful.

3.3.1 It can be difficult for professionals to pay appropriate attention to the unborn child when faced with women with such complicated histories. Professionals were acutely aware of Ms A's losses, adopting a very sympathetic stance in their practice with Ms A during and following pregnancies. Feelings of sympathy impacted on the level of consideration given as to whether Ms A's actions/ inactions during pregnancy were in the best interests of her unborn child, whether Ms A would have been best cared for by the perinatal mental health team, or whether there was need for a multi-agency response to protect Ms A's unborn baby.

3.3.2 Review of the two pregnancies within the review period has revealed a repeat pattern of behaviour. Ms A engaged and was compliant up to 20 weeks of pregnancy but disengaged at this point; the reasons for this were not explored by professionals at the time or post-delivery. Ms A appeared more comfortable with straightforward questions. Questions of a more probing nature were met with suspicion and created mistrust

between Ms A and the professional.

3.3.3 In contrast to pregnancy, women with PD may experience intense attachment to their babies following birth. This appears true for Ms A whose mental health was always significantly affected when a child born alive subsequently died; Ms A marked every live birth with a bespoke tattoo. Professional's sympathy and desire not to upset Ms A further, impeded them from fully exploring and therefore understanding, the effect of the losses on Ms A. On occasions Ms A's distress and the children's presence served to act as barriers to professionals initiating these difficult conversations. Ms A had an understandable fear of Child Z dying and it is notable that between Child Z's birth and discharge home mother had seven months of continuous involvement with MHS 1.

3.3.4 Of note, not all occasions when Ms A cited the anniversary of a loss as the reason for a missed or cancelled appointment were truthful. This would not necessarily have been known to professionals at the time.

Finding: In this case no professional examined the patterns of pregnancy, miscarriage and loss. Lack of engagement between Ms A and the services best placed to undertake this work, and professional sympathy, impeded professionals having a full understanding of what pregnancy and being a mother meant to Ms A. Mr B was absent from all discussions and so his thoughts and feelings were never established.

3.4 How was history used by agencies within safeguarding practice?

3.4.1 The importance of considering history when predicting the likely actions and functioning of families, has long been recognised both within guidance and Serious Case Reviews as crucial to protecting children. Getting the balance right between considering what happened historically and factoring in advancements and changes within the family, comes from robust assessment. In this family many of the indicators that would be seen as significant when considering risk, were present.

3.4.2 Ms A had an extensive history of CSC involvement as a child having been looked after. Ms A was known to have witnessed domestic abuse, parental drug and alcohol misuse and neglect resulting in long periods in the care system and experiencing multiple (17+) placements and moves. Ms A had turned to drugs and alcohol in teenage years. Ms A had a diagnosis of Personality Disorder. Personality disorders are caused by multiple factors, including adverse childhood experiences[7]. Ms A was detained under the Mental Health Act aged 17, suffering from post-traumatic stress disorder. Ms A reported to the reviewer she had been abused, physically, sexually and emotionally during her time in care. Ms A indicated disclosures of abuse were not responded to positively by professionals and she felt she was left in abusive situations with nowhere to turn. Ms A reported the inaction of professionals during this period has left her with a deep-seated

[7] Adverse Childhood Experiences (ACEs) are traumatic events that affect children while growing up, such as suffering child maltreatment or living in a household affected by domestic violence, substance misuse or mental illness.

mistrust of professionals. There is nothing within the children's CSC records to indicate this was ever shared or could have been known to current SWs.

3.4.3 Likewise, Mr B had been in care as a teenager. Mr B had a forensic history including perpetrating domestic abuse, and cautions for possession of cocaine. Mr B had spent time on remand for an alleged sexual offence, for which he was later acquitted.

3.4.4 All Ms A's children were brought to the attention of CSC and had been subject to assessment, Child Protection or Child in Need plans at some point in childhood. Ms A recalled her experiences of professionals during this time. Ms A was deeply unhappy that information put before the courts by professionals led to the placement of her three eldest children in their father's care.

3.4.5 Whilst this was outside this review timeframe this is significant as it compounded Ms A's distrust of professionals and in particular SWs and CSC.

3.4.6 Whilst historic events reportedly had a profound effect on Ms A, there is little evidence that this was fully known by any of the professionals involved with the family during the review period. In addition, the reasons for the court's decision to place the older children with their father do not appear to have been sufficiently considered by professionals. Ms A was open with professionals that she had other children who now lived with their father however, there was a lack of curiosity as to why.

3.4.7 Later, when Mr B and Ms A started their family, there was CSC involvement. Child C was subject to a Child Protection plan for seven months under the category of neglect. Ms A and Mr B demonstrated they had the parenting capacity to care for Child C. A Child and Family assessment during Ms A's pregnancy for Child D resulted in no further action. Ms A and Mr B demonstrated that as a couple they were managing the care of their two children well. During this time Ms A's mental health appeared stable with no crises or involvement with MHS 1.

3.4.8 Subsequently there were many opportunities for professionals to consider Ms A's capacity to care for three young children. The booking of Child Z's pregnancy was the first of these opportunities. Internal processes were followed and a referral made to Midwifery Safeguarding. The convened multi-agency meeting should have received information from CSC, midwifery, MH, neonatal unit and health visiting. Only CSC, and midwifery were present; it is unclear whether any historical information was obtained or considered from other services. No minutes were taken of the meeting, so it has not been possible to understand fully what was shared. No onward referral to CSC was considered necessary by those present; it appears insufficient consideration was given to mother's mental health diagnosis and history. Making decisions on partial information is poor practice. In another local SCR the process by which referrals were sent to the meeting was not found robust enough to ensure that none were missed; this led to a change of process and MASH[8] now process all referrals.

[8] The Multi-Agency Safeguarding Hub, or MASH, is the team within Children's Social Care who receive and process referrals.

3.4.9 Post Child Z's birth there was significant, regular involvement with MHS 1. This involvement was not considered in the context of historical information. Ms A had numerous crises however no referral was ever made by mental health services to CSC throughout the whole review period. Of note there had been additional concerns about domestic abuse during the scope of the review; police were called by a neighbour to one incident, there was an argument on the ward and Ms A reported to a MHS 1 worker that Mr B had hit her on one occasion. MHS 1 focussed solely on Ms A, had they widened their thinking to the children they may have realised the presenting issues were similar to those that had led to the removal of Ms A's older children. Ms A was struggling to self-care, was self-harming, struggling to care for the children, and was heavily reliant on Mr B. Mr B was viewed as a protective factor despite evidence that the couple's relationship was unstable; sometimes they reported to be in a relationship, sometimes they didn't. Professionals were often unsure whether Mr B was living with the family or not. Mr B reported he was struggling with the unpredictable nature of Ms A's mental health, and had expressed concerns regarding the impact on the children of witnessing Ms A's behaviours. Indicators of abuse and neglect were not given sufficient consideration in the context of historical information. This was compounded when discussions within Management Round meetings did not extend to the children and led to a conclusion that there were no safeguarding concerns. There was no specific safeguarding children supervision for the workers involved in this case, reducing the opportunity for this conclusion to be challenged.

3.4.10 The CSC SAAR author made a valid point regarding how difficult and time consuming it was to review all the information for a family with such a complex history.

Finding: All agencies had extensive recordings of their involvement with Ms A and her children however across all agencies there was poor use of history and a lack of analysis. Changes in recording systems from paper to electronic were unhelpful in this regard for some agencies. The greatest challenge for practitioners is having the time to review complex and extensive records at the beginning of a period of involvement. Those best placed to collate the historical information and make judgments on information contained within records, are the professionals who worked with the person or family last.

3.5 Managing Complexity

3.5.1 Managing complex health cases is always a challenge. When so many disciplines and agencies are involved this becomes an enormous, and sometimes onerous, task. In this case there were two areas of complexity within the same family; Child Z in terms of medical need and Ms A in terms of mental health need. Child C and Child D were also known to have lower level additional needs.

3.5.2 Care to Child Z was delivered through a combination of primary, secondary and tertiary services. This brings its own challenges for professionals and families. In this case there was input from Obstetrics, Midwifery, Gastroenterology including the intestinal and rehabilitation service and a specialist nurse for nutrition and gastroenterology,

children's safeguarding specialists (nurses and doctors) across three hospitals and community services, Health Visiting, School Nursing, Occupational therapists, Physiotherapists, Speech and language therapy, Community Nursing Team, Community Paediatrics, Emergency departments, Secondary and Tertiary Paediatric Consultants, ward and clinic staff.

3.5.3 Child Z's care sometimes transferred from one hospital to another and between services. The point of transfer requires careful planning and consideration not only in terms of safety for the child but also the information to be shared which should include medical, nursing and social information. Whilst medical and nursing information are naturally shared, social information is often given less consideration. In this case information exchange at discharge focussed on Child Z's medical needs, with a lack of information exchange relating to the family, their visiting patterns and Ms A's mental health issues. A holistic view of Child Z and the family was not evident.

3.5.4 Early and effective discharge planning for a child with complex needs is key. It is essential that when a decision is made that a child who will have additional health care needs is near to discharge, the process for putting in place a package of support, both financial and physical, is triggered. This requires further referral to the Children with Disabilities (CWD) team for support and an approach to the Health panel for funding. In order for children to receive optimal care, discharge home should only occur when the right level of support has been put in place. Failure to do so is likely to end up with a situation where the child's care needs cannot be adequately addressed or the care givers are placed under undue stress.

3.5.5 Ms A's health needs were also complex. Ms A had input from obstetrics, the Specialist Midwifery Service, MHS 1 and MHS 2, a Consultant Psychiatrist, a psychologist, her GP and the Emergency Department. At times it is not clear who was leading on Ms A's care from a mental health perspective. Ms A should have been open to MHS 2, with a care co-ordinator coordinating her care, from immediately after Child Z was born and throughout the rest of the review period. When in crisis, care should temporarily have transferred to MHS 1.

3.5.6 The fact that Ms A related well and trusted a number of professionals within MHS 1 meant care via MHS 2 team was never established; this brings into sharp focus the importance of relationships. MHS 1 were placed in a difficult position and somewhat at a loss as to how to move Ms A over to the more appropriate service. The recognition of Ms A's need for care kept her in limbo between the two services for many months. What was not recognised by either MHS 1 or MHS 2 was what was missing from Ms A's care by perpetuating this situation.

3.5.7 When staff from MHS 1 presented information within multi-agency forums they did so from an individual perspective rather than from a service perspective which led to a more positive representation than was the reality.

3.5.8 Within MHS 1 Ms A was discussed on a number of occasions within management rounds. These discussions endorsed the practitioner's approach. What was needed was

a link to a lead professional with safeguarding knowledge to review the case from a "Think Family" perspective and management to take a more proactive approach to managing the situation.

Finding: The importance of allocating a lead health professional in complex cases is not new and has been a feature of a number of SCRs in recent years. In this case, the allocation of a lead health professional with safeguarding expertise would have been beneficial to Child Z, Ms A and other agencies. The lead health professional is able to collate and analyse information from all health sources, review whether plans are being followed, identify any changes in need for Child Z and the family and support and challenge professional practice. This would ensure that one person holds and coordinates all the information in one place.

3.6 Remaining child focused when parental need is high

3.6.1 The need to remain child focussed when working with parents who have significant needs of their own, is challenging for professionals. This can be difficult even when the children have no additional needs. In this case all three children in the household had some form of additional need during the period under review.

3.6.2 Child Z's needs were many and resulted in numerous professionals and disciplines being involved, rather overshadowing the needs of Child C and Child D. Professionals had recognised all the children's health needs and referred for appropriate support and services. However, during the review period neither Child Z, Child C or Child D were consistently taken to hospital appointments as required. The additional needs of Child C and Child D related to their speech and language delay and development. Some therapeutic intervention was being offered to Child C within school however this could have been enhanced by further input from paediatric specialists.

3.6.3 Professionals' sympathetic feelings towards Ms A and Mr B's situation, and recognition of the immense pressure they were under, clouded their judgement and influenced their behaviour, resulting in a degree of acceptance of indicators of neglect that would have been more robustly challenged if exhibited by other parents. It can be concluded that the focus of some professionals was deflected from the children within this family to Ms A and to a lesser extent, Mr B. Professionals were additionally impeded by a sense of needing to maintain engagement with Ms A and were unwittingly feeding into aspects of Ms A's personality disorder.

3.6.4 Child C and Child D became increasingly invisible to professionals. Whilst non-attendance for health appointments was flagged as per procedures, this was always then considered in light of Ms A and Child Z's health, and the capacity of the couple to manage all their competing priorities. It was not considered in terms of the potential long term impact on the children of not receiving optimal care. Child D, in particular, was described by professionals as a very quiet child; this may have been as a direct consequence of the difficulties she was experiencing in communicating.

3.6.5 Ms A and Mr B were seen by many health workers as extremely competent in delivering Child Z's care. What professionals didn't fully acknowledge was the difference between

having the skills to deliver care versus having the capacity to deliver care. Most people with fluctuating mental health issues will have associated peaks and troughs in their functioning. Reduction in parental capacity to self-care should have flagged the need to consider parental capacity to meet the care needs of the children and appropriate referrals for support made. Understanding the parents' needs and the children's needs and assessing parental capacity to care for the children effectively was key.

3.6.6 At times Mr B indicated he was struggling to care for Ms A and the children, and was not coping. Whilst actions were taken e.g. prescribing of medication, referral to psychological therapies, signing off from work, what did not happen was consideration of the children, a referral to CSC and a full re-assessment of the situation. This assessment should have included talking to the children, and an exploration of Mr B's ability to manage the entire situation, including the impact of the couples' prescribed medication on their abilities to effectively respond to their children's needs. In short what was needed was a proactive, child focused, approach.

3.6.7 The decision to reduce the number of professionals at Child Protection meetings was not child focused, but partly a response to Ms A's frequent complaints, and partly to practitioners wanting support at the Child Protection Conferences. Each organisation was asked to send one representative to present the entire organisation's information. However, no one person had their entire organisation's information and thus they presented what they knew resulting in a rather skewed picture. Lack of recognition of the need for a lead professional for health meant this remained unnoticed and unaddressed.

3.6.8 Those present at core groups were selected because they had the greatest day to day contact with Ms A not because they had a role with the children. What was not acknowledged was who was missing, and that those selected represented those services Ms A chose to engage with; core members were trusted and, as Ms A saw it, on her side. Hearing first-hand the views of those professionals struggling to establish a rapport with Ms A, who had concerns and were unable to offer the therapeutic interventions required by the children and Ms A, would no doubt have altered the collectives' opinion.

3.6.9 Opinions of professionals and the content of reports to conferences were often polarised, with some professionals reporting the children as dirty and neglected and others claiming they had seen no such thing. This polarisation was evident at the practitioners' event. The reviewer is of the opinion that on the whole professionals were reporting the situation accurately as they saw it, be it with a level of variation of thresholds. This becomes somewhat unsurprising when reviewing all professionals' records. Records show a decrease in access to the children and the home for professionals, at times when the couple were struggling. Whether this was conscious by the couple, or as a result of reduced capacity to cope with professionals, has not been established. Acknowledging that this was a pattern of behaviour would have helped professionals to recognise when support and services needed increasing to meet the needs of the children. The admission for Child Z which prompted hospital 3 to refer regarding neglect, occurred when Ms A was acutely mentally unwell.

3.6.10 Adult mental health workers made little reference to the children, in fact the children were largely viewed as a protective factor in stopping Ms A acting out her suicidal thoughts. The children did not feature in any mental health assessment of risk or within internal management round discussions.

3.6.11 Cleaver et al.[9]considered the impact of parental problems such as mental illness and concluded that *"a single disorder could negatively affect parents capacity to meet their children's needs, but co-existence of problems had a much greater impact on parenting capacity. The impact of mental health issues might leave parents with a sense of apathy, blunted emotions and low self-esteem. The ability to control emotions might also be affected, leading to extreme mood swings, unpredictable violence and irritability, unresponsiveness and anger. These are all factors that can affect the parent–child relationship and particularly the attachment process. Parents might also experience difficulty in organising their lives and fail to sustain family rituals and routines – events key to cementing family relationships. Feelings of depression and despair and the effects of alcohol or drugs may result in parents neglecting their own and their children's physical needs.*" This was evident in this case.

Finding: Maintaining child focus when a case is complex and parental need is high, is difficult. Named and Designated professionals have a role to play in such circumstances. Conferences and core groups are designed to bring professionals and the family together to share information, make decisions and plan interventions to address the issues. The inclusion of a lead, Named or, when appropriate, Designated professional for such complex cases to provide objective oversight needs further consideration.

3.7 Recognising and responding to indicators of neglect and abuse

3.7.1 There are many families who live in neglectful circumstances which are less than ideal. A study by the NSPCC[10] found in 2009 9% of 18-24 year-olds and 9.8% of 11-17year-olds when asked reported they had experienced severe neglect as children. Determining when neglect has reached a threshold where there is a risk of it causing significant harm requires knowledge and skill. When the level of neglect fluctuates this can cause additional complications as cases are stepped up and down between services.

3.7.2 During the review period different members of all medical teams had different perceptions and accounts of the family at different times. This produced a divide between professionals which was unhelpful. Dr Adshead advised this kind of split in professional view, and oscillating evaluations of a person, is characteristic of the kind of staff dynamics that complicate the management of people with PD. Two different health professionals from the same team went at different times on the same day; one cited Ms A was unkempt and a strong odour coming from the house, the other noted no such concerns. Some professionals saw Ms A as a good parent doing her best, others believed parenting was neglectful. This suggests professionals were applying different standards.

[9] Cleaver, H., Unell, I. and Aldgate, J. (2011) Children's needs – Parenting Capacity

[10] NSPCC (2018) How Safe are our children? The most comprehensive overview of child protection in the uk.

In safeguarding children there has been much discussion regarding what constitutes 'good enough' parenting. Research by Chaote & Engstrom[11] suggested that clinical literature failed to offer workers guidance on the practical application of this terminology and left families with the probability that the standard against which they were judged varied from worker to worker as can clearly be seen in this case.

3.7.3 Whilst all professionals believed they were being accurate in their accounts, these were presented in rather black and white terms. Whilst some professionals may not have seen Child Z as a dirty and neglected child, they had seen oscillating standards of hygiene within the home, poor self-care by both Ms A and Mr B at times, and had awareness of missed appointments for all three children. Community based professionals were not cited on neglect. This may be in part because across the locality professionals are not guided to use any single recognised neglect tool. No neglect tool was used in this case. The reviewer learned access to such tools can be difficult. There are multiple places the tools can be accessed; the LSCB website is not easy to use; LSCB are aware that the website is not user-friendly and are in the process of commissioning a new one. Such a tool has the potential to focus professionals on what they are seeing and be clear on when the situation is changing and reaching unacceptable levels.

3.7.4 During Child Z's long stay in hospital there was a change in the frequency of visiting. Initially the couple were visiting 2-3 times a week. However, from July 2016 to October this reduced with 23 visits over four months and from November to January 2017 there were 8 visits recorded. Ms A gave a number of reasons including her own ill health, the children's ill health, and financial difficulties for not visiting however the impact of not visiting warranted further exploration especially as Ms A had identified difficulties in bonding with Child Z initially. There were occasions when Child Z was taken for surgery unaccompanied by either Ms A or Mr B. Whilst in an emergency this is sometimes unavoidable this also occurred for a pre-booked surgery; there was a lack of recognition of the potential effect on Child Z and whether this constituted neglect.

3.7.5 An article by A Rokach[12] found that "*Recent empirical data highlights that adverse effects of hospitalisation on children, have been found to be stronger when parents are not present, or when parents are highly anxious and were not able to calmly respond to them[13]. Illness and hospitalisation are traumatic, anxiety provoking and can lead to transient or long-term behavioural and psychological difficulties in children[14]. Estimates of the incidence of emotional problems resulting from hospital experience have been*

[11] Peter W. Choate & Sandra Engstrom (2014) The "Good Enough" Parent: Implications for Child Protection, Child Care in Practice, 20:4, 368-382,DOI: 10.1080/13575279.2014.915794

3.3

[12] Rokach, A. (2016) Psychological, emotional and physical experiences of hospitalized children

[13] Shields L (2001) A review of the literature from developed and developing countries relating to the effects of hospitalization on children and parents. *Int Nurs Rev* 48: 29-37.

[14] Hägglöf B (1999) Psychological reaction by children of various ages to hospital care and invasive procedures. *Acta Paediatr Suppl* 88: 72-78.

reported to vary from 10% to 30% for severe psychological distress to as much as 90% for slight emotional upset in hospitalised children[15]."

3.7.6 Prior to Child Z's initial discharge there was a three-week period during which Child Z's parents were receiving training to deliver PN. Careful examination of that period reveals that a two-week training programme took three weeks. Ms A dropped out of training on day 2 but later re-engaged. On day 10 Ms A accidentally disconnected a line; she then did not attend for three days. On this occasion Ms A put up the PN but staff judged Ms A needed further practice which was met with anger. Ms A reported she was confused about what she needed to do to get Child Z home. In the week prior to discharge there were a number of issues on separate occasions that are of concern:

- Ms A attended too late to put up Child Z's PN
- The children were noted unkempt
- Mr B reportedly smelt unpleasant
- Ms A failed to respond to an alarm
- Ms A failed to attend

Comment. There are always some issues in PN training as parents try to grasp complex tasks and adjust to taking a sick child home who has been in hospital for a long period of time.

3.7.7 These indicators of neglect should have been robustly addressed prior to discharge. There was opportunity for the neglect concerns to be discussed at the discharge planning meeting, however discussions were focussed on Child Z's medical needs. Significant information about Child Z's stay in Hospital 1 and the family history was not available to staff. On the day of discharge, the hospital Safeguarding team challenged the SW as to whether CIN was appropriate and was informed that the SW would conduct a home visit. The concerns were not formally escalated.

3.7.8 In the subsequent months, had all professional's concerns been brought together and considered purely from the children's perspective there was the following evidence:

- Damaged and dirty Hickman line
- Dirty Gastrostomy tube
- Cluttered and sometimes dirty home
- Missed appointments
- Poor school attendance for Child C
- Removal of Child D from nursery

[15] Yap JN (1988) The effects of hospitalization and surgery on children: A critical review. *Journal of Applied Developmental Psychology* 9: 349–358

- Children undressed late morning
- Home environment, children and their belongings smelling of cigarette smoke
- Lack of toys/activities for the children
- Speech and language delay
- Children witnessing Ms A's self-harm and their parents struggling to cope
- Mr B expressing concern regarding the effects of Ms A's behaviours on the children
- Rejection of the care package

3.7.9 Many of the issues listed above when considered alongside the threshold document[16] do fall into the "*Children in Acute Need*" category. Professionals needed to focus on all indicators of neglect, sharing those they had been privy to rather than dismissing those observed by other professionals.

3.7.10 Turning down the agreed care package is unusual and a significant aspect of this case. The majority of families fight hard for additional hours to support them to provide optimal care for their child/ren. Ms A was consistent in her rejection of the agreed package on offer, indicating the house was too small to have a night sitter. Whilst Ms A did agree to extra nursery hours and child minding this was far less than had been assessed as required to meet Child Z's needs. There is evidence that professionals frequently encouraged Ms A to accept more help however the impact of Ms A's refusal on the children and on the couple was not fully acknowledged or challenged and was not seen as neglect.

3.7.11 The children and their possessions smelling of smoke was a good indicator that one or both parents were smoking in the house. The effects of passive smoking, particularly for a child with complex health needs, was not given sufficient consideration.

3.7.12 An interesting question was posed at the practitioner's event; Do you see things when you are working with the same family for a long time? Reflective supervision when working cases over long periods can assist. There is also a need for all professionals to be open to, and consider, other professional's opinions.

3.7.13 Sadly, polarisation of professional opinion occurred which proved unhelpful. Dr Adshead indicated that PD management was complex enough in mental health services; but even more complex to manage in the medical/ paediatric community and in hospital teams who were less familiar with PD as a diagnosis and as a complex treatment problem.

Finding: Professionals were not sufficiently sighted on neglect. Use of a neglect assessment tool may have assisted professionals who had direct contact with the family to fully understand the impact of neglect in this family.

[16] London Child Protection Procedures (2018) Threshold Document: Continuum of Help and Support

3.7.14 Community mental health professionals were not recognising safeguarding concerns. Changes in self-care, the home environment and Ms A's avoidant behaviours were viewed as indicators of improving or deteriorating mental health, or that the couple were overwhelmed, and were not challenged. The wider thinking of what this meant for the children, their lived experiences, and whether the threshold for neglect had been met, was absent. Whilst there is evidence of information sharing between MH workers and other health professionals and CSC, this was inconsistent. There were opportunities to share information that might have given a fuller picture of the children's lived experiences.

3.7.15 Mental health management rounds were intended to offer an element of safeguarding supervision and were an opportunity for cases including safeguarding concerns to be discussed. Whilst risk was part of those discussions risk was considered only in terms of risk to Ms A and not in terms of risk to the children. What was absent from discussions was any focus on the impact of Ms A's fluctuating mental health on her ability to meet the needs of the children; nor was there evidence of any challenge to the professionals' thinking. There is no evidence that any of the plans that resulted from these discussions considered the needs of the children. All management rounds concluded no safeguarding concerns; there are numerous times when it is difficult to understand this conclusion. The single agency analysis report has made a recommendation to improve the use of "*Think Family*" within supervision.

Finding: Mental health management rounds paid little attention to the safeguarding needs of the children and did not provide challenge to the workers or opportunities for further reflection.

3.8 Expert parents

3.8.1 An interesting dynamic in this case was the position the parents held in delivering the care Child Z required. Training of Ms A and Mr B to administer PN at home was carried out at Hospital 3. This hospital was reliant on the transferring hospital to make an initial decision about suitability of the couple for this training. Referral implies that they were deemed suitable by Hospital 1 however Hospital 1 had little understanding of the family's functioning, in part because of the low levels of visiting and, in part because it was also a tertiary hospital. Hospital 1 were of the view that this would be considered further as part of the assessment/training at Hospital 3, Usually transfer to Hospital 3 is from a local hospital but the hospital local to the family did not have the expertise to care for Child Z's PN. The challenge here is how tertiary hospitals can obtain the social information they require when the local hospital is not involved.

3.8.2 The role of Hospital 3 was to train the parents and provide oversight for as long as Child Z required PN. Both Ms A and Mr B were trained and deemed competent to carry out these cares and whilst there were some concerns about Ms A's behaviours, (see section 3.7.6) there was never a suggestion that these impacted on her competence.

3.8.3 When Child Z required attendance/admission to Hospital 2 administration of PN remained the responsibility of her parents; Mr B fulfilled this role. This placed Ms A and Mr B in a position of authority amongst professionals.

3.8.4 Ms A and Mr B spoke about the care of Child Z's PN knowledgeably, so non-health professionals viewed them as experts in Child Z's care. This skewed the parents' status from parents to experts.

Finding: Placing parents in positions where they have greater expertise to manage the health needs of their children than qualified nursing staff has brought about the unintended consequence of elevating their status to expert. Whilst the reviewer is not suggesting a change to practice as research shows the incidence of line sepsis in PN delivered at home is reduced[17], it is important that the parameters of expertise are carefully differentiated and made clear to non-health professionals.

3.9 Effective Communication within and between agencies

3.9.1 A number of services had extensive and prolonged involvement with either Ms A or the children. In these situations, it can be difficult to maintain consistent levels of communication between disciplines and across agencies. Within records there is evidence of regular communication between some services. The issue in this case is not one of no communication, but one of communicating with the right people at the right time and communicating and utilizing useful information in the most appropriate way.

3.9.2 Twelve weeks after Child Z was born a Section 85 notification should have been sent by Hospital 1 to CSC. This notification alerts Children's Services that there is a child who has been in hospital for a significant period of time. It can trigger an assessment that starts the process for considering what support and services might be required on discharge. The impact of this notification not being made is twofold. CSC were not alert to and preparing for Child Z's discharge into the community, and information that could have been helpful for health professionals in developing a more holistic view of the family and discharge plans, was not shared.

3.9.3 Trying to collate all the information relating to Child Z's health in one place would always be challenging. This was compounded as, throughout Child Z's life, there was no clearly allocated lead overseeing all her health needs. GPs are often considered the lead by CSC as they receive all health information regarding their patients from secondary and tertiary care services and often care for all family members. Whilst the GP did receive letters from these services, Child Z was not attending the GP when unwell as the family had been advised to return to hospital in such circumstances, thus the GP did not meet Child Z. The reduced opportunity for GPs to home visit complex families compounded this situation. When CSC sought information from the GP they were not in a position to present a holistic view of Child Z, her needs and how well Ms A and Mr B were responding to her needs.

[17] Cunha, Burke A. "Intravenous line infections." *Critical care clinics* 14.2 (1998): 339-346.

3.9.4 Whilst both Ms A and Mr B were registered with the same GP, Mr B's records were not flagged in the same way as Ms A's. Whilst father was open about his relationship with Ms A and the children, the GP surgery did not join up and place on Mr B's records the children's safeguarding status.

3.9.5 Introduction of the Lead Professional role in Health should help address some of the communication issues evident in this review as it will provide an additional communication pathway. Professionals must consider whether the mode of communication chosen is the most appropriate when placed in context of other events. There were times when the children were not taken to appointments where communication of non-attendance was made via letter. Letters arrived just after a multi-agency meeting had taken place. Therefore, information that would have been useful to making decisions and plans, was not considered. Communication of non-attendance did not always include the level of concern this generated for the practitioner. When children are known to be subject to CIN or CP plans consideration should be given to more immediate forms of communication, e.g. telephone or email.

3.9.6 At the practitioner's event professionals identified that there were times when there was lack of understanding of each other's information; there was no common language. Terms such as "*cluttered", "reasonable*" and "*acceptable*" were found in records when describing the appearance of Ms A or the family home. The lack of use of descriptive language left professionals who had neither sight of Ms A or the home, applying their own perceptions of acceptable and reasonable. Time pressures within meetings were also felt to have inhibited communication and reduced the amount of useful discussion.

Finding: The lack of common, descriptive, language by professionals reduced the effectiveness of communication between services. All professionals need discouraging from using vague language and encouragement to accurately describe what they observe and mean.

3.10 Impact of fear on professional practice

3.10.1 It is not unusual for service users to deny allegations, be angry or make complaints. Interactions with angry-critical clients can often leave professionals experiencing fear, anxiety, anger, self-doubt, and helplessness. These interactions can also hinder professional's ability to concentrate and make decisions. Frequently, professionals will withdraw or give in, and not address presenting issues appropriately.

3.10.2 In this case the number of occasions where denial, anger or complaint featured, was higher than usually experienced by services. An additional factor was Ms A's self-harm and suicide attempts. How services and professionals responded to all these factors became an interesting feature of this review.

3.10.3 Ms A often denied she had problems and would challenge professional's views that did not accord with her own. There were occasions when professional concerns were based on fact and on these occasions the professional needed to stand firm. Many professionals did not view Ms A as angry but as assertive and controlling. However, Ms A had been angry enough to leave a meeting in order to calm down. Mr B could also be

volatile, making threatening statements. Whilst no professional indicated they were afraid for their own safety, one professional did describe being on' eggshells' and others as being 'wary'. There was a general fear of upsetting Ms A, this fear was that Ms A would self-harm or attempt suicide. Professionals often changed their views in response to Ms A's, and occasionally Mr B's, anger or complaint. This change in view suggests they might be afraid that the anger and complaint would be turned on them.

3.10.4 Departments and individuals who investigated Ms A's formal complaints sometimes did so without having all available information to hand. Findings and recommendations made through internal processes were not shared effectively with those professionals involved, nor were they challenged. Recommendations sometimes interrupted the natural progression of the case.

3.10.5 Ms A's complaint about all the children being placed on Child Protection Plans was partially upheld and led to the recommendation that there should be consideration of stepping down to Child in Need for Child C and Child D at the next conference. The decision to place Child Z on a Child Protection plan was upheld. Ms A was notified of these findings but there was no formal notification to the professionals involved in the conference. Many of the professionals learned of the decision informally or via Ms A, and the findings were subject to misinterpretation. The Independent Chair of the Conference was not informed of the official finding until after the review conference by which time Child Z had been stepped down to CIN and Child C and Child D to Team around the child (TAC).

Finding: There is no agreed process for officially informing professionals involved with children subject to CP plans of the outcome of a parent's complaint regarding care and decisions made at conference.

4 Recommendations

Recommendation 1: LSCB and its partners to provide guidance to professionals on how to elicit children's views and reflect these in records.

Recommendation 2: Adult Mental Health services and Children's Services to provide awareness training regarding mental health diagnoses (including PD) which may affect parent's abilities to parent, either through fluctuation of mental health or physical ability, and consider how information can be effectively shared with partner agencies.

Recommendation 3: LSCB and its partners to ensure its employees are sighted on neglect by:

1. reviewing and promoting all assessment tools, training and guidance
2. ensuring neglect tools are being consistently used across all services locally by professionals trained in their use
3. prompting professionals to use descriptive language that conveys what they are seeing and what they are meaning in understandable terms.

Recommendation 4: LSCB and its partners to review the systems and processes for complex cases to ensure:

1. health partners embed a consistent, effective process of early referral for support and funding including Section 85
2. all cases are subject to senior practitioner oversight across all agencies, through supervision (clinical and safeguarding),
3. health partners have allocated the most appropriate professional to lead on the child/ren's health in conjunction with the health professionals working with the parents
4. CS in conjunction with Conference Chairs ensure an active decision is made regarding the appropriate level of representation at Child Protection meetings
5. mental Health services ensure current safeguarding supervision arrangements are sufficiently robust to assist adult trained workers to fulfil their safeguarding children responsibilities
6. that the full role of child protection conference chairs is understood and supported by all professionals
7. there is guidance for professionals on working with complexity that supports them in their practice and in multi-agency forums
8. Loss and the impact of loss on parents and siblings is included in both single and multi-agency assessments

Recommendation 5: LSCB and partners, with advice from complaints and legal services, to introduce a system and process that ensures accurate, relevant information and outcomes from investigations of complaints is shared with partner agencies where children are subject to child protection plans.

Recommendation 6: LSCB to seek assurance from all partner agencies that a summary of historical information is produced periodically and at the end of each episode of care, and is being held on record, for use by future practitioners.

Recommendation 7: LSCB to seek evidence from maternity services that the newly devised maternity pathways and existing internal processes, are ensuring pregnant women with pre-existing diagnoses, are receiving services designed to meet both their needs and those of their unborn children. Refusal of a service, or discharge against medical advice, must be considered from the perspective of the unborn child and information shared with health partners, and when appropriate CS, to safeguard both child and mother.

Recommendation 8: LSCB and its partners to revise escalation policies to include guidance on dispute resolution.

5. Conclusions

5.1.1 The death of Child Z is a tragedy and was unexpected. It has not been determined by the Courts or the Coroner whether Child Z's death was as a direct consequence of neglect. It is, however, clear that the home environment was not deemed suitable to care for a child with Child Z's complex health needs, or indeed Child C and Child D, at the point Child Z died.

5.1.2 This case brings into focus the difficulty of effectively managing complex health and social cases, especially when families do not function in ways professionals expect. There were multiple systems in place but they were not sufficiently robust to manage Child Z, Child C and Child D's health needs alongside Ms A's mental health.

5.1.3 Ms A and Mr B had effectively cared for Child C and Child D without additional support for sixteen months prior to Child Z's birth. Recognition and assessment of the impact on Ms A of caring for another child, even one without complex health needs, alongside her diagnosis of Personality Disorder, was essential.

5.1.4 Lack of a multi-agency approach during pregnancy and whilst Child Z was an in-patient, meant opportunities to develop trusting relationships with professionals, who would be involved long term in Child Z's care, were missed. Over reliance on self-report, means that when patients do not share their mental health diagnoses and professionals do not seek historical information, there is a danger they will not be referred to, and subsequently managed by, the most appropriate service. In the locality, pathways to appropriate maternity services to manage patients with mental health issues are under development.

5.1.5 An initial decision during pregnancy (based on incomplete information) that CSC did not need to be involved, lack of referrals when Ms A's mental health declined after Child Z's birth, followed by no Section 85 notification when Child Z was twelve weeks old, meant there was no CSC involvement until Child Z was near to discharge home aged 14 months. Lack of direct and effective communication between community services and hospital during Child Z's admission in Hospital 1 meant hospital staff were largely unaware of what was occurring in the community.

5.1.6 Declines in Ms A's mental health could potentially have been predicted by professionals if they had developed a greater understanding of the triggers for decline. Loss and the fear of loss affected Ms A's mental health constantly until Child Z was discharged from hospital. Recognising the impact of this on Ms A's ability to care for Child C and Child D was essential. Professionals 'felt sorry' for Ms A and Mr B and as a result excused neglect of Child C and D's health needs.

5.1.7 Once Child Z was discharged home professionals were mindful not to discriminate against Ms A because she had mental health issues. Ms A and Mr B showed themselves to be competent to care for their children when well. However, when unwell they were unable to adequately care for the children or themselves. The increased care needs of Child Z proved too much for them to manage. Rejection of Child Z's care package was seen as parental choice rather than neglectful or putting the children at risk.

Professionals with regular contact with the family were over optimistic about the couple's abilities to care for the children. Their positive communications with newly allocated professionals and services led to 'group thinking' that the care afforded was 'good enough'.

5.1.8 The timing of the referral for additional support and services, as Child Z neared discharge home, was significant. The impact was twofold. There was insufficient time to put services and funding in place before Chid Z was discharged, and it was not initially understood by Ms A and Mr B that this referral was based on Child Z's additional needs. The referral was viewed as a personal criticism by Ms A and Mr B, and from Ms A's perspective the criticisms were unfounded.

5.1.9 The lack of a lead professional overseeing Child Z's health needs meant there was no one professional who had all the necessary information required to make a holistic assessment of the situation. Non-attendance at appointments for all the children was excused on the basis of the parent's health and capacity, with insufficient thought to the impact on the children.

5.1.10 Mr B was seen by community based professionals as the main carer for the children and of Ms A when she was unwell despite indications that the couple's relationship was ending or had ended, and that Mr B had another address. There is little evidence to demonstrate that professionals included Mr B in assessments, or took sufficient time to explore Mr B's role and how Mr B was managing to meet the competing demands of Ms A and Child Z's complex needs, in addition to caring for Child C and Child D. With the benefit of hindsight, it is hard to see how one person could have managed this with the limited support the couple accepted. Occasionally Mr B indicated he was struggling and required additional support and services, or he was concerned about the unpredictable nature of Ms A's mental health and its effects on the children. These disclosures should have served as a prompt to professionals to escalate the case and intervene quickly. Rejection of the support offered was too readily accepted by professionals without full assessment of what this meant for the children.

5.1.11 Parental complaints, challenge and anger adversely affected interactions in this case. The process of responding to complaints, and informing the complainant first, inadvertently placed the parents in a position of power. Because professionals did not receive the outcome of complaints at the same time as Ms A, Ms A's verbal interpretation of the findings became accepted as accurate.

5.1.12 The couple's history and previous experience of Children's Services had created a reluctance to accept CSC involvement; they were fearful that the children would be removed. Their personal experiences, and Ms A's experiences of care had left them with trust issues. These issues continue to this day and unless addressed will continue to act as barriers to the right support and services being taken up by the family.

5.1.13 Relationships were key to delivering interventions. Lack of investment in building relationships prior to transfer from one case holder to another, resulted in disengagement from services and treatment. This left the children at risk of harm and

Ms A at risk of self-harm. When Ms A's mental health was being managed by the crisis team due to non-engagement with the longer term team, wider thinking by managers, of what was missing from the care she was receiving was absent. There needed to be thought as to how to deliver therapeutic interventions, that provided an increased probability that Ms A would reach stability, in a different way.

5.1.14 Throughout the period under review there was insufficient focus on the children's needs and an over reliance on Mr B to keep both Ms A and the children safe.

3.11 Glossary of Terms & Abbreviations

A&E	Accident and Emergency
AMH	Adult Mental Health
C&F	Child and Family
CAF	Common Assessment Framework
CCN	Children's Community Nurse
CIN	Child in Need
CNS	Central Nervous System
CP	Child Protection
CSC	Children's Social Care
CWD	Children With Disabilities
DWP	Department for Work and Pensions
ED	Emergency Department
EYCT	Early Years and Childcare Team
FSW	Family Support Worker
FTA	Failure To Attend
GP	General Practitioner
GSCB	Greenwich Safeguarding Children Board
HV	Health Visitor
ICPC	Initial Child Protection Conference
IT	Information Technology
IV	Intravenous
IVH	Intra-ventricular Haemorrhage
LA	Local Authority
LAC	Looked After Children
MASH	Multi-Agency Safeguarding Hub
MH	Mental Health
MHS 1	Offering support to people in acute mental health crisis
MHS 2	A therapeutic service for adults with mental health conditions requiring care and treatment
MRSA	Meticillin-Resistant Staphylococcus Aureus

MW	Midwife
NEC	Necrotising Enterocolitis
NNU	Neonatal Unit
OT	Occupational Therapy
PD	Personality Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PLO	Public Law Outline
PN	Parenteral Nutrition
PT	Physiotherapy
PTSD	Post-Traumatic Stress Disorder
RCPC	Review Child Protection Conference
SAAR	Single Agency Analysis Report
SALT	Speech and Language Therapy
SCR	Serious Case Review
SW	Social Worker
TAC	Team Around the Child
Hospital 1	Tertiary Hospital delivering Neonatal and Paediatric care
Hospital 2	Local Hospital delivering Emergency and Paediatric care
Hospital 3	Tertiary Hospital overseeing Parenteral Nutrition