Serious Case Review

Baby M

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1. INTRODUCTION

1.1 This Serious Case Review was commissioned by the Essex Safeguarding Children Board following the death of a mother and her three-and-a-half-month-old baby. Mother and baby had been found deceased at their home and following a post mortem it was determined that it was most likely that Mother had killed her baby and then herself. Mother was an insulin dependent diabetic and two small puncture marks had been found on the baby's leg. Following further tests, both Mother and baby were found to have died of an insulin overdose and there was also evidence that Mother had used alcohol and cocaine in the period before her death.

1.2 As a result of the death of the baby (known as Baby M throughout this report) the Chair of the Essex Safeguarding Children Board decided to commission a Serious Case Review.

1.3 Since this review was commissioned by the Essex Safeguarding Children Board, the focus of the review has been on Baby M with relevant background information considered and included where appropriate about the two siblings. However, as the review progressed, it became apparent that the way in which agencies responded to Mother as an adult who clearly had needs of her own would inevitably be an important aspect of the review, and the Essex Safeguarding Adult Board has been kept fully up to date with the progress of the review and participated in review team meetings.

1.4 This review refers to the following family members:

Mother	Mother of the three children referred to in this report
Sibling 1	Mother's first child and half sibling of Baby M, the baby who is subject of this review – aged 11 at the time of Baby M's death
Sibling 2	Mother's second child and half sibling of Baby M the baby who is subject of this review – aged 5 at the time of Baby M's death
Baby M	The baby who is subject of this review
Partner 1	The father of Sibling 1
Partner 2	The father of Sibling 2
Partner 3	The father of Baby M
Maternal Grandmother	
Maternal aunt	

2. THE SERIOUS CASE REVIEW PROCESS

2.1 An independent Lead Reviewer, Jane Wonnacott was appointed by Essex Safeguarding Children Board to carry out the review and write this report. Jane is a qualified social worker with over twenty years' experience of conducting Serious Case Reviews and is the author of over one hundred reports. She is independent of all organisations in Essex.

2.2 A review team made up of senior professionals within the Essex area was appointed to work with the Lead Reviewer. Members of the review team were:

- Designated Nurse/Named Professional Primary Care, local CCG,
- Service Manager, Essex Children Social Care, Assessment and Intervention
- Detective Inspector - Public Protection Investigation Hub - Essex Police
- Head of Safeguarding - Essex Partnership University Trust (Adult Mental Health)
- Safeguarding Adviser to Schools - Essex Education
- Safeguarding Representative from the City, District and Borough Councils Group
- Director of Safeguarding and Quality Assurance - Essex Adult Social Care
- GP representative - local CCG
- Interim Safeguarding Lead, Children's - out of area hospital
- Business Manager, Essex Safeguarding Children Board

2.3 Written chronologies of professional involvement with Mother, Baby M, and Sibling 1 and 2 were requested of all the agencies/organisations who had some involvement with the family, and these reports were analysed by the review team.

2.4 Practitioners from those organisations who had direct involvement with the family were invited to meet with the Lead Reviewer and a member of the review team in order to explore the factors influencing practice and lessons for the future.

2.5 Members of Baby M's extended family were invited to contribute to the review and the review team are very grateful for the contribution made by Baby M's grandmother and aunt. Despite the very painful circumstances, they were able to help the Lead Reviewer and the team understand more fully the circumstances leading up to the death of Mother and her baby.

2.6 The Lead Reviewer worked with the review team to agree a draft report and this was shared with practitioners who had contributed to the review. The final draft was scrutinised by the Serious Case Review Sub-Committee before being presented to the Essex Safeguarding Children Board. The Sub-Committee discussed the degree to which information about Mother's background, needs and vulnerabilities and information about siblings should be included in the report. The strongly articulated view of the sub-committee was that this information was relevant and should be included in the report presented to the Essex Safeguarding Children Board (ESCB) in order that they could fully understand the way in which these factors had influenced the final findings and recommendations.

2.7 The full report was accepted by the Essex Safeguarding Children Board and work began to implement the recommendations. After due consideration, the Essex Safeguarding Children Board decided that it would not be appropriate for the full and detailed serious case review report to be published, especially given that the siblings would be able to access the published report in due course. The ESCB took the

decision to publish an edited report, with the assurance that the key learning points from the full serious case review and rationale in relation to the findings would be included in this published report.

3. BACKGROUND PRIOR TO MOTHER'S PREGNANCY WITH BABY M

3.1 Although the focus of this review is Baby M, there is substantial information available about previous history including Mother's lifestyle, her presentation, and agencies' responses to her. This has been of relevance in formulating the findings and recommendations of this review as previous assessments had an influence on subsequent decision making in relation to Baby M.

3.2 Maternal Grandmother and Maternal Aunt were very helpful in helping the review to understand Mother's early life before the birth of her first child. They told the review that Mother was diagnosed as a type 1 diabetic at the age of 11 and after a period at boarding school she returned to London where she began to associate with people using drugs and became pregnant with Sibling 1. Mother had a history of depression and alcohol use and the family have told the review that they did their utmost to support Mother and were worried that social workers would take the children away if they shared their concerns about Mother's behaviour.

3.3 Mother's three children had different fathers, none of whom were a constant in Mother's or the children's lives.

3.4 Mother had contact with a number of agencies from the birth of Sibling 1 until the deaths of herself and Baby M (a twelve-year period). This included Children's Social Care, Mental Health Services, the Police, GPs, Hospital and Midwifery Services, Health Visitors and Schools, and while there were several assessments and child in need plans put in place during this time (for the older two children), practitioners really only managed to scratch the surface in terms of being able to understand what was going on within the family.

3.5 Key events

Sept. 2005	Sibling 1 born in Hospital 1. Mother was reported to then have taken an overdose of prescribed painkillers. Referral to London Borough Children's Social Care and case closed January 2006.
Feb. 2011	Mother booked for second pregnancy at Hospital 2. GP referral noted Mother's alcohol use and Mother was referred to the specialist midwife.
Sept. 2011	Sibling 2 born.
2011 -12	Police involvement due to domestic abuse. Referral to Essex Children's Social Care in March 2012 resulted in an assessment.

April 2012	Case closed to Children's Social Care.
May 2012	Mother was admitted to a hospital out of area whilst staying in a hotel with symptoms related to alcohol use. Essex Children's Social Care became aware following referral by the ambulance crew. Children were cared for by the extended family.
July 2012	Anonymous referral to Children's Social Care reporting Mother's alcohol and drug misuse. This resulted in an assessment and child in need plan for Sibling 1 and 2.
Aug. 2012	MARAC[1] as a result of an assault on Mother by Partner 2.
Jan. 2013	Sibling 1 called police worried about being left alone by Mother. Mother provided an explanation and no further action by police.
Jan. 2013	Case closed to Children's Social Care as Mother no longer in a relationship.
Jan. 2013	Case reopened by Children's Social Care following car crash involving Mother who was allegedly drunk and not wearing seatbelt. 35-day assessment completed alongside "monitoring".
March 2013	Case closed to Children's Social Care.
Feb. 2014	Fire brigade referral to Police and Children's Social Care due to two fires at Mother's address and concerns about the environment, care of the children and evidence of empty alcohol bottles.
March 2014	Children's Social Care assessment completed resulting in a recommendation for a child in need plan.
May 2014	Anonymous referral to Essex Police concerned about Mother's alcohol use and care of the children.
Nov. 2014	Sibling 1 called an ambulance due to Mother's ill health. Attendance at school had dropped to 82%.
Jan. 2015	Children's and Adult's safeguarding referrals by the ambulance service. Case closed by Children's Social Care following enquiries
May 2015	Mother moved to homeless accommodation
June 2015	Sibling 1 again called the ambulance for Mother. A referral was made to Children's Social Care.
Aug. 2015	Mother evicted from homeless accommodation after being arrested for alleged arson.

[1] Multi-Agency Risk Assessment Conference. A meeting where information is shared between local agencies in high risk cases of domestic abuse. The purpose of the MARAC is to safeguard victims and coordinate community responses.

Sept. 2015	Social work assessment recommended a child protection conference but after further discussions the manager agreed a child in need plan was more appropriate.
Nov.2015	Mother arrested for criminal damage and burglary (possibly drunk)
Jan. 2016	Case closed to Children's Social Care due to support of extended family.

4. MOTHER'S PREGNANCY AND POST BIRTH SERVICES

4.1 Mother continued to see GPs at practice 1 on a regular basis and in April 2016 was noted to be pregnant by a new partner. Because of her pregnancy and concerns about her need to reduce her medication, a referral was made to the Community Mental Health Team. The GP practice were aware that Mother was moving but since the practice cannot refer out of area, they felt it was best to make the local referral to make sure that something happened. They did not want to rely on Mother making the referral. Issues relating to GP referrals to mental health services are discussed in detail in Finding One.

4.2 The GP practice also sent a maternity referral to Hospital 3 which highlighted that Mother had experienced mental health issues, depression, alcohol abuse and domestic abuse and she was known to Social Care. This combination of factors would have warranted a referral to Children's Social Care but at this stage it seems that the GP was not aware that the case had closed.

4.3 The Mental Health Access and Assessment Team carried out a telephone screening during which Mother said she would be registering with a new GP. They sent a referral letter and patient summary to the new GP practice (Practice 2) advising that Mother should be re referred to Mental Health Services.

4.4 The new GP practice contacted the previous GP practice asking them to forward reasons for the referral to Mental Health Services. This was received and Mother was asked to make a double appointment. The GP discussed with Mother coming off her anti-depressant medication and felt that as Mother had been stable on this medication for many years, they were confident Mother coming off the medication could be managed within the practice, rather than via a referral to Mental Health Services.

4.5 Mother was subsequently referred by the new GP Practice for antenatal care at Hospital 4 and Mother informed Hospital 3 that she had transferred but there is no record that the GP referral from Practice 1 outlining the concerns was passed on to Hospital 4.

4.6 Mother was booked by the diabetic midwife at Hospital 4 who books all women with diabetes. The midwife remembers Mother being likeable and well-presented and at

booking she answered “no” to alcohol and substance misuse questions and said she had suffered with anxiety and taken anti-depressants *in the past*. She did not have any concerns about domestic violence. The diabetic midwife felt Mother was a confident well controlled diabetic with a supportive mother.

4.7 At the end of May, Mother called the out of hours GP saying that she was suffering from severe vomiting and asking for medication (which was prescribed) saying that her GP had not prescribed the usual medication and the next dose was due. Ten days later Mother called the practice asking for more tablets saying her partner had accidentally discarded hers when clearing out the cupboards. The prescription was made out to collect in the pharmacy. Issues relating to prescriptions are discussed further in Finding 1.

4.8 At the end of June 2016 Mother was taken by ambulance to Hospital 4 with vomiting and abdominal pain. During the consultation there was a concern that she was asking for more morphine than was required in the circumstances. The hospital also received a call from a member of the public passing on concerns that Mother was smoking and drinking excessively. The doctor spoke to Mother who denied drinking alcohol but admitted smoking. She also said she was struggling emotionally. The doctor called the safeguarding midwife (responsible for issues relating to unborn children) and the paediatric liaison nurse (responsible for live children). The paediatric liaison midwife and the doctor (who had not completed a referral before) together completed a multi-agency referral form and sent it to Children’s Social Care. Mother was not informed of the referral as the doctor felt that she might abscond as she had become defensive and agitated when Children’s Social Care had been mentioned.

4.9 Mother took her own discharge from Hospital 4. She did not attend her next two appointments with the diabetic midwife and at this point the diabetic midwife told the review that she remained unaware of her admission to hospital.

4.10 A social worker had been allocated to the case because of the referral from Hospital 4 and a pre-birth assessment was started. Social Care concluded there was no evidence of alcohol use and wondered if it has been a malicious complaint. Mother explained her request for additional morphine as being because she had vomited the original morphine. Agency checks from the GP and the older children’s school had been requested but not returned and the social work manager asked for further clarity from health professionals particularly the diabetes nurse. There was then a conversation with the nurse and previous comments regarding warm interactions between Mother and children were uploaded onto record and the case closed. Issues relating to this information gathering process are discussed in in Finding 2.

4.11 Meanwhile Sibling 2 started at primary school in September 2016. The general comment from the head teacher to this review was that Mother “came to everything”

at the school and was always well presented, well turned out and had a close relationship with Sibling 2.

4.12 During September 2016 during a GP appointment Mother spoke of feeling poorly and struggling with the other two children and having help from her sister and mother (it was unusual for Mother to admit to anyone that she was struggling with the children). Mother was noted to be aware of the risks of taking her medication during pregnancy.

4.13 By the end of September, Mother (now 30 weeks pregnant) had transferred her maternity care back to Hospital 3. According to maternal grandmother Mother decided to change hospitals because Hospital 4 had "pulled her up on her drinking and drug use".

4.14 The booking midwife did not have access to the original GP referral letter that had been sent to Hospital 3 at the start of the pregnancy. Mother spoke of taking anti-depressants before the pregnancy but reported that she was emotionally fine and coping well. She denied any alcohol use, drug use or social services involvement. She was assessed as having a mild risk of mental ill health in pregnancy.

4.15 Baby M was born at the end of November 2016 and following the birth, Mother and Baby M stayed for a while with maternal grandparents. According to Maternal Grandmother the relationship between Mother and Partner 3 had finished before Baby M was born.

4.16 The health visitor for maternal grandparents' address made various attempts to see Mother at maternal grandmother's house but eventually a new birth visit was carried out by the health visitor once Mother had moved back to her home address. Mother was noted to handle Baby M with care and confidence. No risks were identified, and Mother was offered universal services. This health visitor described to the review her perception of Mother as a charming chatty woman. The health visitor knew nothing about the previous history and felt that even if it had been available, it is unlikely she would have had an opportunity to read it, as the visit was fitted in at the last minute.

4.17 Baby M was seen for the six-eight week health review by the health visitor and observed to be settled and content. The EPDS[2] was completed and the health visitor discussed Mother's history of anxiety with her. Mother reported feeling anxious again and was encouraged to book an outstanding six-week postnatal review with the GP.

4.18 Mother saw the GP two days later and the GP prescribed medication for anxiety and increased the dose of anti-depressants. The number was also given for Therapy for You (T4U, a counselling service) but there is no evidence that this service was taken up.

[2] Edinburgh Post Natal Depression Scale – a commonly used self-rating tool to identify depression in the post-natal period.

4.19 Meanwhile, Mother was expressing some concerns regarding Baby M's problems with a cough.

4.20 During a GP consultation three and half weeks before her death, Mother spoke of disagreements with her family and said that the medication was not working. The prescriptions were therefore adjusted.

4.21 There are some indications that Mother was neglecting her own health as by approximately two weeks before her death she had missed three diabetic screening appointments. There is no record that the GP was notified of this.

4.22 The last GP consultation ten days before her death lasted over 40 minutes and as well as a review of medication, Mother discussed her fluctuating mood over the years and said she had not sought help as she was concerned it would raise concerns about her children's care. She also spoke about stress at home but denied alcohol and drug use. The GPs plan at this point was to refer to mental health services. This referral was made four days before Mother and Baby M's death and included mention of Mother's long history of anxiety with depression, her current financial concerns and her medication.

4.23 Four days later Mother and Baby M were found dead at home by Partner 2 who was returning Sibling 2 home, after an outing.

5. THE FAMILY'S PERSPECTIVE

5.1 It was not considered appropriate to discuss all the issues that were shared by the family within this report. They provided extensive information about Mother and her life which was valuable to the review team in thinking about her relationships with professionals.

5.2 It is important to stress that from the family's perspective there would have been little opportunity for professionals to have changed the outcome for Baby M and Mother. The family were aware of her vulnerability but recognised that she loved her children very much. They did all they could to support her and stepped in in order to make sure that the children remained within the family and were not taken into care. They did not always find social workers easy to communicate with in an open honest way, although more recently their experiences had been more positive.

5.3 The family were aware that things were difficult for Mother during and after the birth of Baby M and wondered whether the prescribing of antidepressants by the GP was the best course of action, knowing that Mother might well exceed the recommended dose.

6. SUMMARY OF LEARNING

6.1 This is a very sad set of circumstances that ultimately led to the death of an adult and her baby. It is speculative as to whether anything could have made a difference to this very sad outcome, but there are a number of areas where agencies could have done things differently.

6.2 It is possible to see that there were a number of risk factors that came together at the point Mother and Baby M died but the significance of individual risks was either not understood or known to any one individual, whether a professional or member of the family. Communication and information-sharing between agencies was not effective and resulted in no one agency having a clear or full picture of what was happening within the family.

6.3 It is important to stress that this was not a case of so called “disguised compliance”. Evidence suggests that Mother complied fully when she wished to do so but at other times it should have been obvious that she did not attend key appointments either for herself or her children. Professionals accepted her explanations and were deflected from focusing upon the impact of her behaviour on her children and the potential risks. The likely reasons for this are explained in 6.6 below.

6.4 There are indications that the voice of her oldest child (Sibling 1) became lost and was not taken into account by practitioners working with the family. Although Sibling 1 was loved and cared for by the extended family, the fact that he/she did not live consistently with Mother and called the ambulance on more than one occasion when his/her mother needed help should have meant that more attention was paid to understanding his/her needs and circumstances.

6.5 There are many instances where an objective analysis of the information could have identified a combination of factors known to increase risk. Taken together, these factors should have prompted further consideration by any of the practitioners working with the family about the vulnerability of Mother and her children. These important factors include:

- Frequent and recent house moves
- Longstanding concerns about Mother’s mental health
- A history of domestic abuse
- Evidence of Mother’s self-neglect in relation to her diabetes control
- Reoccurring concerns about alcohol use, accompanied from time to time by supporting medical evidence
- Requests for more prescription drugs than were required, both in the hospital and the community.

6.6 Why these factors were not understood is explored further in the individual findings set out below. In summary, the review team concluded that:

- Mother's presentation tended to disarm professionals as she was able to persuade them that all was well. She was described by professionals as being likeable, well-presented, confident and seemingly a well-controlled diabetic (although this does not seem to be consistent with the number of hospital admissions). She rarely spoke of stresses or problems except in relation to incidents of domestic abuse, and on occasion to GPs in respect of her anxieties and mental health.
- Practitioners' responses also seem to have been driven by consistent observations that the children were loved by their mother and were developing well.
- The extended family provided a great deal of support which mitigated the negative effects of Mother's circumstances on the children. It is now known that throughout the family there was a fear that the children might be removed, and this would have influenced relationships with professionals and the information provided to them. In particular, the family feared the children would be taken away if the family shared all their concerns about Mother's behaviour with Social Workers.
- Practitioners were unsure how to manage alcohol misuse in the face of parental denial and a perception that there was a lack of "evidence".
- The potential confusion of signs and indicators from a combination of type 1 diabetes and alcohol use.
- There were differing views between GP practices as to the management of situations where a pregnant woman needs to reduce anti-depressant medication.
- Information flow within the health system and between health professionals and other agencies was not effective. Notably:
  - GPs were not always aware of domestic abuse incidents and Children's Social Care assessment and plans.
  - Discharge letters from hospitals took several weeks to reach GPs (or were not sent at all) meaning that they could not take Mother's admissions into account in their consultations with her.
  - Where Mother decided to change the provider of maternity care from Hospital 4 back to Hospital 3 important information was lost.
- The system for tracking repeat prescriptions for drugs liable to abuse could have been more effective in managing potential risks associated with Mother over ordering medication.
- The separation between children's and adult social care presents challenges in assessment and provision of support services to parents who have their own complex needs.

6.7 As a consequence, there are a number of areas for learning most notably in relation to:

- How to maintain respectful uncertainty when working with people whose outward persona hides distress and behaviours that compromise their capacity to provide appropriate and consistent care for their children.
- The challenges associated with understanding roles, responsibilities and where information resides in a complex safeguarding system
- The importance of understanding relationships and dynamics across the whole family system, including factors affecting relationships with professionals.
- Information-sharing and communication between professionals.

7. REVIEW FINDINGS

The review contains a number of findings and recommendations to improve local multi-agency safeguarding practice.

Finding One

Practitioners were not aware of the full extent of Mother's mental health problems, her use of alcohol, prescribed and illegal drugs and did not recognise the impact of these factors, alongside her exposure to domestic abuse, on her own physical health and ability to care for her children. As a result, services did not meet either Mother's needs or those of her children.

7.1 Although the case records show instances where individual professionals at various times were concerned about Mother's diabetes, mental health and use of alcohol, there is no one point where the severity of the concerns and interaction between them was understood. In relation to drug use, concerns were less clearly expressed within the records and reasons for this are explored below.

7.2 There are two main issues here; firstly, how well Mother's own needs were understood and responded to and secondly, the degree to which her parenting capacity was compromised and the need for long term stability for each individual child fully considered.

In relation to Mother's mental health

7.3 A theme running through all of the practitioner discussions was how well Mother disguised problems through appearing friendly and outgoing and having good social and family supports. This serves as a reminder that people experiencing mental health problems do not conform to one stereotype and there may not be obvious outward signs of any distress.

7.4 It is mainly through Mother's consultations with GPs that any concerns about her mental health became apparent but there was little effective two-way communication between GPs and those responsible for the wellbeing of the children. GPs were

frequently unaware of the concerns of other practitioners including the presence of child in need plans and therefore did not share relevant information.

7.5 There was inconsistent contact between social workers and GPs. In some instances, GPs were asked for information but the reason for the request was not made clear. In other instances, they were not contacted at all. For example, GPs were unaware of the child in need plan until some months after it had started. In other instances, requests for information were made by social workers but GPs did not respond. The result of this inconsistency is that social workers did not focus on Mother's mental health and consider whether the plans fully addressed either her support needs or the wellbeing of the children.

7.6 There were differences of opinion within primary care as to when a mother taking medication for anxiety and depression should be referred to mental health services. GPs have spoken to the review about the need for clearer guidelines as to when to refer to perinatal mental health services. At the time of this incident there was no local pathway for practitioners to follow where a decision is to be made regarding referral to perinatal mental health services.

7.7 NICE Clinical Guideline 192[3] is aimed at the identification and care planning for women who have, or are at risk of, mental health disorders during pregnancy and the postnatal period and their partners and carers. It covers women who have in the past or currently suffer from depression, anxiety disorders, eating disorders, drug and alcohol use disorders and severe mental illness (such as psychosis, bipolar disorder and schizophrenia). The guidance encourages consideration of referral to secondary mental health services.

7.8 The Perinatal Mental Health Service is an Essex-wide specialist service and will assess and treat women with serious mental illness or complex disorders in the community who cannot be appropriately treated by primary care services. The service will also provide a number of consultative functions to support professionals working with women in the perinatal period. Enquiries can be made directly to the service. This includes: i) Prescribing advice to GPs; ii) Advice to non-mental health professionals with specialist or lead roles in perinatal mental health such as midwives and health visitors.

https://eput.nhs.uk/for-gps/essex/south-essex-mental-health-services/adults/perinatal-mental-health-service/

7.9 In addition, local child protection procedures[4] are clear that in such circumstances a referral should be made to Children's Social Care. *Where agencies or individuals anticipate that prospective parents may need support services to care for their baby*

[3] https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations#treatment-decisions-advice-and-monitoring-for-women-who-are-planning-a-pregnancy-pregnant-or-in-2
[4] Southend, Essex and Thurrock Safeguarding and Child Protection Procedures (2016)

or that the baby may be at risk of significant harm, a referral to local authority Children's Social Care should be made as soon as the concerns are identified. The GP practices were in the best position to understand the support that Mother might need as a result of her mental ill health, but no referral was made at the time of Mother's pregnancy with Baby M. This appears to have been in part due to Mother's ability to present a positive persona, but a more objective consideration of her history should have prompted a different response.

7.10 A local pathway Perinatal Mental Health Pathway is now in place and the Essex Safeguarding Children Board will need to be confident that this is being used to inform practice.

Recommendation One
Essex Partnership University Trust (EPUT) to ensure that the Perinatal Mental Health Pathway has been disseminated across Essex and demonstrate evidence that it is being used and is making a positive improvement to practice.

Recommendation Two
Children's Social Care should work with health partners to review cases where children are subject of a Child-in-Need plan, to ensure that these plans are disseminated to all relevant partner agencies and practitioners with family consent.

In relation to Mother's alcohol use

7.11 Mother's use of alcohol is regularly documented within records in all agencies but at no time was it fully assessed in relation to its impact on her own health and her parenting capacity. From a review of the records it would seem that her alcohol use was not taken as seriously as it should have been, but it seems that she was adept at minimising her alcohol use when challenged. Even where there were signs that her use was having a detrimental impact on her health, particularly in relation to diabetes control, practitioners found it hard to address this when she assured them she had stopped drinking.

7.12 Practitioners noted that there was no obvious sign of alcohol use when they saw her and that this seemed to influence their assessments. Consequently, social work assessments and resulting plans did not address the risks to the children from Mother's alcohol use and tended to focus on the more tangible concerns relating to domestic abuse.

7.13 From the perspective of GPs, the flags within Mother's records should have prompted more consideration of the extent to which her alcohol use was very likely to have been affecting her parenting. Notwithstanding Mother's denials and reluctance

to engage with alcohol services, there were grounds for the GPs to consider a referral to Children's Social Care.

7.14 There is evidence that during the social work assessment in January 2013 that information given by the GP (Practice 1) regarding Mother's condition may not have been fully understood by the social worker and led to an interpretation that diabetic ketoacidosis was the explanation for her behaviour rather than alcohol misuse. This potential confusion of signs and indicators was also a feature of the interaction between other practitioners and Mother.

7.15 It is well documented that Mother had a history of being prescribed anti-depressants, self-regulating her diabetes and using alcohol. These factors resulted in a number of presentations to hospitals, a series of hospital admissions, various conversations with GPs and at times incidents with the emergency services as a result of her drinking. One theme throughout these presentations was the difficulty in differentiating whether they were a consequence of self-management of her diabetes, alcohol use or neglect of her own health issues. The pattern of Mother denying or minimising her alcohol use was a clear feature of the review and in differentiating. In essence, there were a significant number of opportunities where the issue of alcohol use could have been followed up.

7.16 Children's Social Care have informed the review that current practice is for there to be a multi-agency meeting at the point of case closure and that this would have provided an opportunity to understand the whole history from each professional's perspective and assess the impact of Mother's alcohol use on the children.

In relation to Mother's drug use

7.17 Mother's use of illegal drugs including cocaine, was less visible than her use of alcohol. One opportunity to explore this issue was when an anonymous referral to Children's Social Care mentioned alcohol *and* drug use but there is no indication that any concerns about drugs were explored with Mother.

7.18 Possible dependence on drugs did arise with her request for more morphine than was deemed necessary when she was seen in the gynaecological ward at hospital with vomiting and abdominal pain. At this stage the safeguarding system within the hospital worked well. The doctor appropriately liaised with the paediatric liaison nurse and the safeguarding midwife and a referral was made to Children's Social Care. This was the same hospital where Mother was receiving antenatal care and seeing the diabetic midwife on a regular basis. Even though an error had occurred with Mother having two hospital numbers the paediatric liaison nurse made sure that action was taken to remedy this and made a note of the referral on all relevant records.

7.19 However, when the social worker later called the diabetic midwife for information, explained the reason for social care's involvement, the Social Worker was told that the midwife had no concerns about Mother. The midwife did not explore further the reason for social care's involvement and look carefully at the information on the hospital records. This episode is discussed more fully in Finding 2.

7.20 An additional issue in relation to this episode is that there is no evidence of a discharge letter from the hospital to the GP and subsequent GP consultations and prescribing practice could not take account of the potential risks associated with a patient who had been noted to request more medication than was required. There was however a warning on Mother's GP records home page that addictive medication was not to be prescribed.

7.21 This review has identified an issue relating to prescribing practice where a patient has a number of repeat prescriptions and how these are reviewed. This has been fully explored within a Serious Incident Report by the Clinical Commissioning Group and a report by Medicines Management. This is a subject of ongoing discussion between health professionals and the CCG has been asked to take the lead on resolving this issue.

7.22 It should be stressed that there is no evidence that overuse of medication was a factor in either Mother or Baby M's death, although there is concern that Mother was asking for more medication than was necessary. From the review team's perspective, the critical issue in relation to this case is the management of medication at the start of the pregnancy.

Recommendation Three
Essex Clinical Commissioning Groups should (i) evaluate the effectiveness of the services provided by the Medicine Management Team concerning prescribing drugs with addictive potential and (ii) share the findings of this review with GP surgeries in order to encourage best practice in managing repeat prescriptions.

Recommendation Four
Essex Clinical Commissioning Groups should promote the use, by all GPs, of the medicines management team for advice in complex cases.

In relation to Mother's physical health

7.23 Records and assessments across all agencies note that Mother was a type 1 diabetic and there are frequent consultations and admissions to hospital which indicate that her condition was poorly controlled; most likely through a degree of self-

neglect. This could have been understood in relation to her mental ill health and substance misuse but generally her physical symptoms were treated in isolation. Even though there is recognition in medical records that her alcohol use negatively impacted on her diabetic control there was little practitioners felt they could do to take any action. Good practice would have been for Health professionals to have come together to discuss this issue and any possible impact on parenting.

7.24 It would have been good practice for all practitioners to consider more carefully the implications of Mother's health conditions on her children. Notwithstanding the issues relating to alcohol use and mental health, the number and frequency of hospital admissions should have prompted more assessment of whether the arrangements for the care of the children were adequate or whether the family needed further support. This has, however, also to be considered within the context that these children were not being seen as having significant or additional needs.

In relation to domestic abuse

7.25 Domestic abuse perpetrated by Partner 2 is more clearly documented within Children's Social Care records than other factors affecting the children, and this was the focus of Children's Social Care assessments in 2012 and 2013. The case was too readily closed when Mother was noted to have separated from Partner 2.

7.26 There was a MARAC (Multi-Agency Risk Assessment Conference) in 2012 which identified the risks to Mother from domestic abuse. At this meeting the manager from Social Care was not the manager responsible for Mother and her children and it is not clear how the very worrying information considered by the MARAC influenced thinking about risks to the children. The MARAC system in Essex has changed considerably since 2012 and the current operating protocol makes it clear that risks to children will be considered and each agency representative has responsibility to alert relevant staff to their role within an action plan. A pilot is also underway whereby domestic abuse notifications are sent to a central point and sent to relevant staff. High risk notifications are reviewed, and information sent to the MARAC meeting.

7.27 However, information from health representatives is still not fully captured within the discussion as the review has been informed that the MARAC receives no information in respect of maternity, adult health or from GPs. Similarly, there is no route for sharing information from the MARAC meeting to these professionals although GPs do receive information regarding domestic abuse incidents when appropriate consents are in place. Some GPs are unaware of the MARAC process. Those GPs who contributed to this review identified this as a gap in the system as they may not be able to take the potential for domestic abuse into account in their consultations with adults or their children.

Recommendation Five
The Essex Domestic Abuse Team should be asked to consider how information about the MARAC processes is provided to GPs, and how GPs can both feed into the MARAC processes and receive relevant information to enhance their role in safety planning for the victims of domestic abuse.

Mother as an adult with care and support needs

7.28 Although at one stage Mother was noted within GP and health visitor records to be a "vulnerable adult" and this was certainly the view of the Fire Service when they made a referral in respect of Mother, there is no evidence that this view was really integrated into the thinking of professionals. It is also not clear what happened to the referral to Adult Social Care at the time of the fire. Health visitors told this review that Mother was not seen as vulnerable and social work assessments did not consider this aspect when looking at her capacity to parent.

7.29 The current separation of children's and adults social care services is challenging when managing situations where a parent has a number of complex needs in their own right but does not reach the threshold for adult social care intervention. In this case, social workers in Children's Social Care did not have ready access to expertise which would help to ensure a whole family assessment which looked at the needs of both adults and children. The review has not found a culture of joint working in such cases and this may be an area for development within the system.

Recommendation Six
Essex County Council (both Children's and Adult Social Care) to consider how the Think Family approach can be implemented where there are identified risks to both adults and children.

Impact of Mother's circumstances on the children

7.30 An overwhelming message from those that knew Mother was that she genuinely loved her children. Her positive demeanour, combined with the willingness of her family to step in and care for the children when she was unable to do so, diverted attention from the emotional and physical impact of Mother's circumstances and behaviour on the children.

7.31 Generally, the impact of Mother's circumstances on the children was not recognised due to the fact that for much of the time (with some exceptions) their physical needs were met and their development was not a cause for concern.

7.32 The chronology indicates that Mother led a lifestyle which involved a degree of drama, frequent house moves and hospital attendances. In day to day practice, the

impact of this is only going to be addressed by appropriate information-sharing and clear understanding of each agency's role and responsibilities.

7.33 Any concerns about the children primarily focused on Mother's experience as a victim of domestic abuse, and the volatility of her relationship with Partner 2 but explanations that this relationship had ended (even though at times there are indications that it had not and Mother was living on his property) were accepted as minimising any risk. Some steps were taken to offer her advice and support but plans for support were not followed through and there was little exploration with the children as to their feelings about their home environment.

7.34 Mother's circumstances and behaviours at times potentially put the children at some physical risk. For example, the children received injuries when she crashed the car and may have been under the influence of alcohol at this point but left the scene before this could be established. The ambulance service should consider whether a referral to Children's Social Care should always be made in these circumstances and this is subject of a recommendation below.

Finding Two
Assessments and plans implemented by Children's Social Care would have benefited from an approach that looked beyond the immediate presenting problem, engaged the extended family and took account of where information may be held within health services.

7.35 The quality of social work assessments and plans was variable and early assessments tended to focus on incidents of domestic abuse rather than a holistic look at the family dynamics and circumstances.

7.36 Social work assessments did not always use information gathered from health colleagues including GPs which did give information about Mother's history of depression and concerns about alcohol use. At times social workers asked for information but did not give the GP any background as to why the information was being requested or the outcome of the assessment. For example, the first time GPs at Practice 1 became aware of a child in need plan was in October 2015. In 2016 information was requested from the GP but not obtained (possibly as Mother had just changed GP practices). This was not pursued.

7.37 An assessment in September 2015 was more thorough, contained a chronology and recommended a child protection conference but this was not agreed by the manager and child protection conference chair. This was because it was recognised that there had been deficiencies in previous assessments and it was felt that more work was required in relation to Mother's alcohol use within a "tight child in need plan". However, the case moved to another team, there was a change of social worker and

this plan was not followed through. During the next three months despite further concerns about alcohol use, Mother's denial of any alcohol use took precedence in the mind of the new social worker and the view of both the social worker and the manager was that the extended family provided an important safety net for the children. At the time that the case was closed the support of the extended family was noted including that they were taking responsibility for safeguarding the children.

7.38 Learning during practitioner discussions for this review identified that although social workers did talk to the extended family, assessments could have involved a deeper analysis of family relationships. In this case the extended family gave a high level of support. This was taken for granted and the relationship with the family was not developed sufficiently well to understand that this support stemmed from a real concern about Mother's parenting and a fear that the children would be removed.

7.39 An additional area of learning relates to making sure that all aspects of "health" information are gathered from individual health professionals, particularly GPs. Where other health professionals were relied upon to give relevant information this was often missing due to lack of communication between health professionals themselves; an issue which is explored further in finding 3. For example, following the house fire in 2014 there appears to have been no liaison with the health visitor or GP with the result that the social work assessment could not take account of a consultation with the GP where Mother had reported worsening anxiety and her medication had been increased.

7.40 Understanding any impact on the children as a result of Mother's physical and mental ill health was a crucial aspect of the assessment in August 2016. This assessment followed the referral from a doctor at Hospital 4 concerned that Mother was requesting more morphine than was necessary. The social worker did attempt to speak to the doctor who made the referral but was unsuccessful at making contact. The referral record did not give a specific contact number for the person making the referral and locating junior doctors within the hospital can be problematic.

7.41 A request for information was also sent to GPs and since this was around the time that Mother moved home, this was sensibly sent to practice 1 and practice 2. No information was received and there is no record of this request for information in GP records. It has not been possible to understand where the request went but possibly it happened at a time when the records were in the process of transfer between surgeries. The review has been told that even though transfer is electronic, this is not necessarily an instant process as it depends upon an administrator completing tasks and notes can take several days to come through.

7.42 This assessment in 2016 should have been carried out under the pre-birth assessment protocol. This requires a multi-agency meeting: *At the point of starting the assessment, a multi-agency Child in Need meeting should be held within 2 weeks in order to plan the Pre-Birth Assessment. The views, information and support*

available from partner agencies should be sought and incorporated into the assessment.[5] Had this meeting taken place it is likely that the assessment would have had a fuller picture of both the historical and current concerns.

7.43 The final outcome of the assessment relied upon discussions with the family and information from the diabetic midwife who said that she had no concerns about Mother's presentation, and she had never appeared under the influence of alcohol. It is now known that the midwife did not have all the information known to GPs about Mother's mental health and in addition, did not have the full picture about the doctor's concerns that had led to the original referral.

7.44 From a social work perspective this was a pivotal moment in the case and the final decision to close the case was heavily influenced by the "health" information from the diabetic midwife.

7.45 Professionals operating outside the health system may assume a greater degree of information-sharing across health organisations than is in fact the case. The social workers in this instance relied on the diabetic midwife to have a comprehensive picture of Mother's health needs yet it would not necessarily be the case that a midwife would have a full and comprehensive health history other than that reported by the mother. Information sharing within health is explored further in Finding Three but learning for social workers carrying out assessments is that individual health practitioners need to be contacted and that GP information is crucial as they are most likely to have the overall picture of any relevant health issues. In this instance the GP had not responded to the request for information and this was not followed up.

7.46 Where other practitioners (particularly health visitors) might have had misgivings about the response of social workers this was not articulated within their own supervision nor escalated with Children's Social Care. This meant that social workers and their managers were not sufficiently challenged by the safeguarding system and prompted to stand back and consider the appropriateness of their responses. The need to understand why such challenge does not take place via the established escalation process has been noted in previous Serious Case Reviews within Essex and work is in progress to improve practice.

Recommendation Seven
Acute health providers should be asked to review their referral processes to Children's Social Care to ensure that they clearly state how Social Care can obtain follow-up information should sufficient information not be included within the referral.

[5] Essex Safeguarding Children Board Pre-Birth Assessment Multi Agency Protocol (2015) Paragraph 4.3

Recommendation Eight
Children's Social Care should ensure that social workers understand the complexity of the health economy and that information will most likely need to be obtained from a number of different sources.

Recommendation Nine
Essex Safeguarding Children Board should ask Children's Social Care for assurance that the pre-birth protocol is adhered to in relation to the holding of multi-agency meetings and that audits are undertaken to ensure that the processes are effective.

Finding Three
Information sharing across the health community was inconsistent and did not enable any one practitioner to have a full picture of Mother's needs and parenting capacity.

7.47 There are many examples within the case narrative of health professionals only having partial knowledge of information that was relevant when assessing Mother's capacity to parent. This is partly a result of health services being provided by separate organisations with differing information systems that do not easily "talk" to each other, potential delay in information transfer at the point when a patient changes GP practice and reliance on these systems rather than face to face communication when necessary. Another factor is an assumption that adults will share information when asked and that self-report is a reliable form of information gathering.

7.48 As well as the need to consider Mother's health in relation to her capacity to parent, the interaction between diabetic care, mental health, alcohol and substance use meant that she should have been considered as an adult with complex health needs. Instead of the interaction between all these factors being understood the general picture is of each being dealt with in isolation. In order to understand complexity, good record keeping, evaluation of information over time and effective communication across the system is needed as well as one practitioner coordinating care. This did not work well in this case.

7.49 The practitioners with the most comprehensive overview of Mother's situation were the two GP surgeries.

Information sharing between GPs and midwives

7.50 In this case there were referrals from GPs to midwives which included detailed information about Mother's history and circumstances. In the case of Mother's pregnancy with Sibling 2 this resulted in regular contact with a specialist midwife working with vulnerable women. The referral from the GP in respect of the pregnancy with Baby M also noted concerns but this information was not transferred when

Mother moved her care back to Hospital 3 from Hospital 4.

7.51 Where Mother was asked by midwives about her medical history and there was no additional information from her GP, the midwife was unaware of any potential vulnerability associated with her mental health. This highlights the dangers of the current national move towards self-referral to midwifery for pregnant women. Where self-referral is the norm, there may be no system in place which ensures that relevant medical and social information is received from the GP. The midwife will need to rely on self-report and where a mother does not wish to divulge information (for whatever reason) the risk assessment by the midwife may be flawed.

7.52 One positive is that in the London Borough where Hospital 4 is located, there is an expectation that GPs fill in a referral form and on this form there are standard questions about the mother's mental health, substance use/misuse, learning disability and domestic abuse. Even where this exists the experience of midwives is that GPs do not always fill in all the medication being taken by the mother.

Information sharing within Hospital

7.53 During Mother's pregnancy with Baby M, the diabetic midwife did not access all the information about Mother's attendance at hospital and specifically information regarding the concerns about Mother's request for morphine. The safeguarding midwife was aware, and it would have been best practice for there to have been a conversation between the two midwives in order to alert the diabetic midwife to the significance of the concerns.

7.54 As a result, when the social worker spoke to the diabetic midwife, she did not have the full picture, and this contributed to Children's Social Care being reassured enough to close the case.

Information sharing between health visitors and GPs

7.55 There is little consistent evidence of information sharing and therefore the detail of Mother's mental health history and current medication were not known to the health visitors. GPs in Practice 1 do have regular monthly meetings, but these are not documented and although it is possible that Mother and her children were discussed, the outcomes of these discussions are not known.

Information sharing between hospitals and GPs

7.56 An inconsistent picture emerged of GPs receiving timely discharge information from hospitals following A&E attendances or in-patient episodes. Generally, GPs told the review that this can be a source of frustration and in this case meant that decisions were made within the GP practice without full knowledge of Mother's medical history.

Recommendation Ten
Health Provider organisations to report to the ESCB via the Health Executive Forum how they will work together to ensure a Lead Health Professional is identified in cases where there are complex health needs and coordination of the case is required.

Recommendation Eleven
Providers of Midwifery Services should consider the effectiveness of the information flow between Midwives and GPs and develop effective systems for sharing information routinely with GPs when a woman self-refers to midwifery services.

Recommendation Twelve
Clinical Commissioning groups should ensure that providers use their systems for sending discharge summaries to GPs in a timely fashion and that these summaries inform patient care.

Finding Four
Early help services were not coordinated in order to improve the experience of the children in the family

7.57 There was an opportunity within universal services, to identify the family as in need of an early help assessment. There is no indication that this was considered by either those providing health or education services.

7.58 During the periods when Children's Social Care was not involved, health professionals noted that the children were developing well, and Mother was well supported by her family. As a consequence, they did not identify any need for additional help to meet the children's needs.

7.59 The Headteacher was aware of the early help process but had not necessarily felt it was relevant in this case, as both children were well-presented and making progress academically and socially. With hindsight, it is recognised that there were opportunities for early help intervention and working together with other partner agencies. This school were unaware of the recent work that has been done across Essex to promote early help assessments set out in the document "*Effective Support for Children and Families in Essex*". Although this may not be the case for schools with a high proportion of children in need of help and who need to use these procedures regularly, the Safeguarding Children Board will need to be reassured that the time and effort that has gone into providing information to the professional community has resulted in a good understanding of the roles and responsibilities in relation to identifying early help services for children and their families.

7.60 Record keeping within the school did not facilitate easy identification of patterns of concern and the rationale for actions and decisions taken. Appropriate record keeping has previously been acknowledged as an area for improvement in Essex schools and this is being addressed through safeguarding forums and termly briefings. Safeguarding templates have also been made available to all schools including a template to record all telephone conversations and meetings with parents/carers.

Recommendation Thirteen
Essex Safeguarding Children Board should ask relevant partner agencies to work together to evaluate the impact of the document "*Effective Support for Children and Families in Essex"* in relation to the quantity and quality of early help assessments, including the role of the lead professional.

8. SUMMARY OF RECOMMENDATIONS

Recommendation One

Essex Partnership University Trust (EPUT) to ensure that the perinatal mental health pathway has been disseminated across Essex and demonstrate evidence that it is being used and is making a positive improvement to practice.

Recommendation Two

Children's Social Care should work with health partners to review cases where children are subject of a Child-in-Need plan, to ensure that these plans are disseminated to all relevant partner agencies and practitioners with family consent.

Recommendation Three

Essex Clinical Commissioning Groups should (i) evaluate the effectiveness of the services provided by the Medicine Management Team concerning prescribing drugs with addictive potential and (ii) share the findings of this review with GP surgeries in order to encourage best practice in managing repeat prescriptions.

Recommendation Four

Essex Clinical Commissioning Groups should promote the use, by all GPs, of the medicines management team for advice in complex cases.

Recommendation Five

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