# Stockport Safeguarding Children Board

# Serious Case Review

**FINAL DRAFT**

This report should not be shared without the express permission of the Independent Chair of Stockport Safeguarding Children Board

## Independent Reviewer: Emma Mortimer

### Additions added to reflect updated information: SCR Panel

[Page deliberately left blank]

## Condolences:

This Serious Case Review has been undertaken following the loss of Baby M's life on 28th October 2017. The Independent Reviewer and Panel Members would like to express their sincere condolences to his mum, dad, brother and wider family, all of whom have been greatly affected by his death.

# Contents

# 1. Introduction

## 1.1 Baby M

Baby M was born in Stockport on 27th March 2017. His mother and father are both also from Stockport. He had an older brother, Child C from his mother's previous relationship who was five years older than him. Child C lived with his mother and Baby M until his brother's death, when he moved to live permanently with his father. Child C's father lives a few miles from Baby M's mother and until Baby M's death, Child C lived in the home as well. The family are all of white British origin.

This Review was told of Baby M's *'infectious giggle'* and his, '*smiling, happy face'*. His mother showed the Lead Reviewer and Board Business Manager photographs of a chuckling and smiling baby boy who was clearly loved.

Baby M was a poorly child at his birth and spent his first twelve weeks of his life on the Neonatal Unit at St Mary's Hospital, Manchester NHS Foundation Trust.

The Review was told how the family held a party for him on the day he was discharged home and his brother had made him a cake to celebrate. Tragically, Baby M died just four months later on 28th October 2017.

## 1.2 Reasons for conducting this Serious Case Review

Baby M was born on 27th March 2017. He had a significant medical history; at his 20 week scan he was identified as possibly having an absent right kidney and at birth, he had other complex health needs.

Baby M was born at Stepping Hill Hospital and subsequently transferred to St Mary's Hospital, Manchester. He was discharged home with both his parents on 19th June 2017, having spent almost twelve weeks in hospital.

Baby M was found apparently lifeless by his mother on the morning of Saturday 28th October 2017. This was confirmed by attending paramedics and police officers who were very concerned that his mother presented as intoxicated and provided apparently contradictory accounts of the previous evening's events. They therefore arrested her on suspicion of Child Neglect, with a key concern being the possibility that she had caused his death by overlay when he shared her bed the previous evening. Baby M's brother, Child C was staying with his father that night as was his routine at the weekend. Child C now lives with his father on a permanent basis and the Family Court has confirmed contact arrangements.

Further enquiries on the days following Baby M's death highlighted that his mother had a history of vulnerability and she had received Early Help Support around her parenting of his brother during 2014-15.

Local Safeguarding Children Boards must conduct a Serious Case Review when
(a) abuse or neglect of a child is known or suspected; and
(b) either -
(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Following notification of Baby M's death, the Stockport Safeguarding Children Board (SSCB) Serious Case Review Panel was convened. The Panel recommended to the SSCB Independent Chair that the criteria for a Serious Case Review were met and the Independent Chair endorsed this recommendation, asking that a Review be conducted in line with statutory requirements.

# 2. Methodology

## 2.1 Legal context

This Serious Case Review is being conducted under Regulation 5 of the Local Safeguarding Children Boards Regulations, (LSCBs) 2006[1].

HM Coroner was notified of Baby M's death and an Inquest is due to be held in March 2019.

Greater Manchester Police, (GMP) conducted a criminal investigation into the cause of Baby M's death, having arrested his mother for Child Neglect. This investigation was concluded in August 2018, with a decision made not to refer the matter to the Crown Prosecution Service due to a judgement that there was insufficient evidence to provide a realistic prospect of conviction.

## 2.2 Overall approach

### 2.2.1 Serious Case Review principles

The Serious Case Review (Review) was conducted in accordance with the following principles:

- Focus on people not process: The Review is concerned with the lived experience of Baby M and will focus on this throughout the process;
- Positive reflection: The intention of the Review is to learn together and improve services, not to blame any individual or specific agency and the Review will highlight positive and innovative practice as well as that which could have been done differently;
- Impartiality: The Review will be conducted fairly and impartially with evidence of balance and objectivity and will be aware of the risk of hindsight bias;
- Equality and Diversity: The Review will be underpinned by an understanding of the inequalities in society that place some groups and individuals at disadvantage and that such groups and individuals are often excluded from services, for example, with respect to their age, gender, physical and mental ability, race, religion, language, sexual orientation and socio-economic status;
- Thoroughness: The Review process will be robust;
- Confidentiality: all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

### 2.2.2 Agency participation in the Serious Case Review

The following agencies participated in the Serious Case Review:

- Stockport Family
- NHS Stockport CCG
- Stockport NHS Foundation Trust
- Greater Manchester Police
- Manchester University NHS Foundation Trust

### 2.2.3 Serious Case Review Terms of Reference

The Terms of Reference for this Review are as follows:

1. To reflect on the sharing of information between different geographical areas and different providers.
2. To consider the effectiveness of the coordination in managing Baby M's medical needs.
3. To consider the opportunity to undertake an Early Help Assessment given agency concerns about vulnerability pre and post birth – considering the cumulative risk factors identified;
4. To consider alcohol misuse and the impact on parenting.

The Serious Case Review timeframe is from January 2016 to the date of Baby M's death, 28th October 2017.

### 2.2.4 Serious Case Review process

This Serious Case Review has been conducted by:

- Analysis of agency chronologies, describing contact and involvement with the family during the specified time period;
- Facilitation of a multi-agency practitioner event and reflection on the insightful and sensitive contributions by those who attended;
- Reflection on discussions held at three multi-agency Review Panel meetings;
- Meeting with Baby M's mother and hearing her perspective on events;
- Discussion with individual agencies;
- Consideration of additional information provided by St Mary's Hospital;
- Analysis of relevant research, guidance and legislation.

The Independent Reviewer also made several attempts to meet with Baby M's father and his paternal grandparents, but regrettably, they declined to participate.

The Lead Reviewer was highly impressed with the commitment to reflection and learning shown by the wide range of practitioners attending the Serious Case Review Practitioner Event. Of particular note is the commitment shown by the family's GP surgery, which enabled two of its GPs to attend the session and Stepping Hill Hospital, from which two paediatric consultants and both a neonatal matron and midwife attended. The session was extremely helpful and positive. However, due to

unforeseen circumstances, it was not possible for St Mary's Hospital Manchester to be represented and this was a missed opportunity for inter-agency learning. However, the Independent reviewer did discuss the Review with the Lead Nurse from St Mary's Hospital and their views are included in this report.

### 2.2.5 Hindsight and positive reflection

The primary purpose of this Review is of learning lessons, it is therefore important that the Review is mindful of the application of hindsight; this comment in the Pemberton Domestic Homicide Review is applicable in any form of review, investigation or enquiry that has a scope over several years; "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[2]

Similarly, it is helpful to reflect on the statements contained in the Report of the Mid- Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

*"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."*[3]

[2] A domestic homicide review into the deaths of Julia and William Pemberton, Walker,M. McGlade, M Gamble, J. November 2008 http://www.thamesvalley.police.uk/aboutus/crprev-domabu/crprev-domabu-whatdomabu/crprev-domabu-whatdomabu-howtvp/crprev-domabu-whatdomabu-howtvp-pemberton.htm (accessed 18.02.2016)

[3] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)

## 3. Brief timeline of key events

The following is a summary of key events that are of relevance to consideration of Baby M's life and his death.

| Date | Event |
|---|---|
| 14.01.2016 | FSW2 recorded that he had written a letter to Baby M's mother, having been allocated the case on 02.10.2015. He said that he was writing to arrange a home visit following the departure of the FSW1.<br><br>In the case note FSW2 confirmed he telephoned Baby M's mother on the mobile number he was given by FSW1 on 10.10.15 and the message he left went to voicemail. The letter asked whether Baby M's mother still wanted a service and offered times to meet. |
| 18.01.2016 | FSW2 visited Baby M's mother and Child C at the address he had for the family. He was informed by the occupier that Baby M's mother had moved and she gave FSW2 the new address and offered to pass the letter on because she had some other post to forward. FSW 2 accepted this offer. |
| 12.04.2016 | FSW TM1 decided to close the case to the Family Support Team as no response had been received from the Baby M's mother to FSW2's contact. |
| 11.08.2016 | Baby M's mother saw her GP and advised that she was pregnant. |
| 12.09.2016 | Baby M's mother attended a booking appointment with her community midwife. |
| 23.11.2016 | Baby M's mother had a scan and he was identified as having an absent right kidney. |
| 20.03.2017 | Baby M's mother was admitted to Stepping Hill Hospital as he was not growing as he should, had unstable lie and there was too much amniotic fluid in the womb (Polyhydramnios). |
| 27.03.2017 | Baby M was born by emergency caesarean due to concerns about his heart rate. |
| 30.03.2017 | Baby M required resuscitation and ventilating; he was transferred from Stepping Hill Hospital to the Neonatal Unit at St Mary's Hospital, Manchester. |
| 19.06.2017 | Baby M was discharged directly home from the Neonatal Unit at St Mary's Hospital. |
| 10.07.2017 | Baby M's GP surgery contacted his mother to question why she had requested so much Dalivit[4] (child's vitamin supplement) for Baby M. Upon discussion it became clear that she had misunderstood the dosage instructions and had been giving him 3M rather than 0.3M / day. |

[4] http://www.dalivit.co.uk/

| Date | Event |
|---|---|
| | |
| 20.07.2017 | Baby M's GP identified that his mother may, '*need more support'* and asked the Health Visiting Team to assist. |
| 13.09.2017 | Baby M's parents took him to Manchester Children's Hospital Emergency Department due to their concerns about him vomiting and having a distended abdomen. He was admitted and diagnosed with a left inguinal hernia. The plan was to operate, but Baby M required treatment prior to surgery. |
| 11.10.2017 | Baby M was taken by his mother to Stepping Hill Hospital as he was in pain and distress; his hernia had enlarged and he had bronchiolitis. |
| 28.10.2017 | Baby M was found by his mother to be laying in her bed, unresponsive.<br>His mother was arrested. His brother, Child C was discussed at a safeguarding strategy meeting and it was agreed that he would remain in his father's care. Subsequently, on 4th June 2018, it was agreed in the Manchester County & Family Court that this arrangement was in the best interests of Child C. |

# 4. Family Context

## 4.1 Family member circumstances

### 4.1.1 Baby M's circumstances

Baby M was his mother's youngest child. She was 25 at the date of his birth. His father had no other children and was aged 23 at Baby M's birth. Baby M's parents had been in an off/ on relationship for some time. His father stayed with his mother occasionally, but lived with his parents in another part of Stockport. This information was not known to all agencies prior to Baby M's death.

Baby M's father worked at a supermarket; his mother did not work. Baby M's paternal grandparents were significantly involved in supporting Baby M's parents after his birth. Baby M's mother's parents were deceased, (her mother) and estranged, (her father). She had contact with her twin brother.

When Baby M's mother had her 20 week antenatal scan, there was an abnormality identified that indicated he had only one kidney. Once born, he was found to have a range of other significant health problems that meant he was moved via emergency transfer from Stepping Hill Hospital in Stockport, where he was born to St Mary's Hospital Neonatal Unit in Manchester. He was a patient there for almost 12 weeks and his time in hospital constituted: 20 Intensive care days, 14 High dependency days and 48 Special care days.

Baby M's principle health problems / diagnoses while in hospital were:

- Cardiomyopathy
- Congenital Hypo-thyroidism
- Congenital abnormality of the right kidney
- Right pneumothorax
- Small Intraventricular haemorrhage grade 2
- Prolonged Neonatal Jaundice
- DIC – a complication of a clotting disorder
- Pulmonary haemorrhage
- Umbilical hernia

Baby M's active health problems on discharge from St Mary's Hospital, Manchester were related to his diagnosis of congenital hypo-thyroidism. All his requirements were to be met by general paediatric follow up, but with the majority of specialist reviews being retained by St Mary' Hospital.

Baby M received an Enhanced Health Visiting Service to provide additional support once he was at home.

Subsequent to Baby M's discharge home, he was also admitted from his GP Practice to Stepping Hill Hospital for medical intervention for the following matters:

- 10.07.17 with Chronic Accidental Overdose of a multi-vitamin supplement (Dalivit)
- 20.07.17 with Respiratory Viral Illness
- 13.09.17 with Vomiting
- 10.10.17 with Possible Bronchiolitis or Pneumonia

Baby M was not taken to the following clinical appointments. Where he was taken on alternative dates, this information is supplied:

1) Ophthalmology Clinic - Stepping Hill Hospital: 13.07.2017 and 29.08.2017 [Please note, however that he was taken to a replacement appointment on 24.10.2017]
2) Manchester Centre for Genomic medicine – Clinical Genetics Service: 26.09.2017 [Please note, this was cancelled by one of Baby M's parents]
3) Blood Tests - Stepping Hill Hospital - 23.08.2017: [Please note, however, he was taken on 07.09.2017].

It should be noted that Baby M's mother was largely caring for him as a single parent albeit with some support and was also caring for Child C, who was at school. This may have impacted on her ability to make some of these appointments.

The NHS CCG Named GP reports that the family's GP had no concerns about Baby M's mother's antenatal appointment attendance; following baby M's discharge home, his mother attended his GP surgery appropriately on his behalf and he was fully immunised. When there had been acute illness concerns, she had accessed timely urgent GP appointments.

Child C's social worker commented at the Practitioner Event that there is evidence that his mother binged on alcohol, particularly at times of stress in her life. However, the toxicology result for the day of Baby M's death indicate that she was not as intoxicated as ambulance and police professionals initially assumed from her presentation. The forensic toxicology report states that her alcohol consumption would have been 147mg / dL. This is described as being a level that would have caused, '*moderate intoxication in a social drinker*'[5]. For reference, the report author advises that the current limit for driving having consumed alcohol is 80mg / dL.

### 4.1.2 Baby M's mother's circumstances

At the age of 2 ½ months, Baby M's mother was admitted to hospital with meningitis; she had a Subdural Haematoma (bleed on the brain) requiring surgery and a month later, Hydrocephalus (build-up of fluid in the brain) and a febrile convulsion. This may have had some impact on her development and the Review heard that she had some involvement of child development services as a primary aged child.

Baby M's mother reportedly had a neglectful childhood; her family had been known to social care since 1991. She is a twin and she and her brother were believed to have regularly been left home alone by their mother who, despite intervention from statutory agencies, had not seemed to fully understand the risk of doing so.

Historic social care records describe the children being observed standing at a bus stop asking strangers for money for food and making their own way to school, sometimes without proper shoes or coats in winter. School attendance was reportedly sporadic. Their mother died in 2007 when Baby M's mother was 16; she subsequently stayed with an aunt, separated from her twin brother who was reportedly sent to live with another family member. The children's father was in contact with them, but irregularly.

By the time she was 18, Baby M's mother had met Child C's father, who was 41. They were in a relationship for approximately eighteen months and there is evidence of him being supportive then

[5] Forensic witness statement for GMP 16.11.2017

and since. He has always been a present father for his son, Child C, who was almost six at the time of his brother's death. Child C's parents maintained a positive relationship after their separation in 2012 and they shared their son's care on an equal and amicable basis since separating. Child C now lives with his father on a permanent basis and this arrangement was endorsed on 4th June 2018 in the Manchester County & Family Court.

Baby M's mother started a relationship with Baby M's father in late 2012, a few months after her relationship with Child C's father ended.

In 2012, shortly after their separation, Child C's father contacted Police, and reported Child C's mother behaviour being challenging. He advised Police that, '*he wanted her to leave because he believed that if she stayed at the address then the argument would begin again and she may become violent or incite him into becoming aggressive towards her'*[6].

GMP has a record of a domestic abuse incident between Baby M's parents that took place in 2012, (shortly after Baby M's separation from Child C's father). There are no other records of domestic violence and / or abuse known to statutory agencies, and it is not known whether this is reflective of that incident being a one-off or if further incidents took place that were unknown to services.

### 4.1.3 Baby M's brother, Child C's circumstances

Baby M's brother, Child C was born in November 2011. His father and mother separated shortly after his birth and his mother presented as homeless with him to Stockport MBC in April 2012. They were placed initially in a homeless hostel for women and children and then in August 2012, moved to a Stockport Homes property.

While living in that property, there were problems reported of:

a) Anti-social behaviour, reportedly largely caused by two men (brothers M1 and M2) who, professionals involved at the time said[7], preyed upon Child C's mother and exploited her financially and materially;
b) Neglect of Child C;
c) Child C's behavioural problems.

In August 2014, Children's Social Care received a referral from Stockport Homes, expressing concern that Child C had been seen wandering in the road, unsupervised. Further, it was stated that there had been disturbances reported at the address around midnight and a female could be heard shouting Child C's name. He was 2 years and 10 months of age.

In November 2014, GMP received reports of Child C, '*regularly playing in the street alone in just a nappy and a vest*'[8]. Officers attended, discussed the report with his mother and formed a view that the address was, '*of an adequate condition, food was present and [Child C] was appropriately dressed and cared for*'. Attending officers spoke to Child C's mother about the importance of supervising her son and not allowing to play outside alone. She denied doing so. A referral was made to Stockport Children's Social Care, which resulted in a Tier Two response; the Common Assessment Framework (CAF) being led by the family's Health Visitor (HV 1).

[6] GMP Chronology
[7] HV1
[8] GMP Chronology

Baby M / Child C's mother is described as being highly vulnerable at this time, with her GP and HV1[9] reporting her experiencing low moods and struggling with Child C's behaviour. It is noted that she worked very well with HV1, developing her basic parenting skills and learning to set appropriate boundaries. She also gained insight into the impact that the involvement of the two brothers, M1 and M2 were having on her life and that of Child C. She decided to move property and applied to complete a Mutual Housing Exchange. Baby M's mother and Child C moved away from the area and the exploitation on 09.11.2015 to a two bedroom, ground floor furnished flat in a different area of Stockport.

Family Support was also offered to Baby M's mother and Child C by Stockport Social Care Integrated Children's Services (ICS), which provided an allocated Family Support Worker (FSW1). That worker provided extensive support to Baby M's mother, working alongside HV1, with whom Baby M's mother had a positive relationship. When the Family Support Worker (FSW1) changed role, FSW2 was allocated to support Baby M's mother and Child C on 02.10.15. FSW2 added a case note to the recording system on that date, noting he wrote a letter to Baby M's mother, asking her to meet with him. FSW2 recorded that he also left a message on Baby M's mother's mobile telephone voicemail. FSW2 sought to visit Baby M's mother and Child C on 18.01.2016. As Baby M's mother and Child C had left the property in November 2015, the new tenant opened the door. She offered to forward his letter and also gave him Baby M's mother's new address. FSW2 accepted the offer of sending on the letter and did not record the new address on the Family Support Service electronic record system.

Subsequently, FSW2's Team Manager decided that the family's case needed to be closed on 12.04.2016 as Baby M's mother had not responded to the contact from FSW2[10]. This decision was made without reference to the well-being of Child C and without review of the family's circumstances.

Agencies noted[11] that once the family had moved house, their situation apparently improved significantly and Child C's behaviour also changed. In addition, his mother would access support and visit her GP where needed and sought support appropriately. Child C started school in the new area and there were no reports of concern from his teachers prior to his brother's death.

[9] Discussion at Practitioner Event
[10] Chronology: Stockport Children's Social Care
[11] Discussion at Review Panel meeting

## 5. Analysis: Terms of Reference

The Review Terms of Reference for this Review are as follows:

1. To reflect on the sharing of information between different geographical areas and different providers.
2. To consider the effectiveness of the coordination in managing Baby M's medical needs.
3. To consider the opportunity to undertake an Early Help Assessment given agency concerns about vulnerability pre and post birth – considering the cumulative risk factors identified;
4. To consider alcohol misuse and the impact on parenting.

## 5.1 To reflect on the sharing of information between different geographical areas and different providers.

Baby M was transferred from Stepping Hill Hospital to the Newborn Intensive Care Unit at St Mary's Hospital (SMH), Manchester University NHS Foundation Trust three days after his birth on 30th March 2017. This was an emergency transfer. SMH is a specialist care centre, supporting babies who are born prematurely or who are very poorly across the Greater Manchester area.

Baby M was extremely poorly when he was born. The information provided by Stepping Hill Hospital (SHH) to SMH on his emergency transfer refers to the following health challenges for Baby M:

- pneumothorax
- pulmonary haemorrhage
- cardiomyopathy
- grade 2 intraventricular haemorrhage
- suspected necrotising enterocolitis
- suspected sepsis
- congenital hypo-thyroidism
- prolonged neonatal jaundice
- congenital malformation of kidney (absent right kidney)
- umbilical hernia

A few days after admission to SMH, he was also identified as having hypo-thyroidism.

Once at SMH, Baby M was a patient there for almost 12 weeks and his time in hospital constituted: 20 Intensive care days, 14 High dependency days and 48 Special care days.

Practitioners at SMH[12] described both Baby M's father and mother visiting regularly and being keen to involve themselves in his care. The Hospital also provided a statement to the Serious Case Review in which the author, the Lead Nurse explains that there were no concerns whatsoever about either parents' care of Baby M.

No concerns have been identified by the Review about the care provided to Baby M when he was an in-patient at SMH. The Neonatal Intensive Care Unit is recognised as being a leading service in the

[12] In telephone discussion with the Lead Reviewer

UK and one of the largest; the Review has no doubt that Baby M received an excellent standard of care while in-patient. Baby M's mother was fulsome in her praise of the hospital and the staff.

The Review has, however reflected on the information that was provided to the family and to local medical practitioners on Baby M's discharge home and the quality of that process. It was evident from discussion at the Practitioner Event and from the discussion undertaken by the Independent Reviewer with the Lead Nurse from SMH and in Review Panel meetings that information exchange between Stockport practitioners who knew Baby M's mother, (HV1) and the Neonatal Unit could have been enhanced had information about the family background been provided on Baby M's admission to the Neonatal Unit at St Mary's Hospital. This would have been discussed as part of the discharge planning process and explored in detail regarding the child's health care needs and what support would be required for the family to ensure they could meet his needs, and ensure he was able to attend all appointments. It is noted that a discharge planning meeting was not held for baby M on discharge from SMH. However, protocol at SMH is that a discharge co-ordinator considers the need for a discharge meeting. As Baby M was considered to have no ongoing health needs that needed community nursing; according to the discharge protocol, no discharge meeting was required.

*BadgerNet Neonatal*[13] forms a single record of care for all babies within neonatal services and this information is shared across hospital services and sites; this is the system that enabled information sharing between SMH and SHH. The content of this record was available to the Review and has been discussed in some detail.

However, information is also provided by SMH within paper-based discharge reports. This is what was provided to both Baby M's parents, to Stepping Hill Hospital in Stockport, and the family's GP when he was discharged home on 19th June 2017.

The Health Visitor Team in Stockport did not receive the discharge information in advance of Baby M going home; there was no discharge planning meeting. HV1 was made aware of the discharge by Baby M's mother who had been texting her with update information while he was in SMH. However, SMH recorded that two members of staff notified the Health Visiting Team of his discharge by telephone on the day he went home and also on the following day. Paper record discharge information was also provided to agencies in Stockport, including the Health Visiting Service after Baby M returned home.

Baby M was discharged once his health conditions had been largely resolved; his main health difficulty on discharge was Hypothyroidism, for which he received medication and requisite general practitioner follow-up. However, Baby M's physical ill health when he was born and the length of time spent in a Neonatal Unit will undoubtedly have impacted upon him, on his parents and his brother, regardless of the excellence of care he received.

It has been well documented that parents, and in particular mothers of infants admitted to Neonatal units are subject to high levels of stress and anxiety[14]. Additionally, parents having to communicate with nursing and medical staff and feeling afraid that the worst may happen to their child, often leads to anxiety, stress and depression. While a baby is on a Neonatal Unit, the parents are surrounded by a whole team of professionals caring for them and their baby. When they are finally able to go home, it can be a daunting and sometimes frightening experience. BLISS, the leading UK

[13] https://www.clevermed.com/badgernet/badgernet-neonatal/

[14] Jambulingam M (2012). Anxiety in mothers with preterm infants in the neonatal intensive care unit. JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing 41(Suppl 1):S152.

charity for sick or premature babies[15] has published a 'Baby Charter' with an accompanying set of principles for excellence in care of sick or premature babies receiving neonatal care. Principle Seven states, '*Discharge should be a seamless and supported transition from the neonatal unit to home. Discharge planning is facilitated and coordinated from admission to discharge to ensure both the baby and the family receive the appropriate care and access to resources'*. Baby M's mother did not refer to this stress when she met with the Independent Reviewer and Board Manager, but she did talk about her anxiety about his health and whether or not she was caring for him correctly.

General practitioners from Baby M's family surgery commented at the Practitioner Event that the information contained within the discharge summary lacked detail and did not help the practice understand the clinical priorities for Baby M following his discharge home. For example, the summary detailed twelve different consultants as being relevant to him, each with the comment '*please arrange appointment as required*', which some practitioners found to be unhelpful in its imprecision.

The Review discussed members' view that communication between the Health Visiting Team in Stockport and the Neonatal Unit could have been enhanced by:

1. Information being provided about the family's background and risks to the Neonatal Unit on Baby M's admission;
2. The Health Visitor / Team contacting the Unit proactively to enquire about and discuss discharge;
3. SMH Neonatal Unit leading a multi-agency discharge plan, which may have resulted in an Early Help Assessment being conducted to support the family. However, it must be noted that SMH followed their protocol around discharge and their decision making was appropriate given the protocol.

This could have enabled effective information-sharing and consideration of:

1. The family's current situation (Baby M's father was not living with Baby M's mother and so was not the supportive factor he had been considered to be by SMH);
2. The family's history, particularly Baby M's mother vulnerability and isolation;
3. The history of neglect of Child C and consideration of risk factors in relation to his welfare at this age and to his new-born brother;
4. The ability of Baby M's mother to both understand and carry out what was required of her as a parent caring for a poorly baby.

The Review noted that having one child does not mean that parents are automatically able to care for a poorly baby who has spent the first three months of their life in hospital and consideration of the impact of this experience on babies and parents by frontline practitioners should be developed as a learning theme from this Review.

This approach could have also enabled the necessary support to be put in place, with a full understanding of any risks and a tight and robust discharge plan. Effective information sharing about a family's context on admission as well as discharge planning that is accessible and includes key frontline health practitioners from the child's local area is vital in providing good quality care and support to babies who have experienced Neonatal care.

[15] https://www.bliss.org.uk/

## 5.2 Consider the effectiveness of the coordination in managing Baby M's medical needs

The coordination of services in respect of Baby M's medical needs, as discussed above could have been improved by effective information sharing both on his admission to SMH and on discharge. However, it must be emphasised that the Neonatal Unit could not share information it did not possess; the Unit had no knowledge of Baby M's mother's background and history. However, a multi-agency discharge discussion that involved the family as well as local practitioners / services could have been of benefit to Baby M and his family and allowed for consideration of the family's history, together with current circumstances, strengths, risks and concerns to be fully explored and considered.

When a health visitor has a child from their caseload on a Neonatal unit they should contact the receiving hospital in order to ensure that all relevant information has been shared. There was an agreement that the GP should share information with Midwifery team and they in turn should then share this with the Neonatal unit. Ensuring a timely cycle of information sharing about relevant family history across and within healthcare services to information consideration of risk is a learning theme for this Review.

Had the Stockport Health Visiting Service been involved with Baby M's care by visiting him in SMH at an earlier point or liaising with the neonatal unit throughout his inpatient stay, this too could have been of benefit, not least as HV1 knew Baby M's mother and Child C, his brother and had been key in providing support when Child C was a toddler and receiving inadequate care and support at home. The Review Panel heard that Neonatal Units welcome the involvement of Community Health Visitors. The Review acknowledged the importance of making contact with a family and considering visiting babies where appropriate on Neonatal Units. In addition, making direct contact with the neonatal teams prior to discharge in conjunction with robust discharge planning is good practice and is this therefore a learning theme for this Review. Despite the protocol being followed, leading to no discharge planning meeting, the review considered it to be basic / good practice for the NNU to contact the Health Visitor directly on discharge. This did not happen in this case and the health visitor was not aware of the discharge.

Those participating in the Practitioner Event questioned whether or not Baby M had received his eight week check-up; this would normally be conducted by a GP, but as he was in hospital at the time, it was assumed that this had happened at SMH. In fact, it had not taken place and practitioners commented that Baby M had already had a difficult start in life; if the check had taken place after his return home, so eight weeks after his discharge, it could have provided an opportunity for assessment of his development. It may also have been a good opportunity for the GP to check on his mother's well-being. However, SMH advised the Review that eight week checks do not take place in a Neonatal Unit as babies are receiving continuous medical checks. The protocol at St Mary's Hospital is that all babies born before 30 weeks' gestation are followed up developmentally for two years at that hospital. In Baby M's case, although he was born at 38 weeks, he was scheduled to be followed up developmentally as per the protocol by Professor Mitchell at SMH and therefore a GP would not be required to complete an eight week assessment.

The Review found good practice at the family's GP surgery which holds a regular multi-disciplinary Safeguarding Meeting at which children identified as having health or social care risk are discussed; in Baby M's case there was discussion on 17.10.2017 about his recent hospital admissions and not being taken to appointments with the Genetics Service. Additionally, one of the GPs at this practice noticed on 10.7.17 that Baby M's mother had requested a repeat prescription on his behalf for Dalivit, a multi-vitamin supplement too soon and had used more than prescribed. The GP telephoned Baby M's mother and discussed the matter at some length, with Baby M's mother explaining that she had been giving him 3ml/day rather than the prescribed 0.3ml/ day. This meant he had experienced a chronic accidental overdose. The GP acted swiftly, asking Baby M's mother to take him to Stepping Hill Hospital. This focus on safeguarding at the practice and which is also illustrated by the attendance of two GPs from the practice at the Practitioner Event is to be commended.

Although there was communication from practitioners in health services about issues relating to their area of clinical expertise, there was no clearly identified lead medical practitioner who could pull together knowledge of Baby M's needs. This may have been explored as part of the discharge planning process and clear roles established. This meant that there was a lack of multi-agency understanding of his daily lived experience. The Review heard that services communicated information that came to their attention, or which was within their remit but the lack of coordination meant that there was no joining up of that information and multi-agency consideration of Baby M's overall vulnerability.

This will, however have been largely due to the fact that there were no real concerns about Baby M's well-being at home prior to his death. While a lead practitioner coordinating services and pulling together a picture of his daily lived experience would have been ideal, the family was not in receipt of Early Help, there were no current concerns about either child's well-being, (other than the Dalivit overdose) and the practitioner with the most significant relationship with the children and with their mother, HV1 was visiting regularly, had provided continuity of care and was focused on the welfare of Baby M and his brother. Indeed, the family was also in receipt of an Enhanced Health Visiting Service and received additional visits to support the family. This involved the contribution of the early years workers in the team who were able to support the family and offer access to infant massage and child development/play based intervention[16].

Following discharge home, Baby M had involvement from various different aspects of the health economy in Stockport and also at SMH. In addition to out-patient appointments, Baby M had bronchiolitis and also experienced pain and distress as a result of an inguinal hernia and this resulted in several attendances at Emergency Department. In addition, appointments were made for him to see, amongst other services, a Speech and Language Therapist, a Geneticist and an Ophthalmology Clinic. The impact of this level of health appointments on a mother who was largely operating as a single mother, with little support, no transport and another child in school is clearly high.

Recent developments have been made within the service delivery in the Neonatal Unit at Stepping Hill Hospital in Stockport, whereby the neonatal team will routinely advise the Community Health Visiting Team when a baby is born in that hospital but transferred elsewhere. This will ensure there is good communication between acute and community health provision for babies in these circumstances. With newly devised admission protocols and pathways at Stepping Hill Hospital this means that when the department receives a baby who has been transferred, they enquire whether

[16] http://www.healthychildprogramme.com/scope-and-the-purpose-of-the-project

there are any known risks or concerns about the baby's circumstances. Similarly, the provider that is transferring the baby should highlight this information to the receiving hospital.

This Review has found that a learning theme for this Review is the importance of trained healthcare staff with Neonatal experience providing a lead role and coordinating a baby's care and other needs. However, the Review also was clear that there was no additional requirement of this family that could not have been addressed by the Enhanced Health Visitor offer and which they received.

## 5.3 Consideration of the opportunity to undertake an Early Help Assessment given agency concerns about vulnerability pre and post birth.

The Early Help Assessment (EHA) is an important means by which children at risk are identified and families supported to prevent harm. Stockport Family advises that[17], '*The EHA assesses the whole family situation and helps to identify the needs of the children and adults in the family…… Early help is about engaging a child/young person, parent or family in a conversation about how to get things going well again'.* The Early Help Assessment is conducted by the agency that knows the family and is referred into the Stockport Multi-Agency Safeguarding and Support Hub (MASSH). This is the single point of contact for all professionals to report concerns, request advice and share information about a child and or family.

The Review heard from agencies that participated in the Practitioner Event and in subsequent telephone interviews with those unable to attend that there were no concerns about Baby M's mother's capacity to parent him prior to his birth. She had moved house from the area where she had experienced exploitation, and was considered to have settled and be doing well.

Baby M's mother booked in early with her pregnancy at eight weeks. She told the Lead Reviewer and Board Business Manager that this was because she was, *'so excited'* by her pregnancy. The latter part of the pregnancy was difficult because she had polyhydramnios, but she attended all the additional appointments and scans that were required and there were no concerns raised by staff.

Observations of her on the SMH Neonatal Unit were of a woman who was confident, loving and positive. The Lead Nurse at SMH reported to the Review that, '*There were no social concerns or documentation of any incidents, concerns or anxieties over parental input in the time [Baby M] was on the Newborn Intensive Care Unit at Saint Mary's Hospital'*[18].

However, it is clearly noted that Child C's mother struggled to parent him effectively. While her parenting improved with support from HV1 and FSW1 in 2014 /2015, she reportedly continued to find boundary-setting a challenge[19]. No agency had concerns about her current parenting, including the Health Visiting Service, which was seeing her and Baby M regularly. However, on the night of Baby M's death she drank alcohol, either took or had illegal substances present in the home and placed him in her own bed to sleep, despite being clearly advised of the risks of doing so.

### 5.3.1 Safe sleeping advice

There is no question that Baby M's mother had been advised about the risks of co-sleeping. The Lead Nurse at SMH informed the Serious Case Review that, '*One of the senior staff has documented they had discussed the contents of the Red Child Health Book where she identifies this as part of a toolbox*

[17] https://stockport.fsd.org.uk/kb5/stockport/fsd/service.page?id=m48l32F4aKU [accessed 28.09.2018]
[18] SMH Statement to the Serious Case Review
[19] Stockport Family comments at Review Panel Meeting 1

*for parents with information and advice*'[20]. This is a national standard health and development record given to parents / carers at a child's birth. It contains advice on safe sleeping, which is particularly important in relation to neonates who have a slightly higher incidence of Sudden Infant Death Syndrome (SIDS). It also signposts parents / carers to the lullabytrust.org.uk. The Lullaby Trust raises awareness of sudden infant death syndrome (SIDS), provides expert advice on safer sleep for babies and offers emotional support for bereaved families.

In addition, Baby M's mother was also given safe sleeping advice by HV1 who also conducted a safe sleep assessment and action plan[21] with her.

The Review acknowledged that despite the safe sleep advice being provided, Baby M's mother took the decision to co sleep with her child. The review recommends that the Stockport Safeguarding Children Board consider how best to disseminate these important messages.

### 5.3.2 Previous Early Help provision

Stockport Family informed the Review that the 'Integrated Children's Service' had been involved with the family prior to the family's move in November 2015 to their current home. This followed several agencies raising concerns about Child C being neglected. The conclusion of the provision of that service, by its replacement service, the Family Support Team was, Stockport Family has advised the review, not of a good standard, with the practitioner concerned potentially breaching the family's right to confidentiality and also displaying a lack of concern about risk and needs by leaving a letter with the new tenant of the previous home. An alternative and more appropriate approach would have been to use the follow-on address provided by the new tenant or contacting Stockport Homes and confirming the new address to ensure Baby M's mother was given the necessary information.

Similarly, the Family Support Team closed the family's case in April 2016 because Baby M's mother had not responded to FSW2's letter. This decision was made without:

- Being sure that the letter had been received by Baby M's mother;
- Challenging FSW2's actions in leaving the letter with the new tenant of their former home;
- Reviewing the family's circumstances;
- Communicating with other agencies;
- Seeing and speaking with Child C;
- Being assured that he was not being neglected.

### 5.3.3 Understanding Baby M's mother's vulnerability and the potential risk to her children

Baby M's mother has presented on occasion[22] as having limited understanding of significant issues and of difficulties in sequencing information.

When children are exposed to adverse and stressful experiences, it can have a long-lasting impact on their ability to think, interact with others and on their learning. Adverse Childhood Experiences (ACEs) are traumatic events that affect children while growing up, such as being maltreated, living in a household affected by domestic abuse, substance misuse or mental illness. National studies of the prevalence and impact of ACEs have been conducted in England and Wales, supported by a number

[20] SMH Statement to the Serious Case Review
[21] SFT Initial Agency Report
[22] Observations by Team Manager, Stockport Family, Independent Reviewer and Board Business Manager

of smaller regional studies. Around 50% of the UK population experience at least one ACE, with around 12% experiencing four or more ACEs[23].

While individuals who experience Adverse Childhood Experiences have an increased risk of poor outcomes as adults, many individuals who experience ACEs do not encounter these effects; the key is about a person's resilience and response to stress.

While there was information available to agencies about Baby M's mother's neglect of Child C, there were no identified concerns when Baby M was born, nor after his birth. This lack of concern meant that, with the exception of HV, who knew the family from that time, there was no consideration of her history. Had, as suggested above, a multi-agency discussion taken place prior to Baby M's discharge from SMH, there would have been the opportunity to consider not only what his needs were and how well she would be likely to meet those, but also, to understand her own history of Adverse Childhood Experience. This may have given practitioners the ability to question how she responds under stress and consider her resilience.

The Review has reflected on the questions that are asked about a family's ability to care and support for a baby who has spent a significant period of time in Neonatal care. These questions could have elicited greater understanding of the risks and strengths of the family and ensured a coordinated response to addressing those needs.

While there were no indicators of neglect noted by practitioners in respect of Baby M, there were risk factors, parental childhood neglect, mental health difficulties, (Baby M's mother had a history of depression) and domestic abuse. These are all considered to be factors that *may* increase the risk of neglect[24]. Baby M's mother's childhood experience may also have impacted on her ability to understand her role as parent. Professor David Howe, OBE[25] notes that parents who have been maltreated in their own childhood often lack understanding of the subtleties and complexity of relationships, especially the parent-child relationship.

Understanding family history is essential when working to safeguard children and young people and particularly when a child or children are at risk of neglect; only by understanding the history can practitioners begin see patterns and risks. Not taking sufficient account of family history was identified as a factor in half of the Serious Case Reviews analysed by Ofsted in 2014.[26]

The Review has identified an absence of concern or significant consideration of risk in relation to Baby M; agencies were looking at presenting circumstances without explicitly evaluating information about Baby M's mother's history and applying this to her parenting capacity and to his lived experience. Consideration of risk may have been hindered by a focus on the complex clinical concerns relating to Baby M. The exception to this was the Health Visitor service, which did probe Baby M's mother about her history and did question her about how well she was coping. However, as noted earlier in this report, HV1 did not share this information with other agencies, including SMH when Baby M was first admitted but may have been explored as part of the discharge planning process.

This is not to say that Baby M's mother's history meant that she would be neglectful of Baby M and Child C once she had additional and poorly child to care for, but it needed consideration. It would

[23] Bellis et al., 2014 and 2015
24 Cox et al., 1987
[25] David Howe OBE Child Abuse and Neglect: Attachment, Development and Intervention, 2005
[26] In the child's time: professional responses to neglect, Ofsted 2014

have been good practice for practitioners to have reflected on the risk factors referred to previously, evaluated strengths and risks, with a contextual understanding of what history told practitioners about how she *could* behave under stress. This may have prompted consideration of the questions that needed to be asked of her to inform an effective risk assessment. This is an area of learning for this Review that has been addressed earlier in this report.

### 5.3.4 Opportunities to refer for Early Help following Baby M's birth

Baby M's GP who identified the chronic overdose of Dalivit (Vitamin A) has suggested that this incident could have been indicator of neglect or of a risk factor for Baby M and for his brother and could have served to initiate an Early Help Assessment.

Section 85 of the Children Act 1989[27] places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and/or likely to exceed twelve weeks. Baby M was in hospital for 85 days, or two months and therefore just five days shy of this duty being a requirement. Had he remained in hospital for a further five days, he would have been referred to Stockport Family with Early Help being a consideration. This would have provided an opportunity to consider his needs and those of his brother, with knowledge of his mother's history and the possible risks. It would have also enabled her to access support.

At the Practitioner Event, those present questioned whether there may be potential, locally to consider flexibility around this notification requirement. The Review Panel considered this question, but formed a view that it would be difficult to set a date that would be relevant for all families; for example were the number of days to be reduced locally to say, 75, another family's circumstances may mean their baby was discharged on day 74, and so it would not apply.

The Review Panel considered that it would be more useful to routinely consider the use of the Early Help Assessment (EHA) as a means of supporting families who present with a child who has complex health care needs. This is a learning theme for this Review.

### 5.3.5 Early Help: Conclusion

The use of Early Help in this case is key and the Review has concluded that there were several opportunities for conducting an assessment, which despite the lack of indicators of neglect could have captured and considered the risk factors of neglect of Baby M.

Using the Adverse Childhood Experiences model to understand parents' resilience and explore their previous history is an important resource to utilise to inform practice. It is being used already in Stockport and notably is referred to in the Safer Stockport Partnership Plan 2018-21[28] and the Stockport CCG Refresh of the Children and Young People's Mental Health Transformation Plan 2018[29].

The use of the Adverse Childhood Experiences model to understand parents' resilience is a learning theme for this Review.

[27] https://www.legislation.gov.uk/ukpga/1989/41/section/85
[28] http://democracy.stockport.gov.uk/mgConvert2PDF.aspx?ID=134942
[29] http://democracy.stockport.gov.uk/mgConvert2PDF.aspx?ID=140260

## 5.4 Consideration of alcohol misuse and the impact on parenting.

Baby M's mother was known to sporadically use alcohol. In 2012, her former partner had contacted Greater Manchester Police, concerned about the impact of the amount of alcohol she had drunk on her behaviour.[30]. However, throughout her pregnancy and her contact with the Health Visitor team after Baby M was discharged home, she denied drinking alcohol and there was no sign of it in her flat; no practitioner reported evidence of alcohol use and Child C's school did not report any concerns. [31].

While Baby M's mother had drunk alcohol on the night of his death, it is not clear how much. She was seen, GMP reported, buying two bottles of vodka, but it is not known who drank this as there were others who reportedly visited her flat that evening[32].

Despite this lack of knowledge of the impact of alcohol use on Baby M's life, there is evidence of it being a factor that was a part of the picture of what happened on the night of his death. It appears that Baby M's mother drank alcohol on a binge basis, spending significant times without using alcohol and then sporadically using it to excess. This seems to have been what happened on the night of Baby M's death.

Binge alcohol drinking is known to cause harm to children. This is clearly established in research conducted by the Children's Commissioner in 2012 and has been identified as an issue of concern for the Stockport Safeguarding Children Board. For this reason, it is important to ensure this learning is collated with that of other reviews in Stockport. Understanding the relationship between alcohol binging and neglect is therefore an area of learning for this Serious Case Review.

# 6. Learning

This Serious Case Review has identified several learning themes. These are as follows:

i. There should be consideration by frontline practitioners of the impact of the experience on babies and parents / carers of a new-born baby being a patient in Neonatal care;

   [This learning is already being addressed by SFT, which has undertaken learning sessions with Health Visiting practitioners. The Review was informed that there is scope for this to be extended across the multi-agency partnership];

ii. There should be a reminder of the importance of ensuring a timely cycle of information-sharing and relevant knowledge of family history across and within healthcare services to inform understanding of risk. This should build upon work undertaken already within SFT and which forms a part of its Standard Operating Procedures; there needs to be evidence from MFT as the discharging hospital

[30] GMP Initial Agency Report and Chronology
[31] SFT Initial Agency report and Chronology
[32] GMP Referral for a Serious Case Review to SSCB 29.10.2017

iii. It would be helpful to support community Health Visiting practitioners in considering good practice by visiting babies where appropriate and their families on Neonatal Units or making direct contact with the neonatal teams prior to discharge;

iv. The need for NNU to liaise with the child's health visiting team and to ensure there is consideration for the completion of a robust discharge planning meeting babies who have identified additional complex health or social care needs.

v. The Review recommends agencies to consider the use of the Early Help Assessment (EHA) as a means of supporting families who present with a child who has complex health care needs.

vi. The Review has highlighted the positive use of the Adverse Childhood Experiences model to understand parents' resilience in order to safeguard children.

vii. The Review has highlighted the risks to children when parents binge alcohol.

## 7. Work Already Underway in Stockport that addresses this Serious Case Review Learning Themes

The Serious Case Review has been advised that the following work is being progressed in Stockport:

- Stockport NHS Foundation Trust has commenced learning and development sessions with frontline community health visiting practitioners, enabling them to reflect on the potential challenges faced by families with babies in neonatal care. The Trust has already proposed a wider roll out of this training to other relevant practitioners in the NHS and beyond. This is to be commended.
- Stockport NHS Foundation Trust has worked with colleagues across the Greater Manchester area to provide clear and consistent messages to families around 'Safe Sleep' and the risks of co-sleeping.
- A Neonatal Discharge Coordinator post has been developed by Stockport NHS Foundation Trust to support the findings from this review and a number of other learning reviews across the GM. Their role encompasses the lead for discharge planning arrangements, parenting education, liaison with multiagency professionals, and liaison with other neonatal units regarding transfers in and out of the unit. The coordinator also ensures as part of the discharge planning process that clear messages are delivered around safe sleep, resus training, sterilising bottles, safety in the home, the use of car seats, and general signposting as well as contributing to the development of early help plans and providing overall support to families during their time on the unit.
- Stockport Foundation Trust Neonatal Unit also endeavours where possible to ensure that babies who are placed out of area on neonatal units who have identified additional safeguarding vulnerabilities should be considered to be returned to the unit for robust local discharge planning.
- Manchester NHS Foundation Trust, Newborn Services recently launched a new initiative which brings Health Visitor Liaison from Care of Next Family Scheme (CONI), to support the education team in staff teaching all new staff to build on existing knowledge and meet with parents to discuss all aspects safe sleeping.

- The developmental care team and newly established Family Integrated Care team (FiCare), at Manchester NHS Foundation Trust, work with families throughout the infants stay to support consistent messages to families around 'Safe Sleep' and the risks of co-sleeping.

## 8. Recommendations

This Serious Case Review recommends that:

i. SSCB should receive assurance that babies discharged from the MFT Neonatal Unit,-are receiving timely and appropriate assessment and support post discharge.

ii. SSCB receives assurance that all practitioners working with babies with complex needs are aware of the impact on the family

iii. SSCB receives assurance that there is a review of current safe sleeping advice and includes the impact of alcohol consumption and smoking when caring for a young baby; and is effectively communicated to families.