MSCP SCR Briefing sheet

Serious Case Review Baby Harris – March 2021

Until September 2019 Local Safeguarding Children Boards undertook Serious Case Reviews (SCRs) when a child dies or has been seriously harmed, and abuse and/or neglect are suspected or known to be a factor, and/or there are concerns about how local agencies worked together. The purpose of such reviews is to learn lessons and improve practice. These reviews have been replaced by local Child Safeguarding Practice Reviews.

This publication, produced by the MSCP, aims to share the learning from the Baby Harris SCR to allow professionals to reflect on their own practice. The full overview report is published on the MSCP website.

Trigger event

In 2019 emergency services were called to the home address in response to a report that Baby Harris' parents thought he was dead. The parents told the ambulance staff that Baby Harris had been asleep in the parent's bed. He had last been fed at 3 am or 4 am and seemed "fine". He was later found unresponsive.

The home was observed by the ambulance staff as unusually warm. The home was described as "cluttered and messy", 8 empty wine bottles were observed in the bin and both parents smelt of alcohol and their appearance was described by the ambulance staff as "dishevelled".

Observations of Baby Harris' body indicated that he had been dead for some time before emergency services had been called.

The baby's older brother, Child A (then aged 6 years old) was in the family home at the time of the death. When the police searched the property, they found hardly any clothing or items in the home for him. The family of four were living in a one bedroomed flat.

Summary of known background

The father of Baby Harris, W, experienced adverse childhood experiences. From a young age, he was exposed to domestic abuse, between his mother and father, which resulted in him being the subject of a child protection plan. He was referred to the local Child and Adolescent Mental Health (CAMHS) as a child. Throughout his teenage years he suffered from depression and anxiety, he struggled to manage his anger and took an overdose in 2014. The support offered by CAMHS ended when W turned 18 years old. He was advised to go to his GP for ongoing support. There was no transition plan and his prescription for anti-depressants was not renewed.

Before starting a relationship with W, the children's mother was married to B. Together they had four children, the youngest of which is known as Child A. The mother had no known background history of alcohol and/or drug misuse before meeting the father of Baby Harris, in June 2018. There is an age difference of 18 years between the father and mother of Baby Harris, the father being the younger of the two adults.

Child A was born in April 2013. Mother did not access all the expected antenatal services from the midwife. Child A was seen by a health visitor on a couple of occasions but did not have his 6-8 week developmental check, 2.5 year review or a review of his readiness to access education. Child A was discharged from the health visiting service as it was considered that he had "transferred to school", meaning school health nursing services. Child A was not enrolled at a school and only started school some 15 months later. Child A was not registered with a GP between June 2017 and July 2019.

W was reviewed by a psychiatrist in November 2016 and it was observed that he suffered from an emotionally unstable personality disorder, a mental and behavioural disorder due to cannabis use and queried a mixed personality disorder. A forensic assessment was recommended but was not undertaken. In early 2017 he was involved in three assaults, one of which involved him being arrested. Following a further referral for a forensic assessment he was seen and was offered a Support Time Recovery (STR) worker, although a forensic assessment never undertaken. As a result of not engaging he was discharged from the service in 2018. Thereafter the only source of support available to W for his mental health needs was from his GP. His unsafe use of alcohol since February 2018 did not trigger a referral to substance misuse services.

There were three domestic abuse incidents in 2018 between W and mother. The first incident was the first time services were aware of their relationship. In the third incident, mother called the police to W's flat where they were both living. He was holding a large knife to his chest, threatening to stab himself in front of the mother. Child A was at home at the time.

An anonymous referral was made to Kent Police about substance misuse and child A not being in school or

registered with a GP. A visit by a social worker was made for assessment and mother informed them she was pregnant. A further anonymous referral was made to Kent police in late 2018 where concerns were shared that a child was being exposed to drug use. Police officers made an unannounced visit to the home address and saw no evidence of drug-taking. They saw appropriate clothing and toys for Child A. The assessment concluded that there was "no evidence of harm" to Child A. There was no assessment undertaken in respect of the unborn baby.

Child A's attendance at school dropped and the school made a referral to the Attendance Advisory Service to Schools and Academies (AASSA) and children's services. In March 2019 mother did not attend a pre-proceedings meeting due to child A's continued poor school attendance.

In April 2019 a further referral was made to the community mental health services by W's GP but it did not result in the provision of any services from the community mental health team, as records showed that he was still open to the service, no new assessment was triggered

In May 2019, mother was seen at home by a midwife. This was due to having missed 5 antenatal contacts. W was not seen on this visit. The midwife completed the Did Not Attend (DNA) checklist which is designed to identify risks. Baby Harris was born in May 2019 in hospital. The mother and Baby Harris were seen by a midwife three times. The mother was advised against co-sleeping with Baby Harris. No concerns were noted about the home conditions or the care of Baby Harris.

When asked about alcohol or drug use and domestic abuse by the health visitor, mother did not disclose any information to indicate these factors were present. Child A was reported to be well and in school.

In June 2019 Baby Harris died. After his half sibling's death, Child A made disclosures of assaults on himself and his mother.

Family and practitioner input into review

Baby Harris' parents contributed to the review and a meeting was carried out with Child A's father. The involvement of the family was important and led to the development of two of the recommendations. Their views have been captured in the main body of the report.
One practitioner event took place involving professionals from health visiting, the school, police officers, an attendance agency and children's services.

Identified good practice

The review highlighted the following areas of good practice:

- the police response to the request of a welfare visit was an excellent example of professional curiosity and child-centred approach
- the social work assessment showed some professional curiosity by seeking information from the wider family
- attempts by the AASSA to do a home visit and contact children's services to gather information about the family

Findings and learning

In this case, the key few reachable moments, which could have facilitated a robust grasp of the risks the children were exposed to, were obscured across the Partnership by:

- high caseloads
- a lack of access to and understanding of the family's history
- a collective poor understanding of the cumulative effects of neglect
- a complex operating model of health services making it difficult for professionals to know who to ask for information or where to make referrals for services
- barriers to effective information sharing between midwifery professionals and children's services
- a lack of "think family" approach when responding to W's mental health issues
- transitions between the health visiting and school nurse services that are not designed to 'hold' vulnerable children
- provision of health visiting services that practitioners felt posed potential risks to vulnerable children, due to health visiting responsibilities being shared between community nurses and health visitors.
- practitioner exposure to poverty and poor housing conditions that were accepted as the 'norm' for this area of Medway
- Ineffective tracking systems between the local authority Admissions Service and the school resulting in Child A's absence from compulsory education not being identified and followed up.

Recommended service improvements

The recommendations most relevant to front line practice are:

- The partnership to seek assurance regarding how the lived experience and voices of children living in neglectful circumstances, are heard and reflected in assessments and plans.
- Embedding learning about the impact of risks associated with poor adult mental health, adult substance misuse, domestic abuse and the importance of engaging families and male carers in assessing risk.
- The importance of understanding family history and how this influences the interventions that are offered to children and their families.
- The partnership to seek assurance about the current model of health visiting
- The importance of holding children at critical transfer points
- The partnership to seek assurance about the availability of services for parents that are experiencing depression and anxiety, but are not presenting as suffering from acute mental health issues.