

**BROMLEY  
SAFEGUARDING  
CHILDREN BOARD**

**Overview report on the  
services provided for  
infant 'P' and her family  
during the period  
November 2006 –  
November 2007**

**Executive Summary**

**9 May 2008**

## INTRODUCTION

Bromley Safeguarding Children Board (BSCB) conducted a Serious Case Review (SCR) of the services provided to 'P' and her family in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance.<sup>1</sup> This guidance sets out the arrangements for the local inter-agency review of in child protection cases where it is considered that there are important lessons to be learnt for the agencies with responsibilities to safeguard children. The detailed current arrangements for review of cases by authorities in London are contained in the London Child Protection Procedures.<sup>2</sup>

The decision to carry out the review was taken at a meeting chaired by Gillian Pearson who is Director of Children's Services for Bromley and Chair of the BSCB on 3 January 2008. The following agencies provided services to 'P' and her family within the period covered by the review:

- Bromley Council Children's Social Care Services
- Bromley Primary Care Trust (PCT)
- Bromley Hospitals NHS Trust
- Oxleas NHS Foundation Trust
- Metropolitan Police Service
- Mayday Hospital NHS Trust (which is located in Croydon and is a member of Croydon LSCB)

A SCR panel including representatives of all the Bromley agencies was convened to conduct the review. In order to carry out the review:

- all agencies reviewed their records, interviewed staff and produced an internal management report written by a person with expertise in safeguarding children who had not been involved in the case
- an independent person not employed by any of the Bromley agencies was commissioned to write an overview report, taking into account information from all agencies

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<sup>1</sup> Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to safeguard children, 2006*

<sup>2</sup> London Child Protection Committee, *London Child Protection Procedures*, section 14.7

- the independent person produced a comprehensive chronology detailing all the actions and decisions taken in the case
- members of the extended family were consulted although it was not possible to consult P's mother because she is currently suffering a serious mental disorder.

The report produced has been adopted by the LSCB and its member agencies. The LSCB has adopted an action plan to ensure the implementation of all the recommendations made in the review.

The review concerns 'P', a black child of African origin who was born in 2007 in Bromley. 'P' was made subject to police protection (Section 46 Children Act 1989) on November 2007 and admitted to hospital after her mother abandoned her in the flat that they shared. She was not badly injured and was well enough to be discharged from hospital three days later. P's mother was in a state of considerable mental distress at the time of the incident and she has subsequently been found to be in need of psychiatric treatment over several months. This has made it impossible for the police to interview the mother in order to establish exactly what happened.

The basic circumstances have however been established and it is clear that P's mother was subject to a rapid deterioration in her mental health which impacted directly on her capacity to care for P. Although 'P' was not badly injured a number of circumstances in her case led the LSCB to decide to hold a SCR. These were that:

- although 'P' had three older half siblings who are in local authority care and agencies were well aware of her mother's pregnancy, there appeared to have been no proper assessment of the potential risks to her before her birth
- although there was evidence of some collaborative working between the local authority and other professionals, no pre-birth child protection conference was convened and there was obvious reason for concern about some aspects of the management of the case
- although Social Care had not taken the action required by the child protection procedures, other agencies had not raised serious concerns about the management of the case.

The terms of reference agreed for the review were to establish the following:

- why it was - given the mother's history of mental health and the fact that her 3 older children were looked after by the local authority – that there was no proper pre-birth multi agency planning
- whether or not the London Child Protection Procedures were followed
- why other agencies did not raise sustained concerns when Social Care failed to respond in an appropriate fashion to the mother's pregnancy
- why there was no proper multi agency planning for the discharge of 'P' from hospital after her birth
- whether there was an adequate level of monitoring for 'P' and her mother in the community
- whether appropriate legal arrangements were used to ensure the protection of PP
- what lessons could be learnt from this case about the way agencies work together to protect the children and unborn infants of mothers with a mental health history?

## **LEARNING THE LESSONS AND IMPLEMENTATION OF RECOMMENDATIONS**

The findings of the review and the recommendations to improve practice are set out in this document. Bromley Safeguarding Children Board has produced an action plan identifying the actions needed, who will be responsible and timescales for completion. The board will oversee implementation of this action plan over the coming months to ensure that lessons are learnt and safeguarding of children in Bromley is improved.

## **KEY EVENTS**

A list of the key events in this case are set out in the appendix to this report.

## THE FINDINGS OF THE AGENCY MANAGEMENT REVIEWS AND THE OVERVIEW REPORT IN RELATION TO THE REFERENCE

### 1 **Given the mother's mental health history and the fact that her 3 older children were subject to Care Orders to Bromley, what prevented multi agency pre birth planning in respect of 'P'?**

The most important factors preventing multi-agency pre-birth planning were:

1. weak assessment by Social Care staff that failed to take into account:
  - a. the specific history of P's mother and the impact of her mental disorder on her care of previous children
  - b. the implications of relevant research findings and clinical experience on the impact of parental mental health problems on children
  - c. the very significant vulnerability of a very young baby in these circumstances
2. poor management in Social Care which failed to:
  - a. recognise the weaknesses in practice set out above
  - b. prevent drift in timescales for action and decision making
  - c. ensure the implementation of more appropriate decisions that had been made
3. inappropriate optimism (which became mutually reinforcing) among the professionals involved who allowed the positive current presentation of P's mother to overcome their understanding that the history and associated risk factors demanded a planned and co-ordinated response
4. the fact that P's mother misled her midwife about who was caring for her older children and this was not checked or challenged.

The SCR identified that an unacceptably large number of different social care staff dealt with this case over a period of 5 months. Notwithstanding the responsibility that individual members of staff and managers must take for specific assessments and decisions in this case, the overall quality of work reflected staff shortages in the assessment

service at this locality and the rapid turnover of members of staff and managers. The report notes that in so far as these circumstances have not changed it is essential that such problems are addressed. The report notes that all of the social workers and front line managers involved in the work on this case are now no longer working for Bromley.

**2 Were the London Child Protection Procedures followed in this case?**

The London child protection procedures were not followed in the following respects:

- the circumstances required a core assessment / investigation under section 47
- there should have been a pre-birth initial child protection conference

**3 When the Social Care Referral and Assessment Team failed to respond in a timely fashion to the mother's pregnancy should other agencies have raised concerns and what prevented them so doing?**

The mental health service and the hospital midwifery team should have recognised the need for properly co-ordinated pre-birth assessment and planning, even taking into account that they did not have all the relevant information. The reasons they did not were that:

- P's mother misled the midwife about her other children and the information she provided was not checked or challenged
- subsequently the midwives took account only of P's mother's positive current presentation and failed to consider the possibility of a deterioration or relapse
- the midwives referred P's mother to Social Care but did not follow the referral up when no action was taken
- in the mental health service, the working assumption throughout was that P's mother should be able to care for her child, unless something negative happened

- the health visitor had no involvement prior to the birth because no one else implemented any pre-birth planning; this may have led her to believe that it was a less risky case than it actually was
- when she saw 'P' her assessment was not sufficiently curious about the family background and the circumstances of the other children although she had clear pointers
- P's mother's presentation to health staff (midwives and health visitor) was positive throughout and they never had cause for concern based on their current contact

**4 Why did multi agency planning around the discharge of 'P' from hospital following her birth not take place?**

The approach taken after the birth of 'P' was a logical extension of the approach taken before and completely consistent with it. The reasons for this are set out above. P's mother was an experienced mother; there had been no agreement to hold a discharge meeting and there was no sign of concern during the period of her stay in hospital to make anyone change their approach.

**5 Following the discharge of 'P' and her mother did agencies provide an adequate level of support and monitoring in the community?**

Taking only the current presentation of 'P' and her mother, the health visitor's decision to place 'P' at level 2 of the needs banding (i.e. needing additional support but not the highest level of risk) was appropriate and the level of visiting planned was in accordance with that. Had the health visitor made a fuller assessment taking full account of the care of the previous children she might have reached a different conclusion.

The CPN made visits in August and September and attempted a later visit in September. P's mother visited the clinic on early October. This level of involvement would have been appropriate taking into account

only P's mother's needs as a mental health patient and was based on assumptions that:

- she would be able to meet P's needs
- if there was any deterioration she would recognise it and seek help.

The level of inter-agency co-operation was low (there was only one contact between the CPN and other professionals) whereas P's mother's actual needs required a co-ordinated plan where everyone knew what their role was and what other professionals were doing.

Social Care involvement after the birth of 'P' was inadequate following from the earlier decision to close the case.

## **6 Were appropriate legal processes used to ensure the protection of 'P'?**

The use of police protection was appropriate, although the agency management review has identified that not all the appropriate internal recording and administrative procedures were followed.

Social Care should have planned much sooner for an application for an Emergency Protection Order or an Interim Care Order in order to ensure that 'P' was safeguarded before the police power of protection lapsed.

The hospital should not have agreed to the discharge of 'P' without having a full understanding of her legal status.

P's mother's views should have been sought and assessed, but it is questionable whether a distressed psychiatric patient who was *effectively* detained in a psychiatric hospital should have been asked to agree to the voluntary accommodation of her daughter. Although it appears to be a more punitive approach, an early application for an EPO or an Interim Care Order would have allowed her to have been represented properly and would have safeguarded her rights.

The application for the Interim Care Order to safeguard 'P' was appropriate.

## **7 Was ethnicity a factor in the case?**

P's mother and all of the family members who had contact with the services under review were black women of African origin. They were all established residents living in the part of Bromley that has the highest proportion of minority ethnic families. They were members of strong community and church networks and P's mother's older children attend at local schools. They were not newly arrived in the UK and there was no lack of background information to hamper agencies' work.

The principal source of risk to 'P' was her mother's bi-polar mental disorder. There is no evidence or suggestion that its origins or re-occurrence were in any way influenced by P's mother's ethnicity or that her treatment and care were in any way adversely affected by this. Her illness had been recognised and she had been receiving community-based treatment for several years.

Treatment and care arrangements for P's mother showed a high level of sensitivity in relation to her ethnic and cultural needs:

- she had had a good, long standing relationship with a care co-ordinator who was of a similar ethnic background
- when she requested a change of care co-ordinator there was a quick response and the CPN who became her care co-ordinator was selected in part because she also had a similar ethnic background
- she was also a CPN who would be well placed to monitor and manage the impact of medication during pregnancy
- both the CPN and the psychiatrist thought very carefully about the tensions that were said to exist between P's mother and other family members
- when these were manifested through an allegation of 'witchcraft' the mental health team discussed thoroughly whether these statements

had a specific cultural meaning or whether they might be indications of a deterioration in her mental health

- there was a good deal of joint working between the CPN and the LAC social worker – she is also a black woman; she was sensitive to the fact that she is of a different nationality to Ms AP and that at times this may have affected Ms AP's attitude to her.

It is recognised that matching workers to service users does not guarantee good quality service provision, however in this case it did make a positive difference. The panel considered all of these issues carefully and reached the view that the main areas of weakness in the work in this case – failure to focus on the child and the failure to work effectively across agency boundaries – were examples of difficulties that could have occurred in any family and were not influenced in any specific way by the ethnicity of the family or a lack of sensitivity from agencies.

### **Could the injuries to 'P' have been predicted? Could they have been prevented?**

The analysis provided in the agency management reviews and the overview report has demonstrated that the agencies involved seriously underestimated the level of risk to which 'P' was exposed. Using only the information available at the time and without the need for the added benefit of hindsight there was a compelling list of risk factors that should have been identified and brought together.

It cannot be said that the actual events that occurred could have been predicted or would have been prevented, but it is clear that:

- there was a very strong possibility that a relapse in P's mother's mental illness would occur
- if this occurred it would very likely impact directly on her capacity to care for a baby and that

- if something went wrong it could be very serious because 'P' was very vulnerable.

This should have led agencies to realise that what was needed was:

1. a very detailed assessment that used a thorough understanding of the past and the current environmental pressures to inform a dynamic understanding of the risks to 'P'
2. a co-ordinated approach whereby agencies worked to an agreed plan
3. a cautious approach which allowed P's mother to care for 'P' in a setting where:
  - her mental illness could be monitored and treated
  - her ability to care for 'P' to be fully assessed
  - tensions between P's mother and the extended family could be discussed and addressed
  - the extent of responsibility and supervision to be adjusted according to the developing assessment.

This approach required a common understanding that the interests and needs of 'P' were paramount and that all decisions and actions should be tested against that criterion. This is the starting point of the legal framework that underpins all services for children and the guidance for other agencies whose services impact on children. In this case this perspective was missing at key points. The circumstances of the case provide an important reminder of how hard it can be to achieve when there are many professionals involved and of a number of very important lessons about how this can happen.

**What lessons can be learnt from this case about the way agencies work together to protect the expected babies of mothers with a history of serious mental health problems?**

**Quality of assessment**

1. Assessment and decision making in all agencies must take full account of a parent's mental health problems and identify clearly the role that they have played in child care or safeguarding concerns.
2. Assessment and decision making must be informed by a good understanding of relevant research and clinical experience.
3. All professionals need to remember the importance of balancing a carer's positive current presentation with a full appreciation of the implications of any past concerns
4. All professionals must be prepared to check and challenge the detail of background information given to them by service users.
5. If a decision is reached within Social Care Referral and Assessment Service to discontinue a core assessment the decision must be ratified by a team manager or someone more senior.
6. Health visitors and other health professionals should fully investigate the circumstances and history of previous parenting of mothers whose children have been looked after or subject to safeguarding arrangements in order to establish whether the previous concerns might continue to be relevant.

**Collective agency working when a parent has a mental disorder - implementation of the Bromley SCB protocol on mental health and children's services**

7. When a parent has a mental disorder or other less serious mental health problems that may impact on the care of a child, staff in all agencies must keep a clear focus on the needs of the child and try to consider what is being proposed from the perspective of the child. This must apply:
  - to staff working in an agency mainly working with adults
  - regardless of whether there are other agencies involved who ought to be playing a leading role in this regard.
8. In line with the existing LSCB protocol on mental health and children's services, whenever there are either current or past mental health concerns assessment and planning must be underpinned by a clear understanding of the roles and responsibilities of different agencies including agreement on how they will work together.
9. Where there is disagreement or disquiet about the approach being taken staff should:
  - seek support from a manager or professional advisor in articulating it
  - express it clearly to the agency responsible
  - express it in writing
  - seek support from a manager or professional advisor if the concerns are ignored.
10. When consideration is being given by either mental health or children's services to the placement of a parent in a mental health unit which accommodates children, the decision should always involve joint assessment and planning involving both agencies. Children's Social Care staff should undertake a core assessment (and if necessary an assessment under section 47 Children Act 1989) in all such cases.

### **The Care Programme Approach in mental health services**

11. Meetings held within the Care Programme Approach on a pregnant woman must fully consider the needs of the child and the steps being

taken to safeguard the child. If the current plan is not considered satisfactory, the concerns must be communicated in writing to the relevant children's Social Care authority.

### **The role of GPs**

12. GPs need to be able to identify historical concerns about child protection from their records, including the records of parents where the children affected are no longer patients. Those providing information to GPs such as local authorities need to flag up that they want the information to be cross referenced on parental records.

## **RECOMMENDATIONS OF THE INDIVIDUAL AGENCY REVIEWS AND THE SERIOUS CASES REVIEW PANEL**

The following is a summary of the recommendations made by individual agency management reviews and by the LSCB review as a whole covered.

### **1 Metropolitan Police Service (MPS)**

The report makes recommendations in the following areas:

- the need to remind relevant officers of police powers, responsibilities and detailed operating procedures relevant to police protection (Section 46 Children Act 1989)
- the need to reinforce the understanding of investigative responsibilities when children are subject to police protection
- the need to review current standard operating procedures (SOPs) in relation to police protection to ensure that they promote the correct approach
- reinforcement among Bromley Child Abuse Investigation Team officers of the need for a proactive response at the outset of an investigation and comprehensive and accurate records of events.

## **2 Bromley Children's Social Care Services**

The report makes recommendations in the following areas:

- the need to urgently review the levels of staffing and competence of the current staff group in the Referral and Assessment Team covering the area concerned and identify a course of action that addresses both systemic and individual weaknesses.
- the need for an action plan to address any remaining staffing difficulties within the Referral and Assessment Service
- the need for the head of service of the Referral and Assessment Service to provide a detailed up to date report to the BSCB Executive by August 2008 on the progress made in improving recruitment, retention and quality of staff in the relevant teams.

## **3 Bromley Primary Care Trust (PCT)**

The report makes recommendations in the following areas:

- recording procedures and arrangements
- audit of record keeping
- arrangements for recording of information and communication arrangements between the midwifery service and the paediatric liaison health visitor
- implementation of the Bromley LSCB peri-natal mental health protocol to ensure that it has been disseminated and is achieving its objectives
- audit of compliance with the peri-natal mental health procedures
- action to be taken when there is inadequate communication from other agencies
- the need to extend safeguarding supervision in the PCT to include children living with significant parental mental illness
- training of staff on BSCB course on safeguarding and mental health issues
- debriefing of the health visitor involved in the case and further training.

#### **4 Bromley PCT commissioned General Practitioner services**

The report makes specific recommendations in relation to:

- the need to check records of pregnant women carefully to identify any relevant issues or previous children
- the need to offer birth control advice when reviewing medication with mothers suffering from significant mental illness requiring long term medication.

#### **5 Bromley Hospitals NHS Trust**

The report sets out a number of relevant steps that had already been taken prior to the completion of the management review which are designed to improve the protection of vulnerable babies:

- an alert system has been created in the maternity computer system to identify vulnerable families to midwives at the time of delivery
- a new document has been developed which is to be used at the *midwifery communication meeting* to ensure that any required actions are taken
- development of the role and training of a midwife with a specialist interest in caring for women with mental health issues

#### **6 Oxleas NHS Foundation Trust**

The report makes recommendations in relation to the following:

- the need for routine joint planning with childcare social work staff as well as midwives, the health visitor and the G.P
- when a pregnant woman has a history of significant mental health problems this should include how post natal support and monitoring will be provided as well as a contingency plan should difficulties arise.
- the need to communicate signs of risk to a child including indicators of relapse or reduced engagement with services to the patient's consultant, as well as other involved professionals, including where relevant child care social work staff, midwives and primary care staff.

- better recording of the decisions of multi disciplinary mental health team meetings
- learning from this case should be disseminated to staff through multi agency briefings and managers should release staff to attend these sessions.

## **7 Mayday Healthcare NHS Trust**

The hospital already has improvement plans in place that deal with the concerns identified in its report about recording. The review also recommends training of staff to improve awareness of the legal arrangements for children, in particular those who are subject to police protection:

## **8 Health Services overview report**

The report makes a series of recommendations relating to some overarching themes to enable learning to be achieved across the health economy. These cover:

1. provision for pregnant women and parents with mental health problems
2. record keeping
3. familiarity with procedures
4. the development of a multi agency communication protocol during the perinatal period
5. supervision and
6. challenging other professionals.

The Serious Cases Review Panel made additional recommendations on the following areas:

1. review of the current version of the multi-agency protocol on mental health and children's services, reissue of the protocol and publicity to ensure that staff are aware of it

2. the current training programme on mental health and children's services should be reviewed so as to ensure that:
  - it's emphasis is on improving inter-agency working rather than clinical information about mental health
  - it addresses cultural and organisational barriers to joint working
  - it is equally relevant to children service staff and mental health staff
3. the need for review of procedures in Social Care and the mental health trust when considering placing a parent in a mental health 'mother and baby unit'
4. the need for changes in the mental health Care Programme Approach procedures and requirements
5. the need for the LSCB to continue to monitor the progress in improving the service provided by the Social Care Referral and Assessment Service.

