



## **EXECUTIVE SUMMARY**

### **Serious Case Review: Baby Robert**

#### **1.0 Summary of Circumstances Leading to the Review**

1.01 Baby Robert died aged 34 days. Baby Robert and his mother were homeless and living with a relative at the time of his death. It was reported that his mother had consumed a large amount of alcohol on the night before his death and Baby Robert was lying with her when he was found dead. An ambulance was summoned and Baby Robert was conveyed to hospital where at 08.26 hrs the same day his life was pronounced extinct.

#### **2.0 Review Panel Members**

- Independent Chair
- NSPCC
- Southend Borough Council Specialist Services
- Southend Borough Council Housing Needs Department
- Essex Police Authority
- Southend Borough Council School Support and Preventative Services
- NHS South East Essex Community Healthcare
- South East Essex Primary Care Trust
- Southend University Hospital NHS Foundation Trust
- Essex Probation Service
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Drug and Alcohol Team
- South Essex Homes
- Named GP Southend

#### **3.0 Contributors to the Review**

- Southend Borough Council Department of Children and Learning Specialist Services
- Southend Borough Council Housing Needs Department
- South Essex Homes
- Essex Police Authority
- NHS South East Essex Community Healthcare
- Southend University Hospital NHS Foundation Trust
- Essex Probation Service
- South Essex Partnership University NHS Foundation Trust (SEPT) (Mental Health)

#### **4.0 Terms of Reference and Scope of the Review**

- 4.01 The following were general issues for all agencies to consider when writing their reports:-
- 4.02 In addressing the identified issues below agencies were asked to produce a robust, comprehensive and well-structured management review of their full involvement with Baby Robert and his family and the outcomes for Baby Robert.
- 4.03 Each report was to include a chronology of engagement with Baby Robert and the family and other agencies.
- 4.04 Each report was to include a genogram detailing family and agency relationships.
- 4.05 Each report was asked to consider how the racial, cultural, linguistic and identity of Baby Robert and his family impacted on the outcome for the child, Report authors were asked to identify any disadvantage and/or social exclusion of the family and its potential impact on the outcome for Baby Robert.
- 4.06 Each report was to include a detailed analysis of the information gathered which is open, thorough and critical against national and local statutory requirements, professional standards and current procedural guidance. Areas for changes in practice were requested to be clearly identified.
- 4.07 Each report was to make reference to hindsight and any relevant national research to judge whether different actions or decisions would have made a difference in the outcome for Baby Robert.
- 4.08 Evidence of good practice was to be highlighted, and any potential for wider implementation considered
- 4.09 Each report was asked to consider the effectiveness of joint working and information sharing between all services working with this family considering for example the timing and appropriateness of referral and quality of shared information and the impact on the outcome for Baby Robert.
- 4.10 The specific issues and questions that Individual Management Review (IMR) authors were asked to considered included:-
- 4.11 The mother's history of local authority care, alcohol abuse, self harm, domestic abuse, terminations of previous pregnancy and criminal convictions; how agencies responded and supported the mother; and the impact on the outcome for Baby Robert.

- 4.12 How far the work done with the mother and Baby Robert fitted within agency protocols; and notably the non-registration of Baby Robert with a GP, and whether the mother was taken up as an active case by the Health Visitor service and how and when this was initiated
- 4.13 Whether the Southend Essex and Thurrock (SET) Child Protection Procedures were adhered to in this case.
- 4.14 The mother's homelessness, what interventions took place, and with what results? How did the mother's homelessness impact on her ability to parent Baby Robert?
- 4.15 Episodes involving violent and or aggressive behaviour (including domestic abuse) **on** or **by** the mother and any subsequent assessment and response by agencies to the risk posed by these episodes to the mother's ability to safeguard, and the impact on the outcome for Baby Robert.
- 4.16 Whether new mothers receive specific advice on sleeping arrangements for babies in light of recent research, particularly where alcohol misuse and homelessness issues are known to exist? Were these issues explored with the mother?
- 4.17 There were no unusual factors identified at this point in this case, and no evident similarities with the previous Southend LSCB Individual Management Reviews or Serious Case Review.
- 4.18 Whilst the Panel agreed there were no obvious failings evident at the beginning of the review which would require immediate action the Chair suggested that the area of the mother's accommodation situation would need particular attention by the agencies involved. Any failings that become evident during the course of the serious case review which require immediate action should be dealt with as they arise.

## **5.0 Time Period Over Which Events Were to be Reviewed**

- 5.01 All reports were asked to cover the period from the mother's 18th Birthday to Baby Robert's death, appropriate to their organisation's involvement with the mother, apart from the report from the Southend Borough Council Department of Children and Learning, which also included a summary of significant events in the mother's childhood which may have impacted on her ability to parent and the outcome for Baby Robert.

## **6.0 Involvement of Family Members**

6.03 The family of Baby Robert were offered the opportunity to contribute to this serious case review on a number of occasions but declined to do so.

6.06 At the conclusion of the report another letter was sent to the mother, and other family explaining that the review had been completed. A further offer of a meeting with the Independent Author was made in order that the family could be informed of the outcome of the Review prior to the publication of this Executive Summary and to afford them the opportunity to express any wishes and feelings. This offer was once again declined by the family.

## **7.0 Family Background**

7.01 The mother was born into a family where there was a history of domestic abuse, alcohol misuse and mental health issues.

7.02 The mother's formative years were characterised by periods spent away from her immediate family and living with relatives or in local authority foster care.

7.03 As she grew into adulthood, she experienced periods of alcohol misuse and self harming by drug overdose. She was a victim and perpetrator of domestic abuse and assault she was involved in the criminal justice system. She had experienced multiple pregnancies none of which had gone to term until the birth of Baby Robert.

7.04 During her pregnancy with Baby Robert the mother became homeless and was eventually placed within a Hostel. She was judged to have made herself intentionally homeless and so time constraints were placed upon the availability of the accommodation in which she was residing, in line with current legislation.

## **8.0 Key Themes from the Review**

### **8.1 Effectiveness of Current Practice and Adherence to Procedures**

8.1.1 The Southend Essex and Thurrock (SET) Child Protection Procedures require that a child protection referral is made where there is knowledge of parental risk factors including mental illness, domestic abuse or substance abuse. It also includes concerns in relation to parenting ability and self care and/ or to care for the child. Other risk factors highlighted include failed appointments and the failure to comply with treatment which could have detrimental to the child. The mother met these thresholds but a number of agencies who had such information did not make a referral to Specialist Services

- 8.1.2 A further example of failing to follow local procedures was evident with Maternity Services not referring the mother for a joint assessment.
- 8.1.3 In both of these situations, the information indicating the need for a referral was not obtained from records or incomplete information from the mother was accepted without question.
- 8.1.4 Due to contextual issues, including staffing shortages, an increase in referrals to Specialist Services after the baby Peter case, and the reconfiguration of services being in progress, there was a period of time in Specialist Services when there was a lack of the necessary management oversight and direction for staff in this service.
- 8.1.5 Recording of information was sometimes below the required standard. Within the Hostel, records were sometimes not made at the time or immediately after an event and were not timed and dated. Within Specialist Services not all contacts with the mother or Baby Robert were recorded
- 8.1.6 The use of the Common Assessment Form (CAF) to make referrals to Specialist Services was also identified as a cause for delay in the making of a child protection referral by the Hostel.

## **8.2 Acquiring, Using and Sharing Information from Records and Clients/Patients**

- 8.2.1 A number of agencies, including Specialist Services, Primary Care Services, Midwifery Services, Health Visiting Services and Probation did not access historical records
- 8.2.3. A great deal of information was already known about the mother as well as there being a number of opportunities by a range of agencies to gather more up-to-date information.
- 8.2.4 During the Initial Assessment with Specialist Services, the check of mother's background did not identify the existence of historical records because of a human and systems error which did not uncover when duplicate records are held , therefore no account was taken of her background and history with other agencies, including Specialist Services. A decision was made that the case should be allocated to a social services worker who specialised in working with homeless parents and children. The unborn child was classed as a child in need and a decision to access information from other agencies was not followed up. From this juncture the focus of attention was upon the mother's homelessness rather than on child protection concerns.

### **8.3 The Desensitisation of Staff to Risk Factors for Children**

- 8.3.1 Health Services which served the area in which the mother lived had a relatively high level of patients from the homeless community many of whom were challenged by issues of domestic violence, alcohol or drug misuse and mental ill-health. The high level of need made it even more difficult to identify the most vulnerable of these individuals resulting in the mother's unborn child's needs being minimised.
- 8.3.2 The review highlighted the importance for professionals of understanding the impact on children and their families of the family and community cultural context within which they live and how vulnerabilities may be heightened by factors such as pregnancy.

### **8.4 Loss of Focus on Baby Robert**

- 11.1 There was a general lack of child protection focus throughout this Review. Services were offered to the mother because of her child. Specialist Services in particular focused upon the homeless issues of the mother. Other Services also failed to recognise the safeguarding needs of Baby Robert.

### **8.5 Impact of Homelessness**

- 8.5.1 The mother's homelessness raised two issues in this case. Firstly, the focus on her homelessness by Specialist Services and by the Health Visiting Service affected which services were offered to her.
- 8.5.2 Secondly, this case highlighted the lack of appropriate supported housing for women with children who are found to be intentionally homeless. The protocol between the Council's Housing Needs Department and Children's Specialist Services is to be reviewed to ensure that mothers with babies are provided with adequate accommodation and support.
- 8.5.3 There is little doubt that the fact that the mother was homeless made it more difficult for agencies to engage with her. There are examples of unsuccessful visits by Health Services in particular which emphasise this point.
- 8.5.4 There is a new service currently being piloted in Southend. The Think Family Project works with families where a number of agencies are involved from both adult and children's sectors. Homelessness is one of the criteria for referral to multi-agency co-ordinated support and involvement. This is the kind of support that may have been the trigger to access services and had this been in place at the time may have possibly influenced the outcome of this case.

- 8.5.5 Agency support was always made available to the mother and, in the main service provision and interventions were timely and effective. However, this support was not always joined up and would have been more effective if agencies had worked together adopting a child protection focused approach.

## **9.0 Identified Actions**

The themes identified above have already been addressed or are in the process of being addressed by the agencies involved. Remedial action has been taken by individual agencies via agency action plans as the result of recommendations made within agency individual management review. These will be the subject of regular reports to the Southend LSCB with evidence of progress and of improved outcomes. The additional recommendations made in the Overview Report are therefore few in number in recognition of the work in progress and aimed at supporting agency recommendations already underway.

## **10 RECOMMENDATIONS**

### **10.1 LSCB**

- 10.11 A review of the use of the CAF as a referral tool for child protection to be commissioned by the Board, to be completed within 6 months. The review will make recommendations in order to ensure that there is a sharp and effective focus on child protection issues within the Southend approach towards integrated working. The review should also take in to account the current work within the SET group to review the referral process and use of CAF, and the recent review of integrated working in Southend.
- 10.12 That within six months of the publication of this Review, the importance of checking an agency's historic records is emphasised in all safeguarding training being delivered.
- 10.13 That the LSCB receives regular updates with regards to the progress of each individual agency action plan in addition to updates on recommendations contained within the Overview Report.
- 10.14 That within six months from the publication of this Review the Board includes in its current regular audit of initial referrals those referrals that do not progress to a Section 47 assessment.
- 10.15 The LSCB, in conjunction with the Children's Trust should undertake a review, to report within 6 months, on the ways in which the agencies in Southend can better operate on an interagency basis in order to take account of, and collectively address, operational pressures and other

issues which may impact on the effectiveness of the safeguarding system as a whole. These may include as they might arise high staff vacancy rates, varying operational pressures, or high referral rates in particular areas.

- 10.16 The LSCB in conjunction with the Children's Trust should undertake a review of the first line/supervisory processes within all agencies key to safeguarding, to report within a time scale of 6 months. The purpose of the review should be to determine how each agency can most effectively balance the achievement of its performance management targets with a high quality and reflective approach towards practice, both within and between agencies, and with a strong focus, in particular, on the dangers of normalisation
- 10.17 That within twelve months from the publication of this Review the LSCB should consider multi agency training focusing on the biennial analysis of Serious Case Reviews.

## **10.2 South Essex Homes**

- 10.2.1 That South Essex homes be included in the review of the Joint Protocol and Communication Strategy being undertaken by Children's Specialist Services and Housing Services to ensure it is robust, fit for purpose and compliant with recognised guidance documented in Working Together 2006.

## **10.3 Joint Police and Specialist Services**

- 10.31 There is a detail at present unresolved in the overview report regarding the issue of a telephone call alleged to have been made. It is recommended that with immediate effect a joint Police/Specialist Services investigation is considered. This should establish whether a telephone call was made to Specialist Services, by the witness known to the Police, allegedly reporting concerns regarding Baby Robert's care three days prior to his death. It should specifically enquire into and interrogate telephone records used by the witness and Specialist Services recording and IT systems. It is suggested that the enquiry should be overseen by the Independent Chair for the LSCB.

## **10.4 Police**

- 10.41 That within six months from publication of this Review the Police should commence providing the LSCB, updates from their quarterly audits of completion of pregnancy markers for both perpetrators and victims of domestic incidents. This is in order to satisfy the Board that Police practice in relation to pregnant women who are subject to domestic abuse is maintained at an expectable standard and complies with procedures.

**10.5 Department of Children, Schools and Families**

- 10.51 That the Department of Schools and Families discusses with the Department of Health an ongoing national campaign to warn parents of the dangers of co-sleeping with young babies.