BIRMINGHAM Safeguarding Children PARTNERSHIP

Serious Case Review

BSCB 2017-18/01

Independent Lead Reviewer:
Paul Sharkey MPA

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Part 1: Introduction

1. The subject of this Serious Case Review (SCR) is a baby who was born in late October 2016 in a Birmingham hospital and was the mother's second child. Due to concerns about the mother's substance misuse, history of domestic abuse and the removal of her first child some years previously, the baby was made the subject of a child protection plan under the category of neglect, the day after birth.

2. The plan entailed multi-agency intervention with the pair from a range of social care, health, family support and substance misuse professionals to support them and reduce risk of harm to the baby. The mother's parents, who lived nearby, also had a supportive role in the plan.

3. Mother and baby were discharged from hospital in early November and, being registered homeless (albeit having hostel accommodation in Birmingham), stayed with a friend in Birmingham, prior to moving to temporary accommodation in Solihull in mid-November. The move resulted in a change of professionals from Birmingham to Solihull and arrangements were made for a receiving-in Initial Child Protection Conference in Solihull for the 05.01.17. Birmingham Children's Services held case responsibility and oversaw the child protection plan over the Christmas and New Year period. However, to assist Birmingham Children's Services a visit was made by a Solihull social worker on the 30.12.16 when no concerns were noted.

4. The baby, aged two months, was taken by ambulance on the afternoon of the 02.01.17 to the emergency department of a Birmingham hospital, suffering from cardiac arrest, where tragically, the baby died. On post-mortem examination the baby was found to have eight rib fractures sustained over a twenty-four hour to twenty-day period. Seven occurred between 4-12 hours and one between 10-20 days before death.

5. The baby was aged just two months old and was not independently mobile and was thus not able to injure itself. Subsequent medical examinations concluded that the injuries were traumatic in origin and caused by significant force. The mother told the police that she (the mother) had fallen asleep during the daytime of the 02.01.17 with the baby on her chest and that no one else had had care of the baby during that time. She said that the baby was never out of her sight or mishandled by her or anyone else. She was arrested on suspicion of neglect and a criminal investigation was started by West Midlands Police (WMP).

6. In the light of the baby's immobility and age, the mother's account of events was thought to be implausible as an explanation for accidental injury or medical cause. The presence of multiple unexplained rib fractures on a baby of two months, sustained on multiple occasions, was thought to be indicative of abusive and/or deliberately inflicted injury.

7. Subsequent expert medical evidence as part of the Police enquiry, suggested that the rib fractures sustained by the baby on the 02.01.17 contributed to the baby's death through progressive respiratory failure caused by shallow, ineffective breathing, leading to a lack of oxygen to the brain, asphyxia and cardiac arrest.

8. Following a very thorough police inquiry, the mother was subsequently charged in late August 2018 with manslaughter and two counts of grievous bodily harm in respect of the baby. Following a trial in March 2019, the mother was found guilty at Birmingham Crown Court in early April 2019 of the said offences and given a custodial sentence of thirteen-and-a-half years.

9. In compliance with statutory guidance[1] and regulations, the Birmingham Safeguarding Children Board (BSCB) commissioned a SCR on the 10.10.17. An independent joint review chair/Lead Reviewer was appointed in late December 2017 and work started on the SCR in February 2018.

10. The SCR was temporarily halted in October 2018 to allow for the conclusion of the trial in April 2019. The SCR Review Team was aware from the police representative that the ongoing criminal enquiry contained some very salient and significant evidence regarding the mother's involvement in the death of the baby, which was not available to the review at the time. This could only be shared and used by the SCR after the trial's conclusion. An interim overview report was provided in October 2018 by the chair/Lead Reviewer to the BSCB SCR sub-group which considered it at the meeting of the 12.10.18. Feedback comments were made by the sub-group which led to additional amendments by the Lead Reviewer that were included in a later (February 2019) version of the interim report. A final version was completed following the conclusion of the trial and sentencing of the mother in early April 2019.

11. There was no information or evidence available to the agencies and professionals involved at the time that would have led them to be able to predict the tragic outcome in this case. The mother must take full responsibility for the tragic death of her baby.

[1] Local Safeguarding Children Board Regulations 2006; 5(1) and (2), see also 'Working Together' 2015, Chapter 4. This was the version current at the time of the death. A revised version was published in June 2018.

Part 2: Aims, Key Issues for Analysis and Review Processes (see Appendix 1)

Family Involvement

12. The maternal grandparents were written to on two occasions following the conclusion of the trial in early April 2019, regarding a meeting with the Lead Reviewer. There was no response. The baby's mother was seen by the Lead reviewer and a review team member on the 29th May 2019. Her views are set out on page 40.

Race, Religion, Language and Culture

13. The family are English speakers of white British heritage.

Parallel Proceedings: The Police Enquiry

14. West Midlands Police completed a very thorough inquiry into the death of the baby.[2] This resulted in the decision of late August 2018, by the Criminal Prosecution Service, to charge the mother with manslaughter and two counts of grievous bodily harm in regard to the baby's death.

15. The Lead Reviewer and review team received an update on the Police inquiry from the police representative at the review meeting of the 14.09.18. The information shared suggested that the mother had continued to engage in substance and alcohol misuse during the period prior to her baby's death and had hidden the fact from the professionals. Moreover, that alcohol and substance abuse had played a very significant part in the death of the child. This information was not known to the professionals involved with the mother and baby prior to the latter's tragic death. Of significance to this SCR, no such information was mentioned in the agency reports and documentation made available (at the time of the interim report of October 2018) to the Lead Reviewer and review team during 2018.

16. The advice from the review team police representative in September 2018 was that none of the detailed material from the criminal enquiry could be used in the interim report pending the conclusion of the later trial. Moreover, it was not possible to interview the mother or her parents until after the trial. On this basis the Lead Reviewer recommended to the BSCB Independent Char and BSCB Business Manager that the review be temporarily halted, pending the completion of the trial in April 2019.

Meeting between the Lead Reviewer and the WMP enquiry team (05.04.19)

17. The meeting agreed that an addendum to the initial police report of April 2018 would be provided from sources used in the Police enquiry and the trial of the mother to cover the following themes:

[2] The enquiry team are to be commended on the diligence, professionalism and commitment shown in the conduct of a very complex investigation.

- The timing, nature and context of the injuries sustained by the baby (see appendix 2 for risk of serious injury to and vulnerability of infants under 12 months old).
- The events between mother and baby between 22.12.16 and 02.01.17 with a focus on the final seventy-two hours leading up to the child's death on the 02.01.17.
- Any evidence of substance and/or alcohol use by the mother from the beginning of her pregnancy to the baby's death, with reference to her contact and dealings with professionals.
- Any evidence of contact between the mother and adult males in the period between the 22.12.16 and the 02.01.17.

Key Findings

Likely cause of death

18. As previously mentioned, the consensus of expert medical opinion provided at the trial in relation to the likely mechanism of the cause of death of the baby was as follows. The baby sustained multiple rib fractures some four to twelve hours prior to death at around 15:00 hours[3] on the 02.01.17 by way of a non-accidental traumatic event. The event involved a compressive significant force being deliberately inflicted on the baby; possibly a squeezing of the chest, amounting to non-accidental injury and assault when the baby was crying, leading to the rib fractures.

19. The traumatic event (namely, the non-accidental assault) probably caused the baby's breathing to be temporarily impaired or to cease for a period of time, leading to a decrease in oxygen supply to the vital organs, including the brain; resulting in hypoxic-ischaemic brain injury and setting up the conditions for a subsequent deterioration in cardiovascular function and ultimately, death.

20. In short, the evidence suggested that the assault by the mother had resulted in the death of her baby.

Timing of Injuries

21. On examination the baby was found to have eight rib fractures sustained over a twenty-four hour to twenty-day period. Seven occurred between 4-12 hours (between 03:00 and 11:00 hours on the 02.01.17) and one between 10-20 days before death (between the 13.12.16 and the 20.12.16).

Events Prior to the Death

22. CCTV evidence obtained by the Police enquiry showed that at 17:50 hours on the 22.12.16 the mother, along with the baby in a pushchair, was recorded furtively drinking wine from a glass in a Solihull public house. She left an hour and fifteen minutes later at 19:05 hours. This was a very significant event as the day before (21.12.16) she had been visited by the Solihull social worker when a discussion ensued with her regarding

[3] The baby's death was formally declared at 16:06 in hospital.

the details and expectations of both the existing child protection and the pre-proceeding plans, including the importance of abstaining from alcohol.

23. The mother was visited by the Solihull social worker on Friday 30.12.16. The baby was asleep in a car seat, wrapped in a blanket and wearing a hat. The mother was challenged about reported sightings of her drinking in the pub on the 22.12.16, despite having given assurances that she had understood the importance of not drinking alcohol and promising to abide by the terms of the child protection and pre-proceedings plans. She said that she had drunk only one glass of wine and thought she was allowed to have a drink over the Christmas period. She was advised that the child protection plan would remain in place.

24. Evidence from the Police enquiry established that the mother had been visited by some friends on the evening of the 31.12.16 (New Year's Eve) who had stayed the night at the flat. They had brought some alcohol (two lagers, a bottle of Cava and half a bottle of red wine) and a wrap of cocaine. It was apparent that the mother already had some cocaine and later took three or four lines along with her friends. She also admitted to the police to having drunk a glass of champagne.

25. Other police witnesses stated that the mother and baby had arrived at a public house on New Year's Day (01.01.17) at around 16:30-17:00 hours to attend a birthday party. The witnesses recalled that the mother had drunk around four or five pints of cider and blackcurrant and 'didn't have much time for the baby', who appeared to have a cold. The mother told another witness that her baby was not very well. She and the baby left the public house at 22:30 hours, five and a half to six hours after having arrived and was estimated by the witness as being 'six or seven out of ten on a scale of drunkenness'.

26. Another witness stated that the mother continued to drink cider during her pregnancy and would have 'a can of an evening, a few times a week'.

27. One of the witnesses arranged for the mother and baby to be taken home from the party by taxi in the company of a male adult mutual friend. The male friend had noticed that the baby looked pale and 'not very well' whilst in the public house. He said that the mother 'was desperate for cocaine' and that he believed that she had spoken to her supplier on the telephone[4] but no-one had turned up. He could not say whether the mother had used cocaine at the public house and did not see her use it at the house. He said that the baby appeared very unsettled until around 4:00 hours, when the mother went into the living room and lay on the sofa with the baby on her chest and both fell asleep in that position. The male witness lay on another sofa and slept for a short time before leaving the property at around 6:30 hours. He said that mother and baby remained in the same position when he left. He did not see the mother do anything to the baby that might have caused the baby an injury.

28. <u>The enquiry evidence would therefore suggest that the baby was seriously injured by the mother sometime between 6:30 and 11:00 hours.</u>

[4] Between 01:00 and 02:50 hours according to the Police enquiry.

Substance and alcohol misuse

29. As previously noted, the enquiry evidenced that the mother drank cider during her pregnancy, drank wine on the 22.12.16, took cocaine on the 31.12.16 and drank several pints of cider over a five to six hour period on the 01.01.17, in addition to contacting her cocaine supplier. Save for the 22.12.16 event, none of the other occasions of alcohol and cocaine use[5] were known to any professional.

30. As part of the criminal enquiry, police found two almost empty bottles of alcohol spirits in the mother's fridge on the 02.01.17. She was also noted on the way to the hospital on the same day to have been smelling of alcohol on her breath. There was telephone evidence that she had sent a text message to a friend on the 22.12.16 which included the words 'I'll just quit fags and booze till I get paid next week'. A message extract of the 29.11.16 said "I'm not allowed to drink alcohol but have on weekends (but) they don't visit over weekends lol!!!! I was gonna get some tonight and maybe a livener but (the) social worker has just told me she's gonna arrange me to be drug/alcohol tested asap haha-grrr".

31. The police seized the mother's phone during the course of the criminal enquiry and examined it for various communications. It transpired that 'behind closed doors and in the company of her inner circle of friends she was continuing to use alcohol and cocaine and would not, or could not, give up drink and drugs for the sake of the baby'.

32. The Police enquiry concluded that 'the mother had been presenting a different face to her family, to some of her friends, and to social and healthcare workers, intending to give them a false impression that she was a responsible and caring parent taking seriously her role as mother to a new born baby'.

Contact between adult males and the mother from 22.12.16 to the 02.01.17

33. The Police enquiry evidenced that the mother and baby had been brought home by an adult male friend from the party at the public house on the night and morning of the 01/02.01.17. Apart from that occasion, there was no evidence of the mother and baby being in the sole company at home of any adult male.

Dissemination of Learning

34. The Independent Lead Reviewer presented the final report to the Executive Board of the Birmingham Safeguarding Children Partnership in September 2019, for ratification and effective dissemination of the learning. The partnership will commission a series of learning events to share the emerging learning with frontline practitioners and managers across the safeguarding partnership in Birmingham. The Executive Board will also oversee the arrangements for publication of the full report on the partnership's website, together with a Learning Lessons Briefing Note aimed at frontline practitioners, and a managers' briefing pack for use in team meetings and supervision sessions to maximise the opportunity to cascade the learning from this case.

[5] Save for the May 2016 positive cocaine test.

Part 3: Case Background and Overview of Agencies' Involvement: The Facts

Social History Prior to May 2016

35. The baby's mother was born in 1986; she comes from the West Midlands and was adopted at the age of eighteen months, along with her older sister. The mother reportedly had a difficult relationship with her parents and described her childhood as 'up and down'.

36. As a young adult in her late teens and twenties, she had a history of mental health difficulties (self-harming and depressive feelings), substance misuse (cocaine and alcohol) and subjection to serious domestic abuse and violence from various ex-partners dating back to 2007.

37. The mother had a child by her then violent partner in early 2008, whilst living in Solihull. Prior to the birth she wanted the child to be adopted, which involved Solihull Children's Services. However, she changed her mind during the adoption process and the local authority undertook an assessment which identified several risk factors, including, domestic violence from her partner, debt, her own depression/low mood and substance misuse. Attempts were made by Solihull Children's Services to work with the parents that aimed to support them in providing 'good enough' care for the child, in a safe family environment.

38. However, the situation deteriorated quickly with emerging serious concerns around continued domestic abuse, substance misuse (cocaine and alcohol), the child being left with other family members for long periods of time, the child's parents prioritising their own needs before those of the child and the breaching of the working agreement regarding the mother's partner having supervised contact with the child.

39. An Initial Child Protection Conference (ICPC) was held in June 2008 which resulted in the child being made the subject of a child protection plan under the category of neglect. At around the same time, the mother left the child in the care of her parents and did not return. The child became a Looked After Child under Section 20 of the Children Act 1989 to Solihull Council and further parenting assessments were undertaken on both parents who by this time had separated.

40. The mother was not able to show the local authority that she could meet the child's needs and was disregarded as a potential carer. The mother's partner successfully completed his parenting assessment and the child was returned to his care in early 2009, still subject to the child protection plan. Father and the child moved to Coventry and a receiving-in ICPC was held in April 2009. There was a further domestic abuse incident between the parents in October 2009. In February 2010, the partner decided that he could no longer manage the child's care and left the child with the maternal grandparents. Solihull Children's Services again took responsibility for the case.

41. The child became cared for by the maternal grandparents but continued contact with the mother who provided some of the care during the day. The child became, once again, the subject of a child protection plan with Solihull who had concerns about the mother's continuing substance misuse, albeit no issues concerning her parents. A further

parenting assessment of the mother started in December 2010 and ended in January 2011 due to concerns about her commitment to the assessment and reported issues of domestic abuse with a new male partner.

42. The child remained in grandparents' care under Section 20 of the Children Act 1989. They applied for and obtained a Special Guardianship Order (SGO) in January 2012, under the auspices of Solihull Children's Services and the child has remained with them since that time. Solihull ended its involvement with the child and the maternal grandparents in March 2012, albeit that there have been annual visits in line with the SGO allowance being paid to the grandparents.

May 2016 to January 2017.

43. The mother attended at the Birmingham Heartlands hospital for an ante-natal booking with the community midwife (CMW1) on the 09.03.16, when six weeks pregnant. The mother's history of substance misuse was noted. She declined a referral to the perinatal mental health clinic. On the 04.05.16 she attended an ante-natal appointment at Solihull hospital at 12 weeks pregnant. An extensive history was noted of substance misuse, earlier Solihull Children's Services involvement, a previous child living with her parents and high blood pressure. A referral was made to the specialist midwife for substance misuse (SMW1) for the 11.05.16 which the mother did not attend.

44. The mother saw the specialist midwife on the 24.05.16 at 15 weeks pregnant. At that point her expected date of delivery was the 11.11.16. A full history was taken when she stated that she was not currently in a relationship, denied any current domestic abuse or substance misuse but admitted to some cider drinking whilst pregnant. She had drunk the day before and was informed by SMW1 of the dangers of foetal alcohol syndrome. She said that she intended not to drink alcohol for the rest of her pregnancy. SMW1 said that because of her previous history of substance misuse a referral would be made to Solihull Children's Services at 20 weeks gestation to which she agreed.

45. On the 27.05.16, the urine toxicology indicated that the mother had tested positive for cocaine thus gainsaying her previous denial of use. SMW1 completed a referral to Solihull Children's Services which was received by the Multi-Agency Safeguarding Hub (MASH) on the same day.[6] SMW1 followed up the referral on the 01.06.16 with the MASH and was told that referrals were not accepted until the mother was 20 weeks pregnant. SWM1 emphasised the seriousness of the mother's history of substance misuse and the referral was accepted. The MASH informed SMW1 on the 02.06.16 that the case was awaiting allocation and the pre-birth assessment started on the 16.06.16.

46. On acceptance, it was believed by Solihull MASH that the mother was resident in the borough, as per the information from the midwifery referral. No checks were made regarding the location of the mother's tenancy which was a hostel in Birmingham, although, as previously mentioned, she had been living temporarily with a male friend in Solihull, whose address had been given by the midwifery referral to the MASH. The male

[6] N.B The mother had given her male friend's address in Solihull to the midwifery service as her address. By the time of the midwifery referral to Solihull Children's Service at the end of May 2016, her male friend had died in the interim period and the mother chose to live with her female friend in Birmingham.

friend died and the mother, despite having the hostel place remaining open to her[7], chose to stay with a female friend in Birmingham, where she continued to live during the time of Solihull MBC's involvement, prior to the later case transfer to Birmingham on the 31.08.16.

47. On the 15.07.16 SMW1 was informed by a Solihull social worker (SSW1)[8], that the referral on the unborn baby was likely to proceed to an ICPC. The mother did not attend an appointment with SMW1 on the 18.07.16. The social worker was informed and the community midwife was asked to visit and seek to re-engage the mother with SMW1. The mother gave a urine sample to SMW1 on the 28.08.16 which, on the 01.09.16, proved to be negative with no drugs being detected.

48. By mid-August SSW1 had completed the pre-birth assessment on the mother. In the course of the assessment SSW1 had established that the mother was, in fact, residing in Birmingham (Sheldon) with her female friend and her children, notwithstanding that her Birmingham hostel placement remained open. Following a contact with the mother by SSW1 in late August, it was recorded that the mother had no intention of getting her own property in Solihull before the birth of the baby. After some discussion between Solihull and Birmingham Children's Services a referral was made to the latter on the 31.08.16. Case responsibility was commendably and promptly taken up by Birmingham Children's Services on the 01.09.16 when a social worker (BSW1, an agency worker) was allocated to start a social work assessment. SSW1 provided the Birmingham MASH with a copy of her completed pre-birth assessment on the 02.09.16 and closed the case to Solihull soon after.

49. On the 29.09.16 SMW1 told BSW1 that the mother had provided two negative drug tests on 26.08.16 and 23.09.16. However, she had previously tested positive for cocaine on 24.05.16. Following that positive test, she then missed four subsequent appointments in July and August. SMW1 told BSW1 following the negative September drug test that the unborn baby's growth was not progressing. There was a possibility that the mother may have had to be induced with an early birth, such were the concerns for foetal wellbeing because of the poor progress. BSW1 asked that SMW1 make a referral to a substance misuse agency (in this case Change Grow Live) for rehabilitation support and fortnightly/weekly drug testing.

50. BSW1 commenced the assessment on the 05.09.16 and completed it on the 21.10.16. Visits were made (at the mother's female friend's home) on the 26.09.16 and the 19.10.16 to inform the assessment. At the former visit no concerns were noted by BSW1; the mother had bought several items in preparation for the birth. She gave no identifying information save to say that the father was a married man who wished to have no involvement with the birth or any future contact with the mother or the baby. In the event of any change in the situation she would let the Birmingham Children's Services know.

51. Police checks on the female friend were requested by BSW1 on the 29.09.16. An electronic request for a strategy discussion was reportedly made to the Police on the 06.10.16 which resulted in a nil response. However, West Midlands Police had no record

[7] Her belongings were still at the hostel.

[8] At this time, SSW1 believed that the mother was staying with her friend in Solihull.

of receiving a request on the 06.10.16 for a strategy discussion. Additional calls were made to chase up the matter but to no avail and on this basis the team manager (BSWTM1) decided to hold the strategy meeting on the 17.10.16. In consultation with Solihull Children's Services and Health (SMW1) the team manager decided to proceed to a Section 47 enquiry and the holding of an Initial Child Protection Conference (ICPC). The Police were asked to provide any relevant information on the mother and her female friend, to inform the enquiry which started on the 09.10.16.

52. The mother registered with a Birmingham GP practice on the 11.10.16 and was seen on the 14.10.16 by a practice nurse for a New Patient health check. The mother told her that she smoked and was tee-total. Family and general history were discussed and recorded with no concerns noted, although nothing was mentioned about the pregnancy.

53. On the 18.10.16, BSW1 spoke by telephone to the maternal grandfather who informed the social worker of the mother's first child having been placed with him and his wife under a Special Guardianship Order since 2012 and the reasons for this. He said that he was happy to attend a family group conference if necessary but would not have the capacity to look after another child. He added that the mother had regular, supervised (at her request) contact with the first child at her parent's home with no concerns noted.

54. Again, on the 18.10.16, the mother attended an appointment with her community midwife whom she had first met on the 09.03.16 at six weeks pregnant. The unborn baby was recorded at below the 5th centile.

55. BSW1 visited the mother on the 19.10.16 to complete the social work assessment. He said that a recommendation would be made to the Area Resource Panel meeting the next day for the start of public law outline[9] pre-proceedings on the unborn baby. This was necessary because of the mother's previous non-cooperation with Solihull substance misuse and family support services as mentioned in the Solihull Children's Services pre-birth assessment. The mother was recorded as saying that she would engage with any drug misuse and parenting support services in Birmingham, albeit she would struggle to attend sessions in the community immediately after the birth of the baby.

56. Consequent to the completion of the social work assessment on the 21.10.16 the team manager (BSWTM1) decided to: proceed to an ICPC; implement a child protection plan under the neglect category; hold a legal planning meeting with a view to starting pre-proceedings on the unborn child and, if necessary; escalate to care proceedings in the event of parental non-co-operation and/or a breach of the former.

57. The Area Resource Panel meeting - chaired by the Head of Service (HoS) - held on the 20.10.16, agreed to the team manager's proposal for a pre-proceedings plan, given the known risks and needs of the unborn child and the requirement for multi-agency risk management arrangements. Progression to a Legal Planning Meeting (LPM) was given. On the 21.10.16 BSW1 made a referral for a community based parental assessment

[9] The Public Law Outline (PLO) is a means by which, through meetings between a local authority and parents, an agreed plan is produced regarding the care of children that seeks to avoid the local authority starting care proceedings. Thus, it is a pre-proceedings device.

with 'Think Family' and sent an email to SMW1 confirming that the mother and her baby were not to be discharged from hospital until after a discharge meeting to be held by the midwifery service, Birmingham Children's Services and the receipt of legal advice regarding pre-proceedings. There was a request for a further drug test on the mother at the birth.

58. The community midwife passed on information to the mother's GP on the 21.10.16 that her baby was due the coming weekend and that there was an ICPC arranged for the 26.10.16. BSW1's name was shared with the GP although there was no subsequent contact made with the social worker. BSW1 visited the mother on the 21.10.16 to inform her of the outcome of the social work assessment and decisions made by the Area Resource Panel, and to complete a genogram. The mother said she was aware of the historical concerns but was now in a better position and wanted to care for her new baby. She was informed of the forthcoming ICPC but was unlikely to attend due to the planned labour on the 25.10.16. She was reluctant to share any information on the paternity of the baby.

59. A referral was made on the 24.10.16 to 'Think Family' by BSW1 for community-based support to start in mid-December. There were concerns that the mother had failed three previous parenting assessments in relation to her first child. BSW1 would be visiting daily post birth with the support of health and other partners.

60. A legal planning meeting was held on the same day involving the team manager, the Head of Service and the local authority solicitor. The current situation and contents of the social work assessment were considered, it being the case that the mother had gone into hospital on the 22.10.16 to be induced, such were the professional concerns for the wellbeing of the unborn baby. The overall post birth plan for a community assessment, the mother's engagement with substance misuse, midwifery and health visiting, family support services and daily social work visits prior to the start of the community assessment in mid-December was agreed, as was the move towards locating it within a pre-proceeding planning framework. A LPM review was scheduled for the 12.12.16

61. On the 25.10.16, the baby was born (some two weeks before the EDD of the 11.11.16) to the mother by normal delivery following induction for intrauterine growth retardation, due to the baby being small for its gestational age.[10] The Emergency Duty Team was notified by the hospital of the birth and the hospital implemented the child protection plan previously agreed with by Birmingham Children's Services. This included no discharge until after a multi-agency discharge meeting and the sharing of the local authority's pre-proceedings initiative. A decision was also made for a urine toxicology test to be conducted (with the mother's consent) in line with the local authority's request.

62. Observations at the baby's birth were satisfactory: the baby was a well baby, albeit it was noted that the baby was of a small birth weight for gestational age (10th centile) with a head circumference on the 1st centile.

[10] See appendix 3 for effects of maternal cocaine and alcohol use on the foetus, new-born children and beyond.

63. The ICPC held on the 26.10.16 made the baby the subject of a child protection plan under the category of neglect. In attendance were the social worker (BSW1), a civilian police representative and a specialist midwife (SMW2).[11] Unfortunately, the Solihull social worker received an invitation the day before the ICPC and, because of the short notice, was unable to attend. The plan included the undertaking of a community-based assessment, intensive multi-agency support and daily social work visits under a pre-proceedings initiative. A net safety score[12] of 2 (from the three professionals in attendance) was given which indicated a very low level of safety and high professional concerns regarding the wellbeing of the baby whilst in the mother's care.

64. The prescient comment was made by the principal officer child protection1 (POCP1) and noted in the ICPC minutes that:

'*There is a risk of professionals being over optimistic in this case. [The baby] is a very small and vulnerable baby[13] who may need more than good enough parenting'.*

65. Moreover, there were concerns from the ICPC about the mother and the baby being discharged to the mother's female friend because of police information concerning previous domestic violence calls to the premises and logs for drug dealing. An email from the ICPC Chair (principal officer child protection - POCP1) was sent immediately after the conference to the team manager, social worker, Head of Service and the principal social worker at Solihull setting out these concerns.

66. The mother was informed at hospital by BSW1 of the case conference outcomes, decisions and concerns about her returning to her female friend's home. Three options were considered. Firstly, that the mother and the baby could stay with the maternal grandparents pending the provision of their own accommodation and the start of the community-based assessment in mid-December. Secondly, that the mother and the baby should go to an allocated temporary accommodation, and thirdly, a return to the female friend's home.

67. The principal officer child protection (POCP1) discussed the options regarding the discharge plan with the covering team manager (BSWTM2) on the same day. The option of staying with maternal grandparents was not viable as they were not in a position to take mother and baby. The risks of mother and baby going to an emergency hostel were too high and the option was therefore rejected. The third option was for mother and baby to return to the female friend's house.

68. BSWTM2 had looked at the concerns around the female friend and established that the domestic violence report related to an incident in December 2015 when her sibling had attacked her with a snooker cue but had since returned to his country of origin. The female friend had contacted the Police to report the incident and seek protection. There had been no reported incidents of domestic violence since that time. In relation to the suggestion of drug dealing this was at the level of uncorroborated intelligence which did

[11] Not SWM1

[12] Where Zero (0) is no safety and ten (10) is a high level of safety – Birmingham Children's Trust – Process for Child Protection Conferences June 2019.

[13] See appendix 2 on vulnerable infants and risk of non-accidental-injury.

not result in any police action or charges brought against her. Moreover, she had two children of her own and there were no concerns about their safety or wellbeing.

69. On this basis a decision was made by Birmingham Children's Services to allow the mother and baby to return to the female friend's home in the short term, under a highly structured safety plan, pending the provision of longer term accommodation in the Solihull area as the mother had previously strongly indicated that she wanted to be rehoused there, given her parents lived there. Birmingham Children's Services felt that the discharge should take place the following week (in early November) to allow arrangements to be put in place for the safety plan, which was communicated to the hospital who were content with the proposal.

70. The specialist midwife (SMW1) challenged the discharge plan with the principal officer child protection on the 28.10.16 for the mother and baby to go to the female friend's home and received an email setting out how the risk was to be managed.

71. The mother tested negative for drugs on the 28.10.16 whilst in hospital. Staff reports from the ward noted that she was attending to her baby's needs and that there were no concerns. The maternal grandparents and the mother's first child had visited the mother and baby on the ward. The mother was told by BSW1 that the discharge date would be early the following week. The baby was noted over the next few days to be feeding and sleeping well with no concerns recorded.

72. BSW1 made a referral on the 31.10.16 to Change Grow Live (a Birmingham substance misuse and support agency) to undertake drug and alcohol work with the mother requiring weekly drug/alcohol testing and an exploration with her of the serious risks associated with substance misuse on parenting and the potential impact on the baby. BSW1 visited the female friend on the same day to ensure that suitable arrangements were in place for the discharge the next day. No concerns were noted regarding the property or a shortage of essentials for the baby.

73. The discharge planning meeting was held at the hospital on the 01.11.16 attended by the mother, the community midwife (CMW1), hospital midwife (HMW1) and BSW1. SMW1 was not in attendance. The baby was noted to have made a noticeable weight gain with no concerns identified regarding growth. The mother was observed to be attending to the baby's needs well and a 'loving attachment' noted. All was in place at the female friend's home and the community midwife would undertake daily visits for the first five days and review frequency after this. BSW1 was also to undertake daily visits.

74. The mother said that her parents would be visiting at least once a week to provide support. She was reminded that no one else should care for the baby and in the event of others, especially male friends (in view of her history of associating with risky males) wanting contact with the baby, she should notify BSW1 who would undertake checks. The mother informed the meeting that the baby's father did not want to play a part in the baby's life. However, should he wish to do so in the future she should notify Birmingham Children's Services. She was reminded of the pre-proceedings and advised to obtain a solicitor.

75. The baby and mother were discharged from hospital and into the care of the community midwife at 17:05 on the 01.11.16. Various checks were completed including, important symptoms information given, along with a cot death leaflet and an explanation of risk factors. GP registration of the baby and the role of the health visitor were explained, and a full physical examination of the new-born was completed.

76. A copy of the child protection plan was received on the 01.11.16 by the mother's (Birmingham) GP who reviewed it. There was no notification received of the baby's birth.

77. On the 02.11.16 a working agreement between the mother and Family Action (a family support agency) was completed which included work around domestic abuse/violence awareness, help with a housing application (the mother was several thousand pounds in debt to a previous social landlord in Solihull) and benefits, self-esteem and confidence, coping with stressful situations without recourse to drugs and alcohol and parenting support. The Family Action worker (FAW1) would visit twice weekly for up to nine months. The mother said she was happy with this level of intervention.

78. Change Grow Live (CGL) received the referral from BSW1 for help in addressing the mother's substance misuse issues and the potential impact on parenting and the baby's wellbeing on the 02.11.16 and uploaded it onto the agency's case record. The referral highlighted historical substance abuse and did not indicate that ongoing abuse was suspected. A key condition for being accepted onto a CGL programme was that there should be ongoing substance abuse. In the mother's case there was no evidence for this, albeit self-reported.

79. BSW1 visited mother and baby at the female friend's home on the 03.11.16. The mother still needed to get a solicitor to assist her with the pre-proceedings meeting which was scheduled for the next day but believed she was not eligible for legal aid. The baby was observed to be suitably dressed for the cold weather.

80. The mother's situation was triaged by CGL on the 03.11.16 who assessed that she was not eligible for its service as the grounds were not met for intervention, namely that there was no evidence for contemporaneous substance abuse. She had self-reported not having taken alcohol since September 2015, cocaine since May 2016 and had obtained several negative drug tests since then. With hindsight, evidence from the Police enquiry and trial demonstrated that she was in fact continuing to misuse drugs (cocaine) and alcohol both during the pregnancy and post the baby's birth.

81. In any event, she was informed that she would not be offered any structured interventions but would be referred to 'Emerging Futures', an aftercare service. A worker would be in contact with her in due course to discuss options. The result of the triage meant that the mother would not be subject to any drug testing or receive intervention to understand the impact on her parenting of the baby, two key elements of the child protection plan.

82. BSW1 was informed by e-mail on the same day by CGL that the mother was being referred to the Aftercare, Phase 5 service.

83. Daily visits by the social worker and the community midwife in early November noted satisfactory progress being made by the mother in her care of the baby with no significant concerns noted. The mother attended a pre-proceedings meeting with Birmingham Children's Trust on the 04.11.16. She accepted the concerns and understood the expectations as set out in the letter before proceedings. She confirmed that she was willing to engage in the plan. BSW1 undertook a visit on the 07.11.16 and observed positive parenting from the mother. The baby appeared alert and relaxed in mother's arms and was putting on weight. Both the midwife and the (Solihull) health visitor (SHV1) had visited, as had the worker from Family Action. No concerns were noted by the midwife who observed that the baby had gained weight steadily; all baby checks were satisfactory and the baby was noted as 'pink and alert'.

84. SHV1 told BSW1 on the 07.11.16 that the mother would be allocated a Birmingham health visitor given that she was living at a Birmingham address. This person would attend the first core group meeting scheduled for the 09.11.16. The category of care was Universal Partnership Plus**.**[14] SHV1 had completed a safe sleeping assessment and the place of sleeping observed (a Moses basket beside a double bed). She advised the mother to remove a soft toy from the Moses basket. SHV1 noted no concerns regarding the baby or the mother. She shared all of the details with the allocated Birmingham health visitor (BHV1) via a telephone call immediately after the visit and the notes were transferred via child health to BHV1**.**

85. The mother cancelled the planned first contact with the Birmingham health visitor (BHV1) on the 08.11.16 with no reason given. A second visit was made the next day when BHV1 noted that the baby was 15 days old, was dressed appropriately and handled with care by the mother. The midwife was still visiting. BHV1 said that she was going to attend the first core group meeting but that it had been moved forward by an hour, unbeknown to her. BSW1 visited at the same time and confirmed that mother and baby would be moving to a temporary Solihull address, pending consideration by Solihull housing agency of a permanent move to a home within the local authority. BHV1 said that this would mean another transfer to the Solihull health visiting service in due course.

86. The first core group meeting was held on the 09.11.16 and attended by the social worker, the mother and the community midwife. CGL was not present because it had previously assessed on the 03.11.16 that the mother did not meet the criteria for a service and was therefore not a member of the core group. Mother and baby's imminent move planned for the next day to Solihull was referred to. There were no concerns noted about any aspects of the baby's care or development whilst in the care of the mother. Neither health visitor was present due to a mix up in times. Meanwhile a handover had again taken place between the Birmingham and Solihull health visiting services, the second time in only a few days. The new health visitor from Solihull was SHV2. BSW1 was notified of the change.

[14] This is part of the Healthy Child Programme (HCP) delivered by health visitors during pregnancy and the first five years of a child's life. There are four levels of service delivery. Universal partnership plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and where appropriate, the Family Nurse Partnership.

87. Mother and baby moved to the temporary Solihull accommodation on the 10.11.16, supported by the maternal grandfather. BSW1 visited the new accommodation the same day and spoke with the mother and the maternal grandfather about the move. The community midwife also visited and noted the mother to be coping with the support in place. Baby was gaining weight steadily. BSW1 visited the next day and said that he would assist the mother with the application to Solihull Community Housing for permanent accommodation. She had got into debt with her previous home because of the housing benefit change regarding having a two-bedroom property (when she was being assessed to care for her first child) and only her being in the home.

88. On the 12.11.16 CMW1 visited and noted the baby to be sleeping in the Moses basket with a regular and appropriate feeding pattern. Baby was examined with all checks normal.

89. A Birmingham social work assistant (BSWA1) visited on the 14.11.16 and saw the baby and the mother. The home was noted as clean, warm and tidy with no concerns raised.

90. On the 15.11.16 the GP (Birmingham/Sheldon) and the two health visitors from Solihull and Birmingham discussed the case at a GP liaison meeting. CMW1 visited on the 16.11.16 and noted that baby was 'pink and warm', with no concerns noted. CMW1 planned a full review for the next week. An entry was made on the 17.11.16 in the Solihull health visiting records that the baby was the subject of a child protection plan under the category of neglect to Birmingham.

91. The Solihull Multi-Agency Safeguarding Hub (MASH) received a referral on the 17.11.16 from Birmingham Children's Services requesting a receiving-in ICPC in regard to baby and mother, who were now living in Solihull. The request was initially refused because a housing assessment was being completed which provided for some uncertainty as to whether mother and baby would be eventually housed in the area. The later advice given to Birmingham on the 22.11.16 by the assistant manager of the Solihull Child Assessment Team was to wait until the outcome of the housing assessment, when it would be clear whether mother and baby were to become permanent residents in Solihull. Consequent to this, a decision would then be made by Solihull about a transfer.

92. BSW1 visited on the 18.11.16 and noted no concerns. The mother presented well with the baby asleep in the Moses basket. Family Action was due to visit that day to continue their work with the mother. Maternal grandfather had visited as per the safety plan and would continue to do so on a weekly basis. BSW1 mentioned that he had been in contact with Solihull Children's Services about transferring the case, given that mother and baby were now residing in Solihull and had applied for permanent accommodation in the authority. The mother was reminded that if she wanted any of her friends to have contact with the baby she should notify BSW1 so that he could carry out checks.

93. CMW1 made a final visit to baby and mother on the 23.11.16. No concerns were noted and the baby was recorded to be gaining weight. Checks were made and recorded as normal and baby was discharged into the care of the Solihull health visitor (SHV2).

94. On the same day BSW1 undertook an unannounced visit and noted that the mother had made some progress but that it was 'early days' and she needed to sustain it. She had

not yet started work with the substance misuse team in undertaking random drug testing and understanding the impact of drug abuse on the baby. It would seem that BSW1 was under the impression that this was still on offer from CGL. This was not the case as noted at the first core group meeting.

95. Mother and baby were seen by SHV2 on the 24.11.16. They were noted to be on Universal Partnership Plus and subject to a child protection plan. Passive smoking and safe sleeping were discussed. Baby was noted to be appropriately clothed with good emotional warmth between baby and mother observed.

96. On the same day, Birmingham Children's Services made a change of social worker from BSW1 to a senior practitioner, BSP1, due to the former deciding to leave at short notice.

97. On the 25.11.16 a statutory visit was done by a Birmingham social worker (BSW2) and a student social worker (BSSW1). The next core group was arranged for the 09.12.16 at the maternal grandparents' home. A pre-proceedings meeting was arranged at a local children's centre for the 14.12.16. Positive signs of care for the baby were noted. The mother was asked if she had heard from the drugs worker and replied no. BSW2 agreed to chase this up. It was noted by Birmingham Children's Services on the 27.11.16 that mother and baby had had several changes of professionals over the period.

98. BSW2 spoke on the telephone to a drugs worker (DW1) at CGL on the 29.11.16 and was told that the mother had been triaged on the 03.11.16. She had not been accepted for service or drug tested because she had claimed not to be using drugs or alcohol. She had been referred to 'Phase Five' aftercare.

99. SHV2 visited on the 30.11.16 and noted the baby to be sleeping on its back in the Moses basket and breathing regularly. BSW2 visited on the 02.12.16 and recorded that the home environment was clean and warm. The mother mentioned having seen her heath visitor a few days earlier and also the family support worker. Christmas plans were discussed when the mother asked BSW2 whether it would be possible to have a glass of wine over the festive season, albeit she knew that it was not part of the child protection/pre-proceedings plan. BSW2 said she would consult with her team manager. No concerns were noted about the baby's care. The mother was continuing to engage with professionals and provide for the baby's basic care needs, with evidence of provision of age appropriate stimulation via a baby play mat/gym in the living area.

100. BSW2 noted the following actions: firstly to contact CGL as a matter of urgency to determine when random drug tests could be carried out. This was despite being told by DW1 that drug testing was not agency policy for clients who claimed to be drug and alcohol free, and was made clear at the first core group meeting of the 09.11.16 Secondly, to ask the mother what her plans were about attending a drug support service and to signpost her to the 'Freedom Project'[15], regarding awareness around domestic abuse.

101. On the 06.12.16 the mother spoke by telephone with her GP (Solihull) about the baby's projectile vomiting after feeds and was later examined by GP1 who advised the mother

[15] A Birmingham domestic abuse/violence project.

to take baby to the paediatric assessment unit (PAU). The baby attended the PAU with mother (at Birmingham Heartlands Hospital) around 6 p.m. and was admitted overnight. The initial assessment of the baby omitted the check for safeguarding alerts despite being the subject of a child protection plan, although it was established that there was social work involvement with the family and that mother's first child lived with maternal grandparents. The accompanying GP letter did not mention that the baby was on a child protection plan.[16]

102. On discussion it appeared that the baby was being overfed, with additional features of reflux. A new plan was suggested of feeding two ounces every three hours with Gaviscon mixed into the feeds. Baby tolerated this well, was stable overnight and discharged the next day with a follow up on the weight by the health visitor. A GP and discharge letter was completed. The mother had previously text messaged BSW2 letting her know about the baby's vomiting and admission to the PAU.

103. SHV2 visited on the 08.12.16 and recorded that the baby was gaining weight along the 0.4 centile and feeding well. Baby was clean and dressed appropriately in a baby grow and had recently been registered with a local (Solihull) GP. Mother and baby were noted as making good eye contact and mother was observed as handling baby in a warm and loving manner with kisses and cuddles. There were no signs of the baby being in distress or injuries recorded. There was no mention made of the child protection plan.

104. On the 08.12.16 Solihull Children Services received confirmation that Solihull Community Housing had completed its assessment and had decided to assist the mother with obtaining permanent accommodation in the area. It was agreed by Solihull Children's Services management to convene a receiving-in ICPC for the 05.01.17.[17] The case was re-allocated to SSW1 (who had completed the original pre-birth assessment) to prepare an assessment for the conference. On the 15.12.16 SSW1 was informed by BSP1 that the case had progressed to pre-proceedings.

105. The second core group meeting was held on the 09.12.16. Baby was reported to be progressing well with no concerns noted. Mother was engaging well with agencies although Family Action announced that they would be finishing their involvement as mother was no longer a Birmingham resident. She was disappointed at this decision as she felt well supported by them. It also meant that the domestic abuse work - which was in its early stage - would finish. The meeting gave a safety score of 4 which indicated a degree of caution and remaining risk in the minds of the professionals.

106. The mother was not involved with a substance misuse agency to address her drug and alcohol issues since CGL had stated at the beginning of November that she did not meet their criteria for intervention. She agreed to refer herself to Solihull Drug Support

[16] Since June 2017, there has been a link between Heath and Birmingham Children's Services (now Birmingham Children's Trust (BCT)) records via CPIS (Child Protection Information Sharing), which provides for real time data sharing between health services and children's services. The information link enables any health professional to know when a child subject to a child protection plan or is looked after presents at a health resource. Additionally, for those children, an alert is sent out to the BCT social worker when an unscheduled health appointment is attended such as an accident and emergency or walk in clinic attendance.

[17] This was within the 15 working day timescale when weekends, public holidays over the Christmas and New Year period and the two extra Solihull Council days are taken into consideration.

Services (SIAS). The proposed Birmingham based community parenting assessment scheduled for mid-December was cancelled given the transfer of case responsibility to Solihull set for the receiving-in ICPC of the 05.01.17. No date was set for a further core group given the forthcoming ICPC in Solihull.

107. There was no evidence that the baby had been cared by anyone other than mother and maternal grandparents. However, it remained a concern that she was unwilling to share the identity of the baby's father, stating that he had chosen not to become part of the baby's life.

108. Baby and mother attended at the GP surgery on the 13.12.16 for the routine six -week medical examination. This is a thorough and essential part of the Healthy Child Programme that includes a physical examination, a review of development, an opportunity to give health promotional advice and an opportunity for the parent to express concerns. The baby's weight, height and head circumference measurements and centiles are recorded. The mother volunteered information about her history of drug misuse, domestic abuse, her first child being with grandparents and the child protection plan for the baby. The examination was satisfactory in all areas with no contra-indications for immunisation or any evidence of injuries or fractures to the baby.

109. The pre-proceedings plan review meeting was held on the 14.12.16 chaired by the team manager at Birmingham (BTM1). Progress with the plan was noted as was the withdrawal of services due to the move to Solihull and the lack of any involvement with drug services. The planned parenting assessment by Birmingham would now not happen due to the move to Solihull. No concerns were noted by professionals or the grandparents - with whom she had improved her relationship – in regards to the baby's care and development whilst with the mother, who had engaged well with agencies. There had been both announced and unannounced weekly visits by the social worker who had observed good attachment between mother and baby, who seemed to be thriving. Frequency of visits would lessen to once a fortnight, although still involve some unannounced ones prior to the transfer in early January 2017.

110. BSP1 undertook an unannounced visit on the 16.12.16 and reported positively regarding good care from mother to baby with a close attachment observed. The mother said that a good friend with alcohol problems had recently died and that she had thought about having a drink but had not. It was suggested that she refer to 'Healthy Minds'. The gap in services over the Christmas/New Year period was noted as was the intended closure by Birmingham Children's Services on case acceptance by Solihull on the 05.01.17.

111. BSP1 sent all relevant information via e-mail to Solihull Children's Services on the 17.12.16 in preparation for the ICPC of the 05.01.17. The baby received scheduled immunisations on the 21.12.16 as per the Healthy Child Programme. That afternoon SHV2 visited, noted the immunisations and weighed the baby who continued along the 0.4th centile. Given the timing of the medical evidence presented in court, it is possible that baby had already suffered one rib fracture prior to this time, albeit, as stated by the medical experts later in the trial, rib fractures can occur without any external signs. No concerns were noted and the ICPC of the 05.01.17 was mentioned.

112. On the 22.12.16 the GP contacted SHV2 to seek confirmation that the baby was still the subject of a child protection plan, having previously been notified to this effect by a letter from SHV2 on the 12.12.16. On the same day BSP1 undertook an unannounced visit and saw baby and mother to check on the baby's welfare and confirm the mother's arrangements over the Christmas period. The visit by SHV2 was mentioned by the mother as was the baby's weight gain. There were no concerns noted regarding the baby's health and development. Baby had been immunised, with the grandfather being in attendance along with the mother. Evidence of good attachment was noted by BSP1.

113. There were no concerns about home conditions although there was an ashtray full of cigarette stubs in the kitchen evidencing that the mother was smoking quite a lot. She said that she ensured adequate ventilation when smoking and kept the kitchen door shut. She mentioned receiving a visit from a Solihull social worker (SSW1) and family support worker (SFSW1) the previous day (21.12.16) to start the assessment. They had noted no concerns with evidence of generally positive care and attentive parenting. The mother said that she and baby would be spending Christmas day at her parents before returning home that evening. A key and very significant part of the meeting involved discussion with the mother regarding the details and expectations of the pre-proceedings plan, including the importance of abstaining from alcohol.

114. On Friday the 23 December, the last day of work before the Christmas/New Year holiday, SSW1 telephoned the Birmingham senior practitioner (BSP1) at 10.55 hours to say that she had started the assessment and had no concerns arising from the visit of the 21.12.16. However, she advised that an off-duty Solihull family support worker who had previously worked with the mother (during the assessments with her first child) had seen her on the 22.12.16 with the baby in a pub, drinking wine. She did not appear to be intoxicated although the incident was in breach of the pre-proceedings plan. Significantly, it happened only one day after she had given assurances to SSW1 that she understood the importance of not drinking alcohol and had promised to abide by the terms of the pre-proceedings and child protection plans.

115. SSW1 was advised at 16:00 hours by BSP1 that there were no concerns about the mother's day to day parenting. The family support worker would need to put her account in writing and that her observations could not substantiate that the mother was drinking alcohol. Nonetheless, it was concerning that she was visiting a pub, given her previous issues with alcohol. It was agreed that SSW1 would make a visit sometime the following week.

116. SSW1 visited mother and baby unannounced on Friday 30.12.16 on behalf of the Birmingham social worker, who was on leave. The mother said that the plan to be abstinent over the holidays was unrealistic, that she had drunk only one glass of wine and she had thought that she was allowed to have a drink over the Christmas period. Despite this, there were no other concerns identified by SSW1. This was the last visit by a professional prior to the baby's death.

117. The mother became registered with her Solihull GP on the 30.12.16.

118. On the 02.01.17 the baby was taken by ambulance at 15:06 hours to the emergency department of Heartlands hospital with a cardiac arrest. Resuscitation attempts were

unsuccessful, and the baby sadly died. The mother said that she had fallen asleep with baby on her chest and that she was not sure how long she had been asleep. She was arrested by the Police on suspicion of neglect of her baby and a criminal inquiry was started.

Part 4: Analysis

119. What follows, by reference to the fifteen key issues cited in Appendix 1, is an analysis of agencies' practice, decision making and actions taken that sought to protect the baby from harm and promote its wellbeing. It is informed by the available agency documentation, including the WMP addendum, in addition to the learning gained from the practitioners' learning event. Relevant findings, themes, conclusions and learning are set out in Part 6 below.

What was the quality of agency intervention in the pre-birth period?

120. Overall, there was good quality work done by the midwifery service as evidenced by the early noting, at six weeks pregnancy, of the mother's history of substance misuse and a full social and medical history taken at 12 weeks of her previous involvement with Solihull Children's Services regarding her first child, domestic abuse and substance misuse. The mother's risks to the unborn baby were well recognised by the midwifery service which resulted in the timely referral to the specialist midwife for substance abuse (SMW1).

121. The mother was advised of the dangers of foetal alcohol syndrome arising from her misuse of alcohol and SMW1 made an appropriate safeguarding referral to Solihull Children's Services. SMW1 was rightly persistent in her challenge made to the Solihull MASH regarding the referral and was successful in getting it accepted on the 01.06.16. The then existing policy of referral of the unborn child at 20 weeks has (according to information given at the practitioner's learning event) since been changed to a 12 weeks threshold; which in the Lead Reviewer's opinion, marks a significant positive practice development.

122. The mother's early denial of substance abuse was proven to be false by the positive urine toxicology test of the 27.05.16 which prompted SMW1's timely referral to Solihull Children's Services. This prescient act should have alerted professionals post the baby's birth to the need for regular substance misuse testing, which for various reasons, was not undertaken and thus presented a significant flaw in the child protection and pre-proceedings planning. Testing could have alerted professionals to the mother's deceitfulness.

123. Although having a place in a Birmingham hostel, the mother had given the midwifery service the address of a friend in Solihull where she had been temporarily staying. This was the address provided to the Solihull social worker (SSW1) who accepted the referral and started the pre-birth assessment on that basis. The friend subsequently died and the mother then moved in with a female friend and her two children in Birmingham, on a temporary basis. It was a month later, well into the assessment, that SSW1 established that the mother was staying with her female friend at the Birmingham address.

124. The evidence suggests that a thorough pre-birth assessment was completed by SSW1 who considered all of the mother's previous background history around substance misuse, domestic abuse, mental health issues and the three failed parenting assessments in regard to her first child. Contemporaneous risk factors around her use of cocaine, missed appointments with the specialist midwife, no fixed abode and her reluctance to name the father were also included and considered. In recognition of the substantive risks to the unborn baby of significant harm, SSW1 appropriately recommended the need for an ICPC and child protection plan. This was communicated in a timely manner on the 15.07.16 to SMW1.

125. SSW1 finished the assessment in mid-August which was signed off by her assistant team manager (SATM1) who concurred with the need for an ICPC and a child protection plan. However, given that the mother was living in Birmingham at the time of the assessment, had an open placement in the Birmingham hostel, had told SSW1 that she had no intention of obtaining a property in Solihull prior to the baby's birth and was in debt to the Solihull housing agency of £18,000 (and therefore not a good candidate for rehousing consideration), it was the collective view of SATM1, the local police and the Solihull Child Protection Unit that she was unlikely to be rehoused in Solihull. Moreover, there had been no involvement with the mother since her first child had been placed with the grandparents, some four years previously. By this rationale they came to the reasonable view that they had no professional or statutory authority to make the baby the subject of a Solihull child protection plan, hence the referral to their Birmingham counterparts.

126. Therefore, SSW1, having established that the mother was living in Birmingham with her female friend, made a referral to (the then) Birmingham Children's Services on the 31.08.16. The latter promptly accepted case responsibility on the 01.09.16, without demur and in a child-focused manner. A fresh assessment was started by BSW1 on the 05.09.16. SSW1 provided her pre-birth assessment to the Birmingham MASH on the 02.09.16 and closed the case shortly after. At the request of BSW1, SSW1 re-sent a copy of her pre-birth assessment on the 16.09.16.

127. By the 21.10.16, BSW1 had completed a good standard pre-birth assessment[18] that identified all of the relevant historical and contemporaneous risk factors[19], albeit apparently without sight of the earlier Solihull version as there was a delay in the document being sent to the social worker by Birmingham Children's Services Information and Advice Support Service (IASS). This was unfortunate as timely use of the Solihull document could probably have resulted in a Solihull Children's Services presence (SSW1) at the ICPC and, arguably, the Birmingham assessment could have been finished at the end of September. This would have given BSW1 more time to have arranged for an earlier ICPC and subsequent planning prior to the baby's birth, thus allowing suitable safeguarding and support arrangements to be in place, rather than holding the conference the day after the birth.

[18] Which, the Lead Reviewer learnt, was nearly exactly the same as the Solihull pre-birth assessment

[19] BCT Information report.

128. Albeit that the baby was born prematurely, child protection arrangements and pre-proceedings planning were somewhat rushed[20], which resulted in delays in the setting up of support services and drug testing arrangements for the mother. In this respect it would have been useful to have known the referral criteria for CGL, given the importance of drug testing for the mother and her self-reported abstinence which precluded intervention from CGL[21] and no drug testing. This proved to be a significant flaw in the later safeguarding plan.

129. In addition, the apparent difficulty in communication between Birmingham Children's Services and the Police in the request to hold a strategy meeting on the 06.10.16 did not help matters, albeit that intelligence on the mother's female friend was later provided by the Police for the ICPC.

130. In summary, the two local authority pre-birth assessments were of a good standard that accurately identified the risks and needs for the baby and the mother. However, there was a delay in IASS forwarding the pre-birth assessment to BSW1, this contributed to delays in holding the ICPC (this was a key recommendation from the Solihull pre-birth assessment), safeguarding planning, timely arrangements for support and risk management and SSW1's absence at the ICPC on the 26.10.16.[22]

131. The Review identified that BSW1 could have used the Solihull pre-birth assessment as the basis of his assessment given its inclusion of the known historical and contemporary risk factors for the baby. In short, the Birmingham assessment could have been completed quicker and in a timelier manner. The delays had knock on effects for the later safeguarding arrangements, particularly around robust drug testing for the mother.

132. A key lesson from this practice episode (and notwithstanding the problem of IT within Birmingham Children's Services at the time), is the need for effective liaison and communication between the two local authority social care teams in the timely sharing of, in this case, pre-birth assessments and working towards the making of timely safeguarding arrangements for the unborn child.

What were the reasons the substance misuse midwife objected to discharge planning? How was the situation resolved?

133. SMW1 objected to the discharge plan because of (i) Police intelligence suggesting previous domestic abuse and drug dealing at the home, and (ii) the very low conference safety score of 2 and high professional concerns (including those of the safeguarding midwife who was at the conference) arising from the ICPC.[23]

[20] Ideally, the pre-birth ICPC should be held at least 10 weeks prior to the date of the child's estimated date of delivery to enable sufficient time to be given to setting up suitable assessment and support services

[21] See appendix 3: National Institute on Drug Abuse, UK.

[22] The Review was told by the Birmingham Children's Trust review team representative that there were I.T communication problems within Birmingham at the time.

[23] No conferences are now held on a Friday because of the weekend risk possibility. Now, if the score is lower than 3 discussions are held with the relevant team manager and child protection manager.

134. The situation was resolved by SMW1 receiving an explanatory e-mail from the principal officer child protection, setting out the case and rationale made by the Birmingham Children's Services for the baby and the mother's discharge to the mother's female friend's home (see paragraphs 68-70). The community and hospital midwives were present at the discharge meeting and raised no concerns, agreeing to the plan. There was no further challenge from SMW1 who had recourse to the BSCB escalation process, but did not feel the need to use it.

Did agencies fully recognise the impact that drug and alcohol misuse and domestic abuse might have on day-to-day parenting capacity? Did members of the core group have a good understanding of domestic abuse and coercive control?

135. The mother's substance abuse issues and the potential impact on her parenting were well recognised both by the two local authority pre-birth assessments and at the ICPC. The minutes state that,

'*[The baby's] health and development could be affected by the mother's drug use and [the baby] may begin to suffer withdrawal symptoms in the next day or so. [The baby] was born with a very low birth weight and this could be a result of the mother using cocaine during the pregnancy. Further risks to [the baby] include exposure to risky adults who are dealing cocaine to [the mother], a lack of finances available to provide for [the baby] and the impact of drug use upon [the mother's] capacity to safely care for and parent [the baby].'*

136. The ICPC minutes asked:

'*Has [the mother] had intervention from drug/alcohol agencies? Is this needed now? Is [the mother] currently using drugs now?'*

The resulting outline child protection plan in its harm statement cited that:

'We are also worried that [the mother] sometimes drinks too much alcohol and takes illegal drugs which will affect her ability to make sure that [the baby] is looked after well enough and always has everything it needs'.

137. However, despite the clear recognition of the mother's substance and alcohol abuse as key risk factors (which was so tragically shown to be the case by the later evidence of the WMP enquiry-see above at paragraphs 24-31) to the baby, there was no explicitly specific agreed action set out in the child protection plan to address this factor, albeit there was a passing reference in the 'Safety Goal/Wellbeing Goal' section:

'It would be safer for [the baby] if [the mother] was working openly and honestly with everyone, including drug and alcohol support agencies and the mental health service and if [the mother] was making safer choices in respect of her relationships'.

138. As previously mentioned in paragraph 64, the ICPC resulted in a net safety score of 2 from the three professionals in attendance. Guidance at the time (Chair's Handbook – A Guide for Chairs for Child Protection Conferences and Other Meetings to Using the

Strengthening Families Framework. (2016)) did not give Chairs any specific direction regarding action to be taken on low scores. This guidance was updated in June 2019 and states that 'Where the score is 0-3 (very little safety) the Chair will need to have an immediate conversation with the Team Manager to address the level of risk and, where appropriate, request immediate safeguarding action to be taken.' Subsequent discussion by the Review Team felt that guidance should be revised to make it more explicit on the need to consider seeking legal advice.

139. In the event, a referral was made to Change Grow Live, a Birmingham substance misuse support agency, by BSW1 on the 02.11.16. However, as previously mentioned (paragraph 81), the mother's self-report to the triage worker indicated that she was not currently taking illegal drugs (cocaine) or drinking alcohol, which did not meet the acceptance criteria for a service,[24] thus precluding her from any structured intervention and drug testing, two key elements of the child protection plan.

140. BSW1 was advised via email (following a telephone call from the CGL worker who was unable to get an answer from BSW1) of the situation. Namely, that the mother had presented at the assessment as abstinent, thus indicating that a referral to an aftercare service for ongoing support to maintain recovery was the most appropriate service provision. In the referral from BSW1, it was stated that the mother had consented to drug testing. However, the CGL triage worker had highlighted in the email to BSW1 that the mother would not be subject to any drug testing from CGL or the aftercare service (Emerging Futures - the sub-contractor for delivery of aftercare provision and on-going recovery support), given that she would not be receiving any structured treatment.[25]

141. In a follow up conversation (December 2018) between the CGL report author and the worker, the latter said that had he spoken directly with BSW1, he could have explained the outcome of the triage assessment in greater detail. He could have asked the referrer about the specific concerns regarding the mother and discussed the service offer regarding aftercare. However, this did not happen as no further contact was made by BSW1.[26]

142. The CGL worker's assessment was confined to a focus on the mother's substance abuse issues and whether these fitted the service criteria. In retrospect[27] the worker, to his credit, has acknowledged that he should have shown more professional curiosity and explored what impact having a baby was having on the mother's abstinence and recovery, and explored in general how she was managing in her current circumstances.

143. In any event, the CGL worker made a referral to the aftercare service (Emerging Futures) on the 03.11.16 who stated that they did not receive the request; albeit that apparently, the mother's name was on the agency's client database and was contacted on the 19.01.17. Notwithstanding the referral, the mother's move to Solihull on the 10.11.16,

[24] CGL's decision not to accept the mother for a programme of structured treatment because she did not meet the service criteria was in line with the agency's commissioning agreement with Public Health (additional report dated 24.12.18 from CGL)

[25] Additional report from CGL dated 24.12.18

[26] Ibid.

[27] Ibid.

precluded her from receiving a service from Emerging Futures, given it was a Birmingham agency. Her Solihull location involved a self-referral to Solihull Integrated Addiction Service (SIAS) which she did not pursue, albeit she had had some previous involvement with Aquarius Action, part of SIAS.

144. The issue of relapse by individuals with substance misuse histories was usefully raised for the SCR Review Team by the author of the Heart of England NHS Foundation Trust information report. The author cited estimated rates of relapse for alcohol misuse at between 30% to 70% and other substances at above 60% (Drug Treatment in England: The road to recovery: National Treatment Agency: 2012).

145. Scientific and professional consensus suggests that alcohol and drug addiction cannot be cured but rather managed by a structured programme of intervention, involving the individual being sufficiently motivated to control their behaviour and being subject to regular unannounced drug testing. Without involvement in such programmes the likelihood of an individual modifying their behaviour and successfully controlling their addiction is minimal. Moreover, life stresses are acknowledged factors in either maintaining substance abuse or prompting relapse, with the birth of a baby being a known stressor.

146. The mother had received no intervention (during the period under investigation) from a substance misuse agency to address her drug and alcohol misuse, nor was she subject to regular drug tests. Therefore, the likelihood, in the opinion of the Lead Reviewer, of her not using alcohol or drugs before and after the baby's birth was minimal, despite the (apparent) negative testing for cocaine on discharge from hospital. Her two failed appointments with the substance misuse midwife in October 2016 were of concern and should have raised questions about her veracity regarding abstinence, particularly with regards to her history of non-attendance on eight previous occasions. In the opinion of the Review Team, this pattern of missed appointments should have raised professional curiosity around the rationale for non-attendance and the implications for the potential risk to the unborn child. A key learning point from this episode is that a missed appointment could be an indicator of substance misuse.

147. This issue has since been reinforced by the evidence from the Police enquiry of the mother's continuing misuse of cocaine and alcohol during the period under examination. Up until the 22.12.16 (when she was seen drinking wine in the public house) the mother was clearly adept at convincing professionals that she was not substance misusing.

148. Given the importance of the mother's involvement in a structured drug and alcohol programme and regular random drug testing as key elements in the child protection/pre-proceedings plans and their function as mitigating mechanisms in the management of risk to the baby, it is the Lead Reviewer's opinion that Birmingham Children's Services should have taken a more pro-active approach to the issue. Birmingham Children's Services should have ascertained beforehand whether CGL was a suitable agency to work with the mother, given its acceptance criteria and the decision not to take her in early November. Likewise, CGL should have been clearer about informing Birmingham Children's Services of its referral and client engagement criteria (viz, that it would not accept a client who self-reported drug abstinence). On learning of her move to Solihull, Birmingham Children's Services should have taken timely action to link her in with a

suitable agency (possibly SIAS) in order for the mother to show her willingness to change, address her substance misuse issues and agree to regular and unannounced drug testing.

149. However, the review learnt that the funding of drug testing was, at the time and continues to be, problematic in so far as social workers and team managers are required to seek agreement for such a resource request through an Area Resource Panel.[28] The apparent rationale for not doing so was an anticipation that the Panel would have declined random drug testing on the basis that the mother had had three negative tests (albeit, she had missed two), that there was no evidence from her presentation in regard to caring for her baby of any relapse, and that the case was due to be transferred to Solihull in early January 2017.

150. Notwithstanding the above, this SCR would agree with the statement from the Birmingham Children's Services (now Birmingham Children's Trust) agency report writer that *'if drug and alcohol testing had been carried out, it may have provided a different picture in terms of [the mother's] substance misuse'* and the attendant risks to the baby. Such knowledge could have been factored in to the overall risk assessment regarding the baby and informed future risk management planning and the pre-proceedings process.

151. In this regard, it is important for Area Resource Panels to be mindful (see paragraphs 144-147) of the extent to which parents and carers who claim not to be engaging in substance misuse may be in denial and cover up. Absence of evidence is not necessarily evidence of absence. A key lesson is for Area Resource Panels to be cognisant of the professional evidence of denial, dissembling and relapse by people with longstanding and entrenched substance misuse behaviour and adopt a robust, albeit proportionate, approach to practitioner requests for drug and alcohol testing.

152. Since the time of the baby's death, significant improvements have been introduced between Birmingham Children's Trust and CGL. These are that there is an effective triage which includes liaison between the social worker and the CGL triage worker, to explore and identify in detail, risk and need of the individual child. There are close working relationships between the child protection conference chair(s) and CGL, to ensure that any concerns raised at conference, including drug testing, are addressed.

153. Regarding the mother's history of being a victim of domestic abuse this was also well recognised by the ICPC as a key potential risk factor for the baby. It was explicitly noted in the ICPC minutes and an agreed action was included in the outline child protection plan that BSW1 was to make a referral to an appropriate domestic violence agency with the aim of engaging the mother in work that increased her awareness of domestic abuse and its impact on the baby.

154. This action was ineffectively implemented as the Child Protection Plan required the social worker to make a referral to an appropriate domestic abuse agency such as Birmingham & Solihull Women's Aid, and the referral was not made. Family Action had agreed to undertake work to increase the mother's understanding of domestic abuse to

[28] A panel of senior managers that gate-keeps access to private sector services such as random drug testing.

ensure that some support in this area was provided. Four out of the six sessions undertaken by Family Action were focused on the mother's needs and included discussion around domestic abuse and healthy relationships. Current relationships were not explored by Family Action as part of this work or by any other agency involved with the family, albeit that there is no evidence to suggest that the mother was in a current relationship. Additionally, there was no evidence of work done with the mother around exploring the impact of domestic abuse on the baby.

155. Family Action by its own admission should not have allocated a very complex case to a student social worker with limited skills around domestic abuse. Nevertheless, Family Action was not expected to continue with any domestic abuse work beyond the first two to three weeks of their involvement as the expectation was that a specialist domestic abuse agency was to take on this element of the Child Protection Plan. The Family Action report noted that a specialist domestic abuse agency could have been particularly helpful in this case and would have ensured that highly trained staff were leading on this area of the Child Protection Plan. Particularly, as Family Action had been allocated the case in order to provide support across a range of other issues with this family.

156. Indeed, this SCR submits that on this occasion, with this case Family Action (and CGL[29] in regard to substance misuse) was not the appropriate agency to undertake a complex piece of domestic abuse work with the mother[30]. Arguably, BSW1, should have ensured that the referral to a specialist agency was made, as required by the Child Protection Plan. However, it should be noted that at the time the resources offered were decided by the Area Resource Panel. This tended to allocate services based on existing availability and not necessarily on the basis of the identified need of a particular child and family. Arguably, these arrangements acted as a systemic barrier to matching the child's identified need with the appropriate resource. In the Lead Reviewer's opinion and within the context of the above analysis regarding Area Resource Panels, the service allocation of CGL and Family Action did not meet the needs of the baby and the mother within the context of substance misuse and domestic abuse.

157. Since then, the SCR Review Team understands that improvements have been made regarding a more needs-led service, as acknowledged in a recent Ofsted inspection: "*Assessments carried out by the ASTI service are completed within children's timescales, and in most cases are thorough, exploring background history, presenting issues and information from partners. When analysing children's needs, social workers make effective use of practice methodology, clearly identifying risk and protective factors, danger statements and safety goals that appropriately inform future actions. Management overview is evident, and the majority of assessments contain clear rationale for recommended action that is proportionate to children's levels of need."* Heads of Service reportedly now have a better grasp of the most concerning cases in their area. They are better placed to have discussions with social workers and managers

[29] The SCR learnt from the CGL Review Team member that the agency was undergoing some significant organisational change in 2016, involving the bringing together of around thirty separate drug and alcohol agencies in Birmingham, all under one umbrella. These changes may have led to a degree of misunderstanding in the mind of BSW1 and his manager regarding the role and remit of CGL in relation to drug testing and risk assessment of parenting.

[30] Family Action provides quality services for families experiencing complex domestic abuse.

to understand the child's individual identified need and match the appropriate agency resource that will meet the need and any risks and facilitate improved family engagement.

158. Likewise, there was an onus on agencies[31] to set out clearly to BSW1 (and Birmingham Children's Services) their respective competencies, expertise and referral criteria in relation to addressing the requisite risk issues identified at the ICPC and contained in the subsequent child protection plan.

159. The Review Team noted that the child protection plan involved manifold agency interventions taking place at the same time, which for someone like the mother with her history of difficulties and the fact of having just given birth to her baby, possibly put her in a position of feeling relatively overwhelmed by the demands of the plan.

160. In this case, how reasonable and realistic was it to have expected her (and others in a similar situation) to have engaged simultaneously with all of the strands of the child protection plan? In hindsight, perhaps some consideration could have been given to the action sequencing and prioritisation of the plan within a reasonable timetable. One that the parent could cope with and be more likely to engage in, rather than expect them to take on all of the actions at once and perhaps, in doing so, inadvertently setting parents up to fail.

161. Arguably, the identification of many risk factors that require change and resulting mitigating actions does beg the question as to whether it is actually unsafe for the child to be living with a parent without a better safety plan, including possible pre-proceedings and removal under a court order. In short, is the child protection plan safe?

162. Therefore, learning points from this episode suggests agency requirement to have proportionate and realistic expectations of parents, dependent on circumstances; and the need, where appropriate, for a degree of appropriate sequencing in the implementation of the child protection plan. Alternatively, is the presence of a plethora of risk factors and resulting actions an indication that it is inherently unsafe for a child to be with its parents/carers?

163. In relation to the core group there were no written records of the first meeting held on the 09.11.16 which is of concern. However, the evidence suggests from the two previous pre-birth assessments and the minutes of the Birmingham ICPC that there was a good appreciation and understanding of the potential risk for domestic abuse and the impact on parenting, which (as was noted in the minutes of the second core group meeting of the 09.12.16) had begun to be addressed by Family Action.

Did members of the core group consider mother's parenting skills and history in determining whether she would work openly and honestly with agencies?

164. The minutes of the second core group of the 09.12.16, noted that, since the baby's birth, there had been no concerns identified in relation to the care given by the mother. Indeed, the latter was noted to have presented as 'an attentive parent and has created a warm

[31] See note 29 in regard to CGL.

and comfortable home for *(the baby*) and herself'. It also noted a remaining concern that the mother had not been willing to share the identity of the father, stating that he had chosen not to become involved with the child's life. Whilst noting that the mother had started making significant changes to her lifestyle and associations 'the concerning history cannot be ignored and (*the baby*) should continue to be subject to a child protection plan/pre-proceedings plan, whilst (*the mother*) continues to engage with support services to address the concerns and evidence her parenting capacity'. There may have been some significance to the scoring of 4 by the review, thus indicating a degree of continuing professional caution and risk that was, arguably, not reflected accurately in the later risk management arrangements over the fateful Christmas and New Year period.

165. The evidence thus suggests that the professionals remained mindful of the potential risks to the baby, whilst being encouraged by the mother's apparent progress and engagement with aspects of the child protection plan. In retrospect, the evidence from the Police enquiry and trial showed that the mother was not adhering to a crucial condition, namely continued abstinence from drugs and alcohol. Arguably, the lack of regular drug testing went some way in enabling her 'to control the narrative' by constructing an image of an attentive parent meeting the needs of her baby and complying with the wishes and expectations of the professionals and the child protection plan. In that sense she was able to show a degree of disguised compliance towards the professionals. Her continuing concealed substance and alcohol misuse proved, tragically, to have been a critical factor in the death of her baby.

166. The core group was informed by the Family Action representative that the agency would finish its involvement with the mother due to the impending case transfer to Solihull[32], albeit that it would attend the receiving-in ICPC scheduled for the 05.01.17. Family Action's work with the mother and baby had been of some significance to the former who had, according to reports, engaged well, attended all of the seven sessions and experienced the intervention as supportive. The mother was reported to have been disappointed with this decision as she had developed a positive working relationship with the support worker and was keen to finish the programme of work.[33]

167. The ending of the service marked a withdrawal of an important source of support to and monitoring of the mother, thus increasing the potential risk to the baby, compounded by the additional potential risk[34] for the mother to engage in drug and alcohol misuse over the Christmas and New Year period.

168. The in-house (Birmingham Children's Services) parenting assessment was due to start in mid-December but did not happen due to the mother and baby's move to Solihull on the 10.11.16. There was an intention for a parenting assessment to be done by Solihull once the case had been taken on by them after the receiving-in ICPC set for the 05.01.17 which, due to the baby's tragic death, did not happen.

169. Thus, a third key element in the original Birmingham child protection plan did not happen.

[32] Family Action was not contracted to work in Solihull.
[33] See Part 5, Mother's views.
[34] Tragically, an actual risk.

What efforts were made to establish the paternity of the baby?

170. Enquiries were made with the mother regarding the baby's paternity by those undertaking pre-birth assessments in Solihull and Birmingham and also explored within the ICPC and pre-proceedings processes. The mother chose not to say who the father was although Birmingham Children's Services understood that there were two possibilities, including a married man who was said by the mother not to want any involvement with the baby. Birmingham Children's Services was keen to undertake a DNA paternity test but without confirmation about the father's identity was unable to do so.

Did mother give any indication that her relationship with the baby's father may still be ongoing? If so, how did agencies respond? Were agencies curious enough around this?

171. The evidence from agencies' reports and the subsequent Police enquiry did not indicate that the mother was in an on-going relationship with the baby's father or any other male, albeit that she was in the company of a male acquaintance on the day of the baby's death. [35] However, given her long-standing history of involvement in abusive relationships, there were continuing concerns from the Birmingham Children's Services social work team that she might enter into a future relationship where domestic abuse and coercive control were risk factors to the baby, thus needing to be assessed and managed. Hence, the condition in the child protection and pre-proceedings plans for the mother to inform Birmingham Children's Services of any new relationships.

Was there anything about the baby's presentation that indicated she was distressed or suffering abuse? If so, how did agencies respond?

172. There was no evidence presented to the SCR Review Team[36] to suggest that the baby showed any distress or had suffered any abuse up to the end of December 2016. The baby had been subject to frequent and regular visits from the Birmingham Children's Services social workers, latterly, the Solihull social worker, and the community midwife and health visitors from Birmingham and Solihull. The professional view was that the baby was developing within normal limits with good attachment and bonding to the mother who seemed to be coping reasonably well with her baby's care. At no time were there any professional concerns noted.

173. The baby's visits to the GP and Heartlands hospital in early December 2016 did not elicit any undue concerns around development, safety or wellbeing. The health visitor on the follow up visit noted that the baby was gaining weight along the 0.4 centile and feeding well. The second core group meeting of the 09.12.16 noted that the baby was progressing well with no concerns. No concerns were noted by the GP when the baby attended the surgery for a routine six-week examination on the 13.12.16. The baby was given immunisations on the 21.12.16 and seen by SHV2 in the afternoon with no

[35] N.B. The Police enquiry ruled out any involvement of the male in the baby's death.

[36] Notwithstanding the later Police enquiry and trial evidence that the baby had suffered a rib fracture sometime between the 13 to the 20 December 2016.

concerns observed. The baby was last seen by BSP1 on the 22.12.16 and SSW1 on the 30.12.16 with no concerns noted.

174. The Police enquiry and trial evidence suggested that the baby sustained a single lateral fracture to the 7th rib between the 13th and 20th December 2016, some ten to twenty days before death. The baby was therefore subject to an assault by the mother during this time for which the latter was found guilty of a S.20 wounding. These dates would have included the baby having been seen by several professionals during this period. However, there was no evidence that the baby presented with any obvious signs of distress to professionals and the rib fracture would not have manifested itself by any external signs of injury.

Did professionals consider the lived experience of the baby? Were they professionally curious*?*

175. 'Lived experience' is defined as '*Personal knowledge about the world gained through direct, first hand involvement in everyday events rather than through representations constructed through other people. It may also refer to knowledge of people gained from direct face to face interaction rather than through a technological medium'* (Oxford English Dictionary).

176. Clearly, the baby was not old enough to communicate to the various professionals about its experience of being cared for by the mother. Therefore, the baby's lived experience was mediated through the mother's self-reporting, which was positive. Arguably, it was in the mother's interests to have provided a positive narrative to the professionals. As shown by the later Police enquiry, the evidence (in hindsight) was that she pursued a convincing and successful 'disguised compliance' strategy regarding her substance and alcohol misuse.

177. As previously noted, there was frequent and regular visiting from and contacts with professionals in line with the child protection and pre-proceedings plans. These were mainly focused on the baby's health and development and how well (or not) the mother was managing her baby's needs and safety. There was no evidence of the mother having contact with any males and her parents who were seen to be supportive did not identify any concerns about the baby's care. The overall professional perception of the baby's care and development was positive as described in previous paragraphs. As previously mentioned, the mother had successfully masked her drug and alcohol misuse from the professionals and in hindsight had, to some extent, pursued a strategy of disguised compliance by presenting as a plausible individual.

178. As previously mentioned, there should have been more professional curiosity and challenge in respect of the mother's substance misuse, for both illegal drugs and alcohol. Suitable arrangements should have been made as part of the child protection and pre-proceedings plans for the mother to have undertaken a structured substance misuse and robust drug testing programme that was not dependent on self-reporting in regard to current use. There was no evidence of any challenge or response by Birmingham Children's Services social workers to the mother's request of having a glass of wine (made on the 02.12.16, see paragraph 99 above) over the festive season, albeit that there had only recently been a change in the social worker. The report of her drinking

wine in the pub on the 23.12.16 (see paragraphs 114-115 above) should have been addressed by the management of Birmingham Children's Services, albeit the timing of the pre-Christmas weekend was problematic.

179. There was a lack of professional curiosity shown at the baby's attendance at the Paediatric Assessment Unit (see paragraphs 102-103) regarding checks being made for safeguarding alerts. The baby was subject of a child protection plan at this time. Despite the mother informing staff of the involvement of a social worker no questions were asked about why and what for?

Were there any issues around communication, information sharing or service delivery that impeded agencies working with the family?

180. As previously mentioned at paragraphs 128-132, there was a delay in IASS sharing the Solihull pre-birth assessment in a timely way with BSW1. This contributed to delays in holding the ICPC (this was a key recommendation from the Solihull pre-birth assessment), safeguarding planning, and timely arrangements for support and risk management.

181. As mentioned at paragraph 64, the Solihull social worker (SSW1) did not attend the ICPC held on 26.10.16 due to the late receipt of the invitation. This was despite having made the transfer referral on the 31.08.16, sending a copy of her pre-birth assessment on the 02.09.16 and, at BSW1's request, resending it on the 16.09.16. is not fully known[37] why there were problems in BSW1[38] receiving SSW1's pre-birth assessment and the late invitation. SSW1's presence at the ICPC would have afforded an opportunity to have given the full historical background and findings of her assessment; albeit that these were similar to the Birmingham assessment provided for the ICPC.

182. There was a twenty-day gap between the ICPC and partner agencies (particularly health) receiving the outline child protection plan, which should have been done in five days and the minutes in ten days.[39]

183. A key issue was the mother's two moves between Solihull and Birmingham and back again. The resultant inter-local authority case transfers caused significant disruption in regard to the continuation and consistency of effective implementation of the child protection plan. Her move to Solihull on the 10.11.16, some nine days after the discharge from hospital, meant a change in health visitor and the later discontinuation of important Birmingham services such as Family Action who finished on the 12.12.16. The mother had found this service very supportive and it was not around during the critical Christmas/New Year period. The proposed Birmingham CS family assessment scheduled for mid-December, a key element in the overall child protection plan, did not occur due to the move. The absence of drug intervention and testing for the mother was

[37] Reportedly related to IASS (now CASS) transition and communication processes which were poor in 2016. Remedial action has since been reportedly taken within the CASS that has seen improvements, evidenced by frequent internal and multi-agency audits and Ofsted inspections.

[38] BSW1 was an agency worker who left Birmingham Children's Services on the 24.11.16. It has not been possible to speak with BSW1 to clarify the reasons why SSW1 did not receive a timely invitation to the ICPC.

[39] Now 48 hours for child protection plans and under negotiation for circulation of minutes.

in part a function of the transfer of case responsibility between the two local authorities and as already alluded to, was a very significant missing element in the child protection plan.

184. Compounding these difficulties was the precipitate departure of BSW1 on the 24.11.17. This would have added to the sense of discontinuity and lack of consistency in the case regarding trust relationships with professionals and the mother, the cohesiveness and knowledge of the core group and effectiveness of services in managing risk to the baby, albeit that there was adequate management case oversight.

185. Thus, the transfer from Birmingham to Solihull led to the cessation of services for contractual reasons[40], changes in key professionals at a critical time in the child protection plan and the diminution of its potential effectiveness.

186. In short, the Birmingham child protection plan never really took off, given BSW1's departure, the absence and withdrawal of the key elements mentioned above due to the proposed transfer to Solihull agreed on the 08.12.16 and the scheduling of the receiving-in ICPC for the 05.01.17. Between these two dates the plan essentially consisted of monitoring visits by BSP1, SHV2 and SSW1 pending the transfer of case responsibility to Solihull on the 05.01.17.

187. This case demonstrates the difficulties for agencies in safeguarding children in families who move rapidly across local authority and organisational boundaries. Differences in threshold and eligibility criteria for resources, service priorities and differing contracting arrangements with private and third sector agencies, within a context of financial constraints, can make for problematic case management and militate against the avoidance of delay, drift and disruption in assessment, planning and intervention.

188. Self-evidently, what is needed is a clear and effective transfer protocol, underpinned by a set of framework principles[41] that inform agreed inter-authority arrangements, protocols and processes that are child-centred,[42] promote case continuity, effective safeguarding, and minimise case transfer, disruption and delay.

Were the decisions taken in relation to case work by the two children's services departments' child-focused or resource led? Was the referral to Solihull Children's Services made at an appropriate time?

189. Solihull Children's Services acted in good faith by accepting the referral for a pre-birth assessment from the specialist substance misuse midwife (SMW1) in late May 2016. The mother had originally given the address of her male friend in Solihull to SMW1 who had passed this on to Solihull Children's Services, but at the time was actually staying with her female friend in Sheldon, Birmingham. This only became known to Solihull Children's Services some four weeks later on making actual contact with the mother in early July, by which time the pre-birth assessment had started. In the Lead Reviewer's

[40] i.e. The important family support service from Family Action.
[41] Ideally, West Midlands wide although it is recognised that this would be a very complex exercise.
[42] Ideally, the framework would also include vulnerable adults.

opinion, the decision to accept the referral (given the mother had stated a Solihull address) was both procedurally compliant and child-focused.

190. With the benefit of hindsight, it would clearly have been in the interests of the baby for the case to have remained with Solihull Children's Services rather than have been transferred to Birmingham in early September 2016. However, this SCR has sought to understand the rationale for decisions and actions taken by professionals within the prevailing circumstances of the time. On that basis, this Review would contend that the decision by Solihull Children's Services to transfer the case to Birmingham Children's Services in late August 2016 was reasonable and defensible.

191. An alternative, albeit in hindsight, scenario/option was that the pre-birth assessment would only have started in early July on making physical contact with the mother who was staying on a temporary basis with her female friend in Birmingham. Moreover, she had told SSW1 that she was not minded at that time to be rehoused in Solihull, had extensive housing debts and had had no involvement with Solihull Children's Services for four years. Given these circumstances with her location, arguably, Solihull could have contacted the Birmingham IASS and the two departments could have agreed that according to existing policy Birmingham would accept case responsibility for the pre-birth assessment and any subsequent follow up safeguarding actions. The mother's expected date of delivery was November and in early July there was a significant degree of uncertainty as to where she would eventually be living. Thus, it would have been reasonable for Solihull Children's Services to have made a referral to Birmingham Children's Services in early July. This may have led to an earlier ICPC and sufficient time for suitable safeguarding arrangements to be in place prior to the baby's birth in late October, rather than holding the ICPC the day after the birth.

192. However, even if this option had been pursued, the mother and baby's move to Solihull on the 10.11.16, the subsequent referral to Solihull Children's Services and its acceptance on the 08.12.16, cut short the Birmingham child protection plan and led inexorably to the disruptive outcomes mentioned above in paragraphs 186-188. Given these developments and (the then) existing inter-local authority arrangements, it is hard to see how continuity and consistency in implementing the original child protection plan and service delivery (mindful of the contractual arrangements of some agencies) could have been maintained and disruption avoided.

193. Once it became clear on the 08.12.16 that the mother and baby had been accepted by Solihull Community Housing for permanent accommodation in the district, Solihull Children's Services was obliged by regional procedures[43] to accept case responsibility and duly arranged a receiving-in ICPC for the 05.01.17, within the 15 working days requirement.

194. Therefore, within the terms of the existing regional framework, the referral by Birmingham Children's Services to Solihull Children's Services was procedurally compliant and timely. Whether it was child-focused remains a moot point and highlights the need to review the current regional transfer framework that locates the welfare of the

[43] Viz, West Midlands Regional Safeguarding Network, 'Protecting Children Who Move Across Local Authority Borders' (revised, January 2013). See chapters 8, 9 and 10.

child as paramount, particularly around the necessity for continuity and consistency of service.

Was the level of planned support and intervention during the period of transfer to Solihull in readiness for the 'receiving-in' Initial Child Protection Conference on the 05.01.17, appropriate for the level of need identified? Did the plan of support and intervention for mother over the Christmas/New Year period consider the maternal grandparents?

195. Mindful of hindsight and outcome bias, the complexities of child protection and the subsequent revelations of the Police enquiry regarding the circumstances leading up to and accounting for the baby's manner of death, this SCR submits that in relation to the Christmas/New Year period, the planned level of support underestimated the level of need and risk. The reasons are as follows:

196. Firstly, in the opinion of the Lead Reviewer there were several potential risk factors that objectively could have indicated the probability of raised risk levels over the said period. These included the possibility of the mother using drugs and engaging in alcohol over the Christmas/New Year period, at a time of reduced contact with agency professionals. This eventuality (which tragically actually happened) was compounded by the lack of any random drug testing, reliance on the mother's self-reporting of substance abstinence and no evidence of having taken any concrete steps to address her substance misuse through involvement in a structured programme. The contractual arrangements not allowing Family Action to continue working with the mother once she had moved to Solihull, the reduced social work and health visiting cover and the lack of a detailed safety plan over the Christmas/New Year period, also constituted additional risks and the raised possibility of an adverse incident arising for the baby. Compounding this was the crucial factor of the case being in a state of transfer between the two local authorities and the attendant risks this could present. Additionally, the objective research evidence (see Appendix 3) on the link between infants under one year old and the risk of non-accidental injury was never considered and factored in to the overall risk matrix.

197. Secondly, in all of the circumstances, it would have been reasonable to think that a dynamic multi-agency risk assessment[44] taking into consideration all of these factors, could have been undertaken by Birmingham Children's Services professionals and the core group. Such an assessment, in addition to considering the above, could have been underpinned by including the possibility of mother's disguised compliance[45], especially in light of her request on the 02.12.16 to drink over Christmas and the report of her drinking wine in the public house on the 22.12.16. On this basis, appropriate steps could have been taken to mitigate any identified risks to the baby by way of a risk management plan. There was no evidence that this took place, nor that the grandparents had been actively involved in the support arrangements over the period.

[44] Defined as 'The continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident', (Thornton. D (2002); Constructing and Testing a Framework for Dynamic Risk Assessment; A Journal of Research and Treatment; 139-153

[45] Albeit, in hindsight she was very plausible in giving the appearance of co-operation with the agencies.

198. In the opinion of the Lead Reviewer the safety plan should have involved enhanced multi-agency support and monitoring oversight by Birmingham Children's Services and the core group, including:

- Giving the mother a very clear follow up (from her query to BSW2 on the 02.12.16, see paragraph 99) message that under no circumstances was it acceptable for her to drink any alcohol or use illicit drugs over the holiday period. Any evidence of substance/alcohol misuse would be a breach of the pre-proceedings agreement and could result in the start of care proceedings.
- Family Action being enabled to continue its service provision until the receiving-in ICPC in early January 2017.
- Arrange for unannounced visits by Birmingham Children's Services professionals (if not the social worker then EDT) over the period until the Solihull receiving-in conference.
- Having a clear agreement with the maternal grandparents setting out in detail what their involvement would be over the period.
- Consideration by the Birmingham Children's Services/Solihull Children's Services team managers of the report of the mother drinking wine in the pub on the 22.12.16 and timely follow up.

199. Thirdly, the support and intervention level over the said time period was based upon an inaccurate perception of need and risk. It did not consider the prescient words of the principal officer child protection (POCP1) at the ICPC in the previous October (see paragraph 64 above). It was perhaps shaped by the succession of positive professional reports that led to an underestimation in the perception of risk to the baby.

200. That said, in the opinion of the lead Reviewer, it would have been unrealistic and unreasonable to have concluded that in all of the circumstances, the level of risk was such as to result in the death of the baby whilst in the care of the mother. There were no known antecedent indicators or evidence that this was a likely outcome and the mother's control of the narrative gave a convincing perception of an attentive parent who was meeting her baby's needs.

201. As later shown by the Police enquiry, the baby sustained the mortal injuries (notwithstanding the earlier serious, albeit non-mortal, rib fracture incurred between ten and twenty days prior to the death) some four to twelve hours before death, following the mother's imbibing of alcohol in the public house on the night of the 01.01.17 and later probable cocaine use. The combined effect of alcohol and cocaine can lead to violent behaviour, lack of impulse control, disinhibition and the taking of careless risks, depression; and the production of a poisonous bodily substance called cocaethylene.

'The combination of the disinhibiting effect of alcohol and confidence inducing cocaine with the addition of cocaethylene leads to a heightened possibility of impulsive or reckless behaviour and even violence.' (http://www.substance.org.uk/harm-reduction-information/cocaethylene-cocaine-alcohol)[46]

[46] See appendix 3 for details

Such a totally unsuitable situation combined with the demands of a two-month-old baby produced a set of highly dangerous circumstances that led to the catastrophic event of the assault and eventual tragic death of the baby.

202. The Police enquiry report included the opinion of the prosecuting barrister that *"The assault on [the baby] that caused [its] death undoubtedly represented an escalation of violence, perhaps reflecting the deterioration in [the mother's] emotional resilience, undermined by successive bouts of heavy drinking and cocaine abuse".* This SCR would concur with this view.

Part 5: The Mother's Views

203. In response to being asked by the Lead Reviewer what she thought of the services provided to her, the mother said that she could not fault them and that she had had previous experience of similar services during the time with her first child. She said that from the period when she was pregnant with the baby and involved with the midwifery service she understood why social services would have to be involved and that she was fine with that.

204. She felt that the First Birmingham social worker was good and supportive when she was in hospital at the baby's birth. It was a bit of shock when he left suddenly in November, one day he was there, then he was gone the next day.

205. The mother was asked about the issues around her drug and alcohol misuse. She said that alcohol was her main issue, although she admitted to 'dabbling' with cocaine. That was eight years ago and she did it as a way of coping with the domestic violence when she was with her first child's father. She said that she stopped drugs after her first child was taken away from her. She claimed also to have been teetotal for 18 months before the death of the baby and didn't have a problem with drink; she was able to drink socially. She had worked with an alcohol agency in Solihull for two to three years and has never had a problem since. She admitted to taking cocaine once in her pregnancy in May 2016. She did this to cope with the death of her male friend who was like a father to her.

206. She said that if social services had got her to undergo regular drug testing as they should have, they would have seen that she was not using. She had brought up the subject at every meeting and claimed not to have known why it did not happen.

207. Regarding the glass of wine at Christmas she said that this was agreed by one of the local authority children's services, but was not sure which one said yes and the other said no.

208. In regard to agency support she found 'Family Action' to have been very good and got on well with the allocated worker, particularly around her past history with men and issues of safety for her and the baby. '*It was gutting to have to stop it'*. She felt sufficiently supported in the transition from Birmingham to Solihull services, in addition to her family and friends and '*never lacked support'*.

209. In response to a question about the child protection plan she said that everything was ok and that she was willing to follow the plan. She said that she was open and honest with the professionals and that she worked with everyone as she did not want to lose her baby. She did miss a couple of appointments for drug testing but claimed to have been on holiday for one and was unwell for the other. If they had tested her, they would have known that there were no problems. She felt let down that the testing was not completed.

210. The mother said that drugs and alcohol were not a problem; otherwise she would have experienced prison by withdrawing and needing medication which was not the case. She did a slow reduction programme with the Solihull drugs programme involving one to one and group work, drinks diary, work on why we drank and completed a gradual reduction. She was told that if she did not stop drinking she would be dead by the age of 26.

Part 6: Key Findings and Lessons

211. There was no information or evidence available to the agencies and professionals involved at the time that would have led them to be able to predict the tragic outcome in this case. The mother must take full responsibility for the tragic death of her baby.

212. Effective work was done by the midwifery service in identifying the mother's substance misuse history and other early risk factors. A timely safeguarding referral was made to Solihull Children's Services who conducted a thorough pre-birth assessment that identified all of the relevant risk factors and appropriately recommended the need for an ICPC and a child protection plan.

Effective Inter-Authority Early Communication and Co-ordination Regarding Case Transfers

213. The two local authority pre-birth assessments were of a good standard that accurately identified the risks and needs for the baby and the mother. However, the lack of early and effective information sharing between Solihull Children's Services and Birmingham Children's Services, lead to a delay in the IASS forwarding the pre-birth assessment to BSW1. This contributed to delays in holding the ICPC (this was a key recommendation from the Solihull pre-birth assessment), safeguarding planning, timely arrangements for support and risk management and SSW1's absence at the ICPC on the 26.10.16.

214. The Review identified that Birmingham Children's Services staff could have used the Solihull pre-birth assessment at an earlier stage of the Birmingham assessment, given the latter's inclusion of the known historical and contemporary risk factors for the baby. If this had been done the assessment could have been completed quicker and in a timelier manner. The delays had knock on effects for the later safeguarding arrangements, particularly around robust drug testing for the mother.

215. Solihull Children's Services, believing that the mother was residing in Solihull, acted appropriately, in good faith and in a child-focused way in both accepting the referral from

the specialist substance misuse midwife (SMW1) in late May 2016 and completing the pre-birth assessment in late August 2016.

216. Birmingham Children's Services, in early September 2016, promptly accepted without demur and commendably took responsibility for, the mother and the unborn baby, in a child-focused manner.

217. A timely referral was made by Birmingham Children's Services to Solihull Children's Services in December 2016 which was child-focused and procedurally correct. Solihull Children's Services made a defensible decision to wait until the outcome of the housing decision on the 08.12.16 before accepting the referral.

218. ***Key Learning Point 1:*** *There is a need for effective liaison and communication between the two local authority social care teams in the early sharing of pre-birth assessments and the resultant working towards the making of timely safeguarding arrangements for the unborn child.*

219. The mother's moves between Solihull and Birmingham caused significant disruption to the continuity and effectiveness of the baby's child protection plan. The planned case transfer from Birmingham to Solihull in early January 2017 led to the cessation of important supportive services for contractual reasons and changes in key professionals at a critical time in the child protection plan.

220. This case shows the difficulties for agencies in safeguarding children where families move frequently and rapidly across local authority boundaries. Differences in threshold criteria for resources, service priorities, diversity in contracting arrangements with private and voluntary sector agencies and financial pressures, all make for a degree of complexity that result in a myriad of challenges to effective case management, especially regarding the avoidance of delay, drift and disruption in assessment, planning and implementation of child protection plans.

221. ***Key Learning Point 2:*** *The current (2013) regional transfer protocol did not meet the requirements of this case. An effective inter-authority transfer protocol should be developed that is child centred, promotes case continuity, effective safeguarding and avoids disruption and delay.*

222. In this regard, the review team understand that Birmingham Children's Trust and Solihull Children's Services are progressing a piece of work clarifying the arrangements for transfer across authority borders. It will seek to address the principles of such arrangements as well as agreed practice guidance. This will be further strengthened by regular liaison work at team manager level. These arrangements will apply to children in need and in care as well as those subject to child protection plans. When finalised, it is hoped that the arrangements will be adopted at regional level.

Professional Scepticism Regarding Substance-Misusing Carers and the Need for Structured Intervention and Clarity about Agency Referral Criteria and Regular Drug Testing

223. The mother's substance abuse issues and the potential impact on her parenting were well recognised at an early stage, both by the two local authority pre-birth assessments and at the ICPC.

224. Because of CGL's acceptance criteria, the mother did not receive any structured substance misuse intervention or drug testing, two very key elements of the child protection plan. She was expected to self-refer to SIAS on moving to Solihull, which given the lack of any intervention to address her substance misuse, was unlikely to motivate her into doing this.

225. A more proactive and robust approach within both the child protection plan and the pre-proceedings process should have been taken in ensuring that the mother engaged with a structured substance misuse programme that included regular and unannounced drug testing.

226. Caution should be taken by professionals when accepting the veracity or otherwise of parents/carers who self-report abstinence from drug and alcohol without any evidence, such as a successful completion of a structured substance intervention programme (along with a robust risk assessment) and/or regular, unannounced drug testing. In these cases, it is legitimate for professionals to be respectfully challenging with parents/carers.

227. The Area Resource Panel system was insufficiently needs-focused at the time of resource allocation regarding the child protection plan, particularly in relation to the commissioning of robust drug and substance intervention and testing for the mother. This has now been addressed whereby identified need and risk are matched by appropriate agency resource.

228. ***Key Learning Point 3:*** *Professionals and service commissioners should understand the addictive nature of drug and alcohol dependency and consider that without structured intervention and regular testing from an agency with clear referral criteria, the chances of a substance-misusing individual controlling such behaviour is minimal.*

229. ***Key Learning Point 4:*** *Effective partnership intervention for drug and alcohol dependent parents requires professionals to closely monitor parental engagement in structured intervention and the outcome of regular testing. Patterns of non-attendance at substance misuse appointments could be an indicator of substance misuse.*

230. ***Key Learning Point 5:*** *There was a breakdown in the continuity of substance misuse intervention and family support during the transfer between local authorities in late 2016. There is an opportunity to explore whether regional commissioning could enhance support for drug and alcohol dependent families.*

231. There was no parenting assessment done by Birmingham Children's Services in mid-December 2016 as per the child protection plan because the mother and baby were by then living in Solihull and awaiting a receiving-in ICPC.

232. Reasonable efforts were made by the two local authorities to try and establish the paternity of the baby. The mother chose not to disclose this. There was no evidence to suggest that the mother was in an ongoing relationship with the baby's father.

233. There was no evidence to indicate to the visiting professionals that the baby was in distress or was suffering abuse prior to 31.12.16.

Professional Curiosity, Respectful Challenge and Disguised Compliance

234. The baby was not old enough to communicate its lived experience to professionals, which was mediated through the mother's positive self-reporting. Professionals could have been more curious regarding the baby's admission to the PAU and being subject of a child protection plan. More robust challenges should have been made in regard to being tested for substance and alcohol misuse, particularly following eight missed appointments with the substance misuse midwife, not attending a structured programme and reports of her wine drinking before Christmas.

235. ***Key Learning Point 6:*** *The mother was able to plausibly present and project a narrative of an attentive parent who was meeting her child's needs. She successfully masked her drug and alcohol misuse from the professionals (albeit she had failed a drug test in May 2016 and missed six subsequent appointments for testing) and was able to pursue a strategy of disguised compliance.*

Dynamic Risk Assessment and Mitigatory Risk Management

236. Over the Christmas/New Year period the planned level of support, monitoring and risk management was not appropriate. It was based upon an inaccurate and static perception of need and risk and overly influenced by the positive professional reports that led to an underestimation in the perception of risk to the baby.

237. The ending of Family Action's support due to contractual reasons beyond their control, at a period of heightened risk just before the Christmas/New Year break, added to the discontinuity of support and monitoring, coming at a crucial time in the evolution of this case.[47]

238. ***Key Learning Point 7:*** *Social workers and other relevant professionals need to be mindful of disguised compliance and an over optimistic mind set. They need to be cognisant that risk and need in child protection are dynamic, contextual entities that are contingent on changing circumstances and of the need to develop suitable risk management plans commensurate with the assessed and accurate degree of perceived risk.*

[47] N.B See paragraph 230 above regarding pan regional commissioning.

Part 7: Professional Challenge and Action Planning

239. The Birmingham and Solihull Safeguarding Children Partnerships and relevant agencies should consider the above key findings and lessons. An appropriate action and implementation plan should be devised that results in lasting improvements to practice and services aimed at safeguarding and promoting the welfare of children in Birmingham and Solihull.

Glossary

BSCB/P	Birmingham Safeguarding Children Board/Partnership
BHV1	Birmingham health visitor 1
BSW1	Birmingham social worker 1
BSW2	Birmingham social worker 2
BSSW1	Birmingham student social worker 1
BSWTM1	Birmingham social work manager 1
BSWTM2	Birmingham social work manager 2 (covering manager)
BSP1	Birmingham Senior Practitioner 1
CMW1	Community midwife 1
CGL	Change Grow Live (substance misuse agency)
DW1	Drugs worker 1 (CGL)
DfE	Department for Education
FAW1	Family Action worker 1
BP	General Practitioner (doctor)
HMW1	Hospital midwife 1
IASS	Information Advice and Support Service
ICPC	Initial Child Protection Conference
LPM	Legal Planning Meeting
MASH	Multi-Agency Safeguarding Hub
MBC	Metropolitan Borough Council
PAU	Paediatric Assessment Unit
PLO	Public Law Outline
POCP1	Principal Officer Child Protection (Chair of ICPC)
SATM1	Solihull Assistant Team Manager
SCR	Serious Case Review
SGO	Special Guardianship Order
SIAS	Solihull Integrated Addiction Services
SHV1	Solihull health visitor 1
SHV2	Solihull health visitor 2
SFSW1	Solihull Family Support Worker 1
SMW1	Specialist midwife 1 for substance abuse
SMW2	Specialist midwife 2

SSCB	Solihull Safeguarding Children Board
SSW1	Solihull social worker
WMP	West Midlands Police

References

Brandon, M. et al (May 2016): 'Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014': Department for Education

Davies, F. et al: 'A profile of suspected child abuse as a subgroup of major trauma patients': www.emj.bmj.com/content/32/12/921

Drug Treatment in England (2012): 'The Road to Recovery': National Treatment Agency

Thornton, D. (2002): 'Constructing and Testing a Framework for Dynamic Risk Assessment; A Journal of Research and Treatment'.

RCPCH (February 2017): 'Child Protection Evidence; Systematic review on Fractures'

West Midlands Regional Safeguarding Network (January 2013): 'Protecting Children Who Move Across Local Authority Borders'.

Working Together to Safeguard Children: Department for Education: 2015

Process for Child Protection Conferences: Birmingham Children's Trust: June 2019

Escalation Guidance: Birmingham Children's Trust: June 2019

Appendices

Appendix 1

2.1 Purpose

The overall purpose of this SCR is set out in Government Guidance[48], namely to undertake a rigorous, objective analysis that will:

- "Look at what happened in this case, and why, and what action needs to be taken to learn from the Review findings.
- Action results in the lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.
- There is transparency about the issues arising from this case and actions which the organisations are taking in response to them.
- Including sharing the overview report with the public"

(Working Together 2015, 72)

2.2 Key Issues for Analysis

1. What was the quality of intervention pre-birth?
2. What were the reasons why the substance misuse midwife objected to discharge planning? How was the situation resolved?
3. Did agencies fully recognise the impact that drug and alcohol misuse and domestic abuse might have on day to day parenting capacity?
4. Did members of the core group have a good understanding of domestic abuse and coercive control?
5. Did members of the core group consider mother's parenting skills and history in determining whether she would work openly and honestly with agencies?
6. What efforts were made to establish the paternity of the baby?
7. Did mother give any indication that her relationship with the baby's father may still be on-going? If so, how did agencies respond?
8. Were agencies curious enough around this?
9. Was there anything about the baby's presentation that indicated it was distressed or suffering abuse? If so, how did agencies respond?
10. Did professionals consider the lived experience of the baby? Were they professionally curious?
11. Were there any issues around communication, information sharing or service delivery that impeded agencies working with the family?
12. Were the decisions taken in relation to casework by the two Children's Services Department's child-focused or resource-led?
13. Was the referral to Solihull Children's Services made at an appropriate time?
14. Was the level of planned support and intervention during the period of transfer to Solihull in readiness for the 'receiving-in' Conference on the 5th January 2017, appropriate for the level of need identified?
15. Did the plan of support and intervention for mother over the Christmas / New Year period consider the maternal grandparents?

[48] Working Together to Safeguard Children (2015): HM Government/Department for Education

2.3 Scope of SCR

The timeframe under examination was from 01.05.16, which included the pre-birth assessment process, to mid-January 2017, when the case was closed by Birmingham CS. The SCR was undertaken under the 'Working Together' 2015 statutory guidance as it was commissioned by the Birmingham Safeguarding Children Board (BSCB) in October 2017, prior to the publication of the current edition of 'Working Together', June 2018.

2.4 Methodology

The following documents, meetings and events have informed and underpinned this SCR:

- An integrated chronology of agencies' involvement and significant events;
- A briefing by the SCR Lead Reviewer/chair for the agency report writers;
- A reading and analysis of ten agency information reports by the Lead Reviewer and review team along with report writers on the 17/18 April 2018;
- Discussion and analysis at four review team meetings held in 2018 and May 2019;
- Learning event involving front line practitioners and managers held on 24 May 2018;
- Conversation with the mother;
- Reference to the fifteen key issues;
- A meeting on the 05.04.19 between the SCR chair and the WMP enquiry team to discuss the findings of the enquiry post-trial and agree on arrangements for the production of a written addendum to the original WMP information report of February 2018;
- Sight of all relevant documents;
- The adoption of a broadly systemic approach to the understanding and analysis of the case within an organisational context of professionals' actions and decision making at the time;
- Being mindful of hindsight and outcome bias; and
- A focus on learning and not blame.

2.5 The Review Team

The Review Team comprised of senior representatives from the following agencies:

SCR Review Team Independent Chair and Lead Reviewer	Mr Paul Sharkey
Change Grow Live	Safeguarding Lead
University Hospitals Birmingham NHS Foundation Trust	Head of Safeguarding

Birmingham Children's Trust	Head of Service – Child Protection
Solihull Children's Services	Acting Head of Service Safeguards and Quality Assurance
West Midlands Police	Detective Inspector Birmingham Child Abuse Investigation Unit
Women's Aid	Operations Manager

2.6 Lead Reviewer/Chair

The Independent Lead Reviewer and joint Review Team Chair was Mr. Paul Sharkey, MPA[49]. Mr. Sharkey undertook an SCR for BSCB in 2014/15 but since then has had no involvement with the BSCB or any partner agencies, including those involved in the SCR. He has a professional background in statutory and third sector safeguarding of over thirty years at senior management level. He has authored/chaired seventeen SCRs since 2002 and has attended several DfE/NSPCC courses on improving the quality of SCRs over recent years.

2.7 Confidentiality

In compliance with Government guidance, this SCR has respected the right to anonymity of the child, the family and the professionals involved in the case.

[49] Master's in Public Administration (2007) from Warwick University Business School.

Appendix 2: Risk of serious injury to and vulnerability of infants under 12 months old.

1. An omission in this case was any consideration of the very informative research into the raised risk of non-accidental injury to babies under one year old. One authoritative study (RCPCH: 2017) states that abusive fractures are more common in children less than 18 months of age than those older than 18 months. That multiple fractures are more suspicious of abuse than non-abuse and that rib fractures in the absence of major trauma, birth injury or underlying bone disease have a high predictive value for abuse. 80% of abusive fractures occurred in children younger than 18 months and that in children less than one year 25-56% of all fractures were abusive.

2. Another study (Davies, C. et al: 2018) identified non accidental injury (NAI) as a significant cause of injury in children under 2 years old, with 76.3% of severely injured children suffering trauma because of suspected child abuse, occurring in infants under the age of one. Brandon et al (2016) found that 'infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy' (p.40). 74% of the fifty cases on non-fatal physical abuse included in the Brandon study were aged under one year. (p62)

Appendix 3: National Institute on Drug Abuse, UK

Cocaine use during pregnancy is associated with maternal migraines and seizures, premature membrane rupture, and separation of the placental lining from the uterus prior to delivery. Pregnancy is accompanied by normal cardiovascular changes, and cocaine use exacerbates these—sometimes leading to serious problems with high blood pressure (hypertensive crises), spontaneous miscarriage, preterm labor, and difficult delivery. Cocaine-using pregnant women must receive appropriate medical and psychological care—including addiction treatment—to reduce these risks.

Babies born to mothers who use cocaine during pregnancy are often prematurely delivered, have low birth weights and smaller head circumferences, and are shorter in length than babies born to mothers who do not use cocaine. Dire predictions of reduced intelligence and social skills in babies born to mothers who used crack cocaine while pregnant during the 1980s—so-called "crack babies"—were grossly exaggerated. However, the fact that most of these children do not show serious overt deficits should not be over interpreted to indicate that there is no cause for concern.

Using sophisticated technologies, scientists are now finding that exposure to cocaine during foetal development may lead to subtle, yet significant, later deficits in some children. These include behaviour problems (e.g., difficulties with self-regulation) and deficits in some aspects of cognitive performance, information processing, and sustained attention to tasks—abilities that are important for the realization of a child's full potential. Some deficits persist into the later years, with prenatally exposed adolescents showing increased risk for subtle problems with language and memory. Brain scans in teens suggests that at-rest functioning of some brain regions—including areas involved in attention, planning, and language—may differ from that of non-exposed peers. More research is needed on the long-term effects of prenatal cocaine exposure.

Impact of Cocaine use on Individual: Information from Frank UK – advice site for Substance Misuse

Powder cocaine (also called coke), freebase and crack are all forms of cocaine. They're all powerful stimulants, with short-lived effects – which means that they temporarily speed up the way your mind and body work, but the effects are short-lived. Both 'freebase' cocaine (powder cocaine that's been prepared for smoking) and 'crack' cocaine (a 'rock' like form of cocaine) can be smoked. This means that they reach the brain very quickly, while snorted powder cocaine gets to the brain more slowly.

All types of cocaine are addictive, but by reaching the brain very quickly freebase or crack tend to have a much stronger effect and be more addictive than snorted powder cocaine. Injecting any form of cocaine will also reach the brain more quickly but this has serious additional risks, including damaging veins and spreading blood borne viruses, such as HIV and Hepatitis C.

Here are the main effects and risks of taking cocaine:

- It can make you feel on top of the world, very confident, alert and awake, but some people can get over-confident, arrogant and aggressive and end up taking very careless risks.
- It raises the body's temperature, makes the heart beat faster and reduces your appetite.
- When the effects start to wear off, people experience a long 'comedown', when they feel depressed and run down. This crash can happen for days afterwards.

Information from NHS, England regarding Alcohol misuse in pregnancy

- When you drink, alcohol passes from your blood through the placenta and to your baby.
- A baby's liver is one of the last organs to develop and doesn't mature until the later stages of pregnancy.
- Your baby cannot process alcohol as well as you can, and too much exposure to alcohol can seriously affect their development.
- Drinking alcohol, especially in the first three months of pregnancy, increases the risk of miscarriage, premature birth and your baby having a low birth weight.
- Drinking after the first three months of your pregnancy could affect your baby after they're born.
- The risks are greater the more you drink. The effects include learning difficulties and behavioural problems.
- Drinking heavily throughout pregnancy can cause your baby to develop a serious condition called foetal alcohol syndrome (FAS).
- Children with FAS have:
    - poor growth
    - facial abnormalities
    - learning and behavioural problems
- Drinking less heavily, and even drinking heavily on single occasions, may be associated with lesser forms of FAS. The risk is likely to be greater the more you drink

Impact of Alcohol use on the Individual

The effects of alcohol can include:

- Reduced feelings of anxiety and inhibitions, which can help you feel more sociable.
- An exaggeration of whatever mood you're in when you start drinking.
- A wide range of physical health problems, either as a result of binge drinking or from more regular drinking. The problems caused by alcohol include high blood pressure, stroke, liver disease, cancers and falls and other accidents.

Mixing cocaine and alcohol

This combination can produce a poisonous substance in the body called coca-ethylene that may affect your heart and stays in your system longer than cocaine alone. Mixing cocaine, a stimulant, with a depressant like alcohol can hide some of the other effects of the cocaine. This makes it easier to overdose as you take more to achieve the same high.