



Serious Case Review re Baby K

**An independent review undertaken on behalf of
Buckinghamshire Safeguarding Children Board**

Executive Summary

**James Blewett
May 2015**

Acknowledgements

In undertaking this serious case review and producing this report the author would like to acknowledge the participation and contributions of the Mother, Ms A, professionals involved in this case, members of the Review panel, the chair of the review and the staff at Buckinghamshire Safeguarding Children Board.

1 Introduction

1.1 On 14th May 2014 Baby K's grandmother telephoned Thames Valley Police on 999 and stated that Baby K's mother, Ms A had rung her and said that one of her one month old twins, Baby K had died at Ms A's address. An ambulance attended the address and confirmed that the baby had died.

1.2 Buckinghamshire Safeguarding Children's Board (BSCB) decided to undertake a Serious Case Review on 27th June 2014. An independent chair and multi-agency panel were appointed and worked with an independent reviewer, the author of this report, in order to complete this review. Each agency provided an individual management review, covering their own agency's involvement. The independent reviewer also interviewed a number of staff individually as well as meeting collectively with many of the practitioners and managers involved in the case.

1.3 The independent reviewer also met with Baby K's mother in order that she had an opportunity to contribute to the process.

1.4 The following terms of reference were agreed by the Serious Case Review Panel of BSCB. The questions the review was asked to address were:

- i. To establish what assessments, including those relating to mother's mental health and alcohol dependency, were undertaken and the quality of those assessments
- ii. To establish what risk factors were identified in relation to the unborn babies and whether appropriate procedures were followed
- iii. To establish what risk factors and needs were identified in relation to the twins after their birth
- iv. To establish if plans were implemented and to what extent the plans addressed any risk factors identified in the assessments
- v. To establish whether practitioners understood the thresholds for intervention – from Early Help through to Child Protection
- vi. To establish if agencies shared information appropriately and involved other professionals or agencies as necessary, including adult services
- vii. To establish if there were factors which enhanced or impeded working relationships with the parent/s
- viii. To establish to what extent the parenting capacity of the parent/s was considered and addressed
- ix. To establish if the diversity needs within the family were identified and addressed
- x. To establish if there were any capacity issues within agencies that impacted on the quality of the services provided
- xi. To establish if staff involved had the skills, knowledge and experience to address the issues within the family

- xii. To establish if staff within agencies co-operated to achieve the best outcomes for the children
- xiii. To establish to what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies
- xiv. To establish if staff directly involved had appropriate supervision and managerial guidance
- xv. Individual Management Review Report writers to identify any additional issues for consideration by the Overview Report writer

1.5 The Coroner's inquest into Baby K's death was held on 28th January 2015. This hearing could not determine cause of death and the Coroner advised Ms A that she will never know how her baby died.

2 Findings

2.1 It is not possible to say whether Baby K's was an avoidable death. The Coroner found at an inquest on 28th January 2015 that the cause of death could not be determined and indeed concluded that the cause would probably never be established. The Police investigated Baby K's death and the Crown Prosecution Service concluded that there would be no criminal proceedings in this case. This review is conscious therefore that the inconclusive outcome of the coroner's inquest can, for Baby K's mother in particular, only compound the tragedy which has occurred.

2.2 The focus of a serious case review is the way that services were delivered to children and their families and the learning that can inform future practice and service development. In this regard it is important to recognise that there were a lot of services provided for this family. In contrast with many other serious case reviews, Ms A and her children did not pass "under the radar". On the contrary a wide range of agencies were significantly involved throughout the period of the review.

2.3 It appears that much of this work was appreciated by Ms A. In particular good support was evident from practitioners in adult mental health, midwifery, the Police, the first GP, the children's centre and, on a practical level, the social worker. The medical care that the children received both ante-natally and post-natally was also of a good standard despite, in the case of the former, Ms A finding it difficult to engage with services on occasions.

2.4 Indeed this review found that there was much good practice with this family from many of the agencies involved. In particular the persistence and commitment demonstrated by professionals, especially in adult mental health and midwifery, when Ms A was regularly missing some of her appointment is to be commended.

2.5 It is arguable that the referral to Children's Social Care should have come earlier. Both the Police and adult mental health had information that raised concerns about how Ms A would cope as a parent from early September. However it is the view of this review that overall this did not compromise the potential support for Ms A. Had Children's Social Care engaged in early December when the referral was made, there was still a lot of time for undertaking a thorough assessment and some robust care planning.

2.6 In terms of case management there was weak professional leadership from Children's Social Care and the complete lack of an appropriate assessment. The one that was carried out was undertaken using an out of date template and timescales were not adhered to. It appears that there was very little exploration of some of the core issues regarding alcohol and the impact of past trauma and Ms A's longer term mental health difficulties.

2.7 Children's social care did not allocate a sufficiently experienced social worker to this case to carry out this work and the team (now called units) dealing with the family were all newly qualified social workers. This lack of experience was compounded by the workers not being sufficiently supervised and this was not in line with the expectations of the Assessed and Supported Year in Employment (ASYE) which is a national scheme to support newly qualified workers.

2.8 However, beyond the local authority's ASYE programme this case does raise questions as to how robust the unit system that had been implemented in Buckinghamshire is when there is a weak manager and newly qualified staff. Indeed this case highlights many of the weaknesses in local practice that were described in OFSTED's inspection of the department which was published in August 2014. This case illustrates that organisational reform does not in itself improve practice.

2.9 These conclusions about weaknesses within Children's Social Care are consistent with the findings of OFSTED when they inspected children's services in the same period as covered by this review. Indeed many of these weaknesses are common to other local authorities and reflect the impetus for the reform agenda currently being implemented in Children's Social Care across the country. The BSCB will want to be assured that ongoing changes in Buckinghamshire children services and their partner agencies are leading to improved practice.

2.10 Midwifery in particular did try to raise concerns about this apparent inaction by Children's Social Care but in general there was an over reliance on Children's Social Care as the lead agency and an assumption that because they were involved the concerns about Ms A's vulnerability that were apparent to all agencies were being addressed.

2.11 The other agencies involved were receiving information which raised safeguarding concerns especially adult mental health. Although these were acknowledged in the work with Ms A there did not appear to be sufficient communication of these with Children's Social Care, even when they were involved after mid-January 2014.

2.12 As with most serious case reviews the learning that was gathered in the *process* of undertaking the review did yield recommendations for all of the respective agencies that took part in the process. Whilst few of these would have had a significant impact on the overall management of this case they are nevertheless important and can make a positive difference to safeguarding practice in Buckinghamshire.

3 Recommendations

8.1 Children's Social Care

8.1.1 Ensure there is a framework for measuring and reporting the frequency and quality of supervision and that action is taken where requirements are not being met.

8.1.2 Ensure there is a framework for measuring and reporting working conditions in the unit and that action is taken where risks are identified.

8.1.3 Ensure there is a local protocol for assessment agreed with BSCB (in accordance with requirements set out in Working Together).

8.1.4 Ensure that local authority undertakes a lead role in developing and implementing CIN Plans and that these are being managed by a suitably experienced Social Worker.

8.2 Thames Valley Police

8.2.1 Thames Valley Police to continue the work of the Protecting Vulnerable People Strategy Unit to establish which risk assessment tools are currently being used within Thames Valley Police in relation to Adult Safeguarding, and identify a consistent approach to be adopted. This should also include research in relation to the approaches adopted by other police organisations.

8.2.2 Thames Valley Police to raise awareness amongst front line staff in relation to their responsibility to obtain informed consent from adults subject to an 'Adult Protection incident' to share their information. This should utilise a targeted approach (feedback of non-compliance to supervisor of officer) and include amending policy and guidance.

8.2.3 Thames Valley Police to liaise with the NICHE¹⁰ team to establish the viability of introducing a template within the notes field (Officer Enquiry Log) of an 'occurrence' to prompt the Police Enquiry Centre staff responsible for creating Adult Protection incidents to record specific information, such as whether the vulnerable adult has consented to information sharing.

8.2.4 Thames Valley Police to ensure that Local Police Area command teams are aware of the multiagency training available through their local LSABs and ensure that sergeants from the Neighbourhood Policing, Patrol, Force CID and Protecting Vulnerable People departments are enrolled on Adult Safeguarding courses.

8.2.5 Thames Valley Police to remind officers investigating rapes and other relevant offences of the need to consider obtaining Early Investigative Advice and record the rationale if the decision is made not to.

¹⁰ Thames Valley Police's Record Management System.

Independent reviewer comment: Although these recommendations are primarily relevant for working with vulnerable adults they are nevertheless very pertinent and should be shared with the Buckinghamshire Safeguarding Adults Board.

8.3 Children's Centre

8.3.1 Request for support form to be adapted to require referring agency to inform Children's Centre of changes in family circumstances.

8.3.2 Health Visitor contact details to be recorded and used, including when family registered outside of Children's Centre catchment area.

8.3.3 Children's Centre Coordinators to check information from Membership & Family Information Form is accurately recorded on Indigo, the centres recording system.

8.3.4 Children's Centre Coordinators to ensure staff undertake regular refresher training to confirm understanding of and compliance with their roles and responsibilities at all stages of the safeguarding process.

8.3.5 The profile and credibility of Children's Centres to be raised across all agencies.

8.4 Buckinghamshire Healthcare NHS Trust (Maternity)

8.4.1 Training for midwives on improving the quality of social care referrals.

8.4.2 Audit to be undertaken of "buff folder" guideline.

8.4.3 Work within safeguarding team to be coordinated by the midwives.

8.5 Buckinghamshire Healthcare NHS Trust (Neonatal Unit / Health Visiting)

8.5.1 An overview to be undertaken in regard to Health visiting and Neonatal services to determine a clear understanding of record keeping practices and how this has to improve.

8.5.2 Ensure clinical staffs within the Neonatal Unit and Health Visiting service have an understanding of mental health and alcohol misuse and its impact on parenting and application to practice.

8.5.3 Neonatal Unit staff and Health Visitor's to access Safeguarding and child protection supervision as per BHT Safeguarding and Child Protection Supervision Policy.

8.5.4 To ensure good information sharing between Maternity, Neonatal and community Services.

8.6 Oxford Health NHS Foundation Trust

8.6.1 To increase attendance of Buckinghamshire adult mental health staff from Oxford Health NHS Foundation Trust at Child Protection and Child In Need Conferences. Child protection case conference reports to be submitted to ensure information is shared formally with other services and reports are uploaded to the patients' electronic record.

8.6.2 Psychological services to identify a safeguarding lead/think family champion to raise awareness of the national "Think Family" agenda. An identified safeguarding lead to attend think family to safeguard network meeting and share relevant items at team

meetings.

8.6.3 To review the referral process between Psychological Services and AMHT to ensure clear accountability of who holds the risk between referral and allocation of cases.

8.6.4 Introduction of new Trust electronic health record to ensure easy documentation of dependants and recording of safeguarding children concern.

8.6.5 Identification of risks to unborn babies, children and effective management plans to be in place to be incorporated into mandatory Safeguarding Children training and mandatory Clinical Risk and Management (CRAM) training.

8.7 General Practitioners (GPs)

8.7.1 Re-circulate information about BSCB Pre-birth procedures with training to reinforce GP professional responsibility within the procedure.

8.7.2 Remind GPs that unborn babies are potentially children in need

8.7.3 Highlight that it is good practice to make early communication with receiving surgery (if details are known) when a vulnerable patient moves surgery.

8.7.4 Ensure that GP records clearly link all family members on their computerised notes.

8.8 SMART

8.8.1 SMART to undertake a review of their child protection systems in terms of ensuring that staff recognise the importance of reporting information that has implications for children (include unborn babes) to their managers and other professionals.

8.8.2 SMART to undertake review of management systems to ensure the passing on of such concerns is not solely reliant on individual practitioners especially as volunteers also work in this project.

8.8.3 SMART to undertake a review to ensure that policies and procedures are being adhered to where work is undertaken in an outreach capacity

8.9 Board level (independent reviewer)

8.9.1 The Board to establish a multi-agency working group with a view to reviewing the effectiveness of its procedures around pre-birth assessments. This review should focus on referral process, nature and timescales of assessments by different agencies, thresholds for child protection plans, pre- and post-birth support.

8.9.2 The Board needs at a strategic level to urgently consider the multi-agency management of Children in Need cases as it appears that at present these cases are receiving at best a very uneven service or in some cases no coordinated service at all.