BROMLEY SAFEGUARDING CHILDREN BOARD

Overview report on the services provided for B and his mother

Executive Summary

December 2008

Introduction and arrangements for the Serious Case Review

Bromley Safeguarding Children Board (BSCB) conducted a serious case review of the services provided to B and his family in order to fulfil the requirements of Chapter 8 of the statutory guidance *Working Together to Safeguard Children* [1] and the London Child Protection Procedures. [2] The decision to hold the review was made by the local safeguarding board Serious Case Review Sub-Committee on 15 July 2008. This meeting was chaired by Gillian Pearson who is the chair of BSCB. The review was completed on 30 November 2008 and adopted by the BSCB Executive Committee at its meeting on 3 December 2008.

The SCR covered the work of the following agencies which provided services for B and his family within the period covered by the review:

- Bromley Council Children's Social Care Services
- Bromley Council Legal Democratic and Customer Services (the council's legal advisors)
- Bromley Primary Care Trust
- Bromley Hospitals NHS Trust
- Metropolitan Police Service
- Bromley Council Housing Department
- An independent fostering agency
- Bromley Children's Project – which provides parenting support services to families in need in Bromley.

All of these agencies have reviewed their records and produced an internal chronology of their involvement and individual management report reviews. Key staff have been interviewed. The authors of individual management reviews are senior staff who had not been involved previously with B and his family.

Background

B is a baby of white UK origin. He had two older siblings who at the time of B's birth they were the subject of proceedings in the Principal Registry of the Family Division to determine their future care.

B died of natural causes in 2008. The cause of death was given as Sudden Unexpected Death in Infancy (SUDI). According to his mother she had been sleeping on the sofa with him and when she woke she found that he was not breathing. This occurred at the home of B's maternal grandmother. At the time of his death B and his mother had been placed by Bromley Council in a 'mother and baby' fostering placement where the mother's care of B could be supervised. B's mother had absented herself from the foster home for three days prior to her son's death.

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v Department of Health, Home Office, Welsh Office, Department for Education and Employment, *Working Together to Safeguard Children*,*2006*

[2] London Child Protection Committee, *London Child Protection Procedures,* section 14.7

B's mother experienced an unstable adolescence characterised by problems of homelessness, family conflict, alcohol misuse and domestic violence. These difficulties resulted in serious shortcomings in the parenting of her two older children and led to their removal from her care. The father of B (who is not the father of the older children) has longstanding problems of drug misuse, criminality and domestic violence. B's mother and father were understood to have separated before his birth, though it was later discovered that his mother covertly made contact with the father after the birth of B.

The LSCB is not *required* to conduct a serious case review when the cause of a child's death is SUDI. However, the guidance gives discretion to do so when the case gives rise to concern about the arrangements for safeguarding children or there appear to be important lessons to be learnt that go beyond the individual case. The Local Safeguarding Children Board (LSCB) decided to carry out a review following the death of B because:

- B was subject to a child protection plan at the time of his death and he was living in a placement arranged by Bromley Council
- there was evidence of weaknesses in the way in which the child protection plan had been implemented and the way in which the local arrangements to safeguard children had operated
- the LSCB wanted to review whether a legal application should have been made in relation to B so that plans for his future could be considered alongside to those of his siblings.

Learning the lessons and implementation of recommendations

The SCR overview report produced has been adopted by the LSCB which has produced an action plan. This identifies the actions needed to implement the recommendations, who will be responsible for taking action and the timescales for completion. The LSCB will oversee the implementation of this action plan over the coming months to ensure that lessons are learnt and practice improves.

The following is a summary of the key findings in relation to the review terms of reference.

<u>Were the assessments that were undertaken prior to B's birth comprehensive enough to ensure a robust child protection plan was in place after he was born?</u>

There was sufficient information in the social care department records, in the working knowledge that was held by staff and managers and in the assessments that had already been completed in the care proceedings in relation to B's older siblings to indicate that either B needed to be removed at birth or there would need to be a very tight child protection plan to safeguard him. Managers in the department recognised this and directed the right initial action (a legal planning meeting and a child protection conference).

The social worker provided enough information to the initial child protection conference to enable it to develop an appropriate plan but she did not prepare a core assessment. This emphasised that B's mother had made positive changes, but there was no assessment of the extent to which any positive

change could be sustained and the ability of B's mother to cooperate with services and accept help.

The initial child protection plan required that several areas of concern be assessed further (particularly parenting ability and the impact of alcohol use on parenting capacity). These assessments were never implemented.

Beyond the initial child protection conference the initial plan was not implemented with sufficient rigour. In particular the way in which B's foster placement was set up and the decisions the social worker made about contact undermined further assessment and could have put him at risk.

Should a legal framework have been used as part of the child protection plan?

A senior lawyer from Bromley has re-evaluated the evidence available to social care staff leading up to B's birth and determined that the threshold for making a legal application was met on the grounds that B would be likely to suffer significant harm, based on the experience of his siblings. If there had been an application it would have been for the court to decide whether to make an order or not and if so which order.

Had there been a successful application B and his mother would probably have been in the same placement. However, joining B to the proceedings on his siblings would have had several advantages and no real disadvantages:

- there would have been no uncertainty about the practical arrangements for the placement and the respective responsibilities of the local authority, the mother and the foster carer
- contact arrangements would have been clearly defined and there would have been recourse to the court if there had been non-compliance or conflict over them
- expert witnesses who already knew B's mother and her circumstances well would have been able to undertake assessments to inform future planning for B
- compliance with assessments would have been much more likely.

Were there any indicators after B was born that suggested his mother's care of him was inadequate?

The midwife saw B on five occasions and the health visitor saw him on three more. Both were aware of the concerns about the parenting of B's siblings and so were aware of the need to be vigilant and to offer additional support. Neither recorded any specific concerns; both recorded that B was being looked after and developing appropriately. Checks on B's weight supported these observations.

The foster carer spent a considerable amount of time with B and his mother. The management review provided by the foster carer's agency states that '*there was no evidence'* of inadequacies. The report states that B's mother was '*doing well with B and doing all that was required of her in relation to meeting his needs and caring for him'.* Her daily reports support this. The foster carer reported no concerns to social care until B's mother absented herself.

The clearest evidence of concern was when B's mother's action in allowing him to have contact with his father. This should have been treated as an opportunity to reassess the viability of a voluntary agreement as a means of safeguarding him.

What quality assurance measures were in place for monitoring the independent fostering arrangement?

The foster carer provided daily reports and a monthly summary and she met with the agency's senior social worker for one face to face supervision session during the course of the placement.

Within Bromley social care, none of the usual commissioning arrangements made for independent sector placement was in place because the placement had not been officially sanctioned. The commissioning team raised concerns about this on one occasion, but no further action was taken by managers - either in the commissioning team or in the service managing the case.

Are there lessons to be learnt from this case about the way agencies work together to protect the expected babies of mothers with a history of poor parenting?

There are significant lessons from this case, but in relation to the statutory agencies they are not new ones. The London Child Protection Procedures and departmental arrangements already contain the relevant directions and instructions to staff. For ease of reference we have summarised them out in the following paragraphs. The recommendations from the LSCB in the SCR report are mainly concerned with auditing important aspects of practice to ensure that existing procedures are being consistently implemented.

The SCR has noted that there are lessons to be learnt for managers in all agencies about the level of challenge that managers may be required to provide to their staff, even those members of staff who have a reputation for being competent.

There are also a small number of areas in which minor adjustments to working practice are required – for example in relation to aspects of the working arrangements between legal services and social care staff in Bromley.

Key lessons that are already contained in policy and procedures

When parents have a history of poor parenting an early pre-birth child protection conference will be required, unless it is certain that all of the previous concerns have been resolved. The approach is set out in the London Child Protection Procedures and the timing of meetings given there should be adhered to. This conference should be preceded by a Section 47 investigation so that agency checks and information are up to date.

The threshold for holding a legal planning meeting should be low so that legal input on the potential to use a court application to safeguard a child is considered at an early point. The principal purpose of the meeting is to provide legal advice on the type of evidence that can be used and how it can be obtained and recorded. Social care staff should be reminded of the legal

thresholds for a successful application and made aware of relevant legal judgements but they should be reminded that in each case the evidence needs to be weighed on its merits. Social workers should always supply reports and other relevant documents in advance of meetings. Everyone attending should have an agreed copy of the meeting notes and the advice given.

If previous children in a family are the subject of current care proceedings an application should be made in relation to the new born baby, unless there are exceptional reasons why not.

There should be early liaison among health professionals including the GP, who should be informed of any significant development. There should be regular liaison between the allocated social worker and health professionals.

A core assessment should always be completed. The core assessment has three linked tasks that need to be worked on in parallel:

- to provide a report to the child protection conference on the background to the case as well as any recent developments
- a thorough review of the history of poor parenting
- an assessment of each parent's capacity to change.

The child protection plan should include:

- measures to secure day to day safeguarding
- any outstanding aspects of the assessment.
- and set the dates of future meetings in keeping with the birth of the child and likely developments in the case.

Managers should ensure that

- detailed notes are kept of all significant meetings and circulated to all participants so that there is a common understanding of tasks, roles and responsibilities
- staff implement tasks agreed within the timescales.

Recommendations of the individual agency reviews and the serious cases review panel

The individual agency management reviews and the LSCB overview report have made recommendations in the following areas.

Metropolitan Police Service (MPS)

- Improving the consistency and quality of information presented to child protection conferences by the local police Child Abuse Investigation Team.

Bromley Council Children's Social Care Services

- Further checks to ensure the safety of other children who were on the caseload of the social worker who was responsible for this case.
- Working arrangements to secure legal advice and the resolution of disputes about legal advice.
- Attendance at child protection conferences and administrative arrangements for child protection conferences.
- Arrangements for making placements with independent providers.

Bromley Council Legal Democratic and Customer Services

- Joining a new baby to proceedings (when other children in the family are being considered by a court) unless there are exceptional reasons not to
- Improved arrangements for legal planning meetings
- The need for legal advice to be taken in relation to all mother and baby placements where there is a need to restrict a mother's ability to exercise parental responsibility
- Arrangements for resolving disputes between social care and legal section.

Bromley PCT NHS Trust

- Improving communication between the Quality Assurance unit and PCT staff over child protection conferences and other meetings

Bromley Hospitals NHS Trust

- To reinforce arrangements for child protection training in the midwifery service
- To ensure that midwife's record progress when they see a patient who does not have the relevant notes available.

Designated Professionals Health Overview report

- Reinforcing procedures for staff making child protection referrals
- Health contribution to initial child protection conferences
- Health contribution to pre birth child protection plans.

Independent fostering agency

- Training for the foster carer involved in this case in relation to child protection
- Development of policies and procedures in relation to parent / child placements
- Improved information to be obtained from placing authorities prior to and at the time of placement
- The need for written confirmation of existing plans and agreements and information on the status of the child
- An expanded internal check list to be used by the agency's senior social worker and foster carer at the placement planning meeting
- Written confirmation of all contact arrangements
- Full procedures and guidance regarding parent and child placements
- A pro-forma for carers to use in assessing parenting ability
- Procedures to ensure that all foster carers are aware of their responsibilities in relation to children and young people who do not return to the placement as required.

LSCB recommendations

In addition to the recommendations made by individual agencies the SCR report has made additional recommendations in the following areas:

- Providing a copy of the SCR overview report to the Children and Family Court Advisory Support Service (CAFCASS)

- Providing feedback on the findings of the review to B's mother at an appropriate point
- Further action under internal disciplinary procedures within Bromley social care services
- Briefing session for all social care managers to consider the implications of the findings of the review for their management practice and supervisory arrangements
- The need to produce guidance and procedures for staff on the legal status of children in 'mother and baby' placements
- A briefing for social care managers on the legal implications of significant recent cases in relation to pre-birth assessment and the protection of new born infants.
- Actions to improve the administration and chairing of child protection conferences
- Audit of the implementation of child protection procedures that were not implemented in this case
- Improving the early registration of vulnerable children with a GP
- Review of the current strategy for provision of information to parents about SUDI and in particular recommended sleeping positions and arrangements for babies.
- Improving compliance with internal council procedures on the arrangement of placements
- Ensuring that legal advice is confirmed in writing after legal planning meetings.