Serious Case Review re Baby K

An independent review undertaken on behalf of Buckinghamshire Safeguarding Children Board

Overview Report

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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, the 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 decided to undertake a Serious Case Review on 27th June 2014. Working Together to Safeguard Children (2013) states that:

"A serious case review should be undertaken for every case where abuse or neglect is known or suspected and either:

a child dies; or

*a child is seriously harmed and **t**here are concerns about how organisations or professionals worked together to safeguard the child;"*[2]

1.3 The Board agreed that this did reach these criteria and in order to undertake the serious case review appointed a chair, Gillian Stimpson, a multi-agency panel and an independent reviewer (the author of this report). It was agreed that the Review would seek to publish its report in March 2015.

1.4 Most serious case reviews involve difficult and distressing situations and this is such a situation as it involves the death of a baby. It is important to reiterate at the outset that this report does not in any sense seek to allocate blame or in any way re-assess the case. Instead it will focus on the way that services were delivered and whether there is learning that can improve local services and practice. 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 Working Together to Safeguard children page 60

2. Basis of the report and methodology

2.1 Working Together (2013) does not prescribe a specific methodology for carrying out reviews. Instead it sets out a set of principles that reviews must adhere to. That is that reviews must:

- Contribute to learning and improvement
- Be proportionate in their methodology
- Be undertaken by an independent reviewer
- Fully involve professionals
- Give families the opportunity to contribute
- Be produced in such a way that they are suitable for publication
- Ensure improvement is sustained so that the findings make a real impact on improving outcomes for children and young people[3]

2.2 The Department for Education argues that if these principles are adhered to the review will in effect be following a *systems methodology*, a further requirement in Working Together. Such an approach was also a key recommendation within Professor Eileen Munro's Review of the child protection system.[4]

2.3 The Board therefore decided that in the first instance a *proportionate* approach would be for each agency to undertake an individual management review and single agency chronology. There was an expectation that the authors of these reports would inspect all case records held by their agency and interview staff who knew the family. It was also agreed that as part of these reports each agency would generate recommendations for their respective agencies. The twins were Ms A's first children and her contact with agencies was relatively limited prior to the review period. It was agreed that the multi-agency panel and independent reviewer would appraise each of these reports and it was agreed that the independent reviewer could then also interview any key professionals and see any documents that he considered particularly pertinent to establishing the findings of the review.

2.4 The independent reviewer has had access to individual management reviews from:

- Thames Valley Police
- Oxford Health Foundation NHS Trust
- General Practitioners (GPs)
- Buckinghamshire County Council Children's and Families Service
- Buckinghamshire County Council commissioned Children's Centre
- Buckinghamshire Healthcare NHS Trust - Maternity
- Buckinghamshire Healthcare NHS Trust - Neonatal Intensive Care Unit / Health Visitor

[3] Working Together 2013 P.66
[4] Munro, E (2011) a Child centred system

There were also shorter reports from

- Chiltern District Council
- Paradigm Housing
- SMART (drug and alcohol services)
- South Central Ambulance Service
- Wexham Park Hospital
- MIND
- Bucks Floating Support

2.5 In relation to the *involvement of staff*, as well as being interviewed within the single agency reviewing process, the professionals were brought together by the independent reviewer and chair of the review. This was in order for the independent reviewer to share his interim findings and test out the emerging hypotheses regarding professional and organisational behaviours and issues around this case. The purpose of the event was also to provide an opportunity for staff to express their views, correct factual information if there were any errors but also crucially to add to the review's understanding of the latent conditions around professional practice. That is, what were the contributory factors in terms of professionals' "mindsets and the local rationality" with regard to practice with this family?[5] The Department for Education has stressed the importance of serious case reviews attempting to establish *why* events might have occurred as opposed to simply describing them. This meeting was attended by 24 front line practitioners, who met the family on at least one occasion, and their managers. The Police, Children's Social Care, midwifery, General Practice, adult mental health (inc psychological services) and children's centres were represented.

2.6 In terms of the *family engaging in the review* the author met with Ms A who kindly shared her views of the services that she received during the period covered by the review.

2.7 In relation to establishing terms of reference for this review, Buckinghamshire Safeguarding Children Board agreed the following questions that the serious case review should interrogate:

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

The Board agreed that timescale for the active period of review is from the notification of the assault on Baby K's mother on 2nd June 2013 to the date of death of Baby K on 14th May 2014.

2.8 The author of this report, the independent reviewer, has worked in children's services for 30 years and been a registered social worker for 22 years. He spent much of his career working in front line social work teams and also worked in CAMHS. He currently combines his role of independent social worker with working at King's College London in the Social Care Workforce Research unit and has written and researched extensively in the area of work with vulnerable families. Much of this work has involved looking at multi agency systems and how they work to protect children. He has undertaken a number of reviews for a range of Safeguarding Boards over the past nine years.

3. Background: the family's story

Family composition

Name	Gender	Relationship	Date of birth	Ethnicity
Baby K	**Female**	**Subject**	**04/04/14**	**Not known**
Baby X	**Male**	**Twin sibling**	**04/04/14**	**Not known**
Ms A	**Female**	**Mother**	**Aged 38**	**White British**
Ms C	**Female**	**Maternal Grandmother**	**Aged 59**	**White British**
Ms B	**Female**	**Maternal Aunt**	**Aged 42**	**Not known**

3.1 It is not necessary for the purposes of this review to provide a detailed social history of Ms A and indeed the individual management reviews only contained limited information in this respect. Nevertheless what information is available suggests that Ms A had a difficult early life. The details of this are not clear from case records but her parents separated when she was a child. She had an older sister, Ms B who went to live with their father. Ms A, however remained living with her mother. Over the years Ms A has not always had an easy relationship with her mother although there have been periods when she has been an important source of support.

3.2 Despite this difficult childhood Ms A appears to have functioned well in much of her adult life. She lived abroad for ten years and for a short period had her own business.

3.3 However, the difficulties that became apparent in the period covered by this review were present beforehand. The GP report states that Ms A had sought help for panic attacks and alcohol use in 2007. There was also reference to past cocaine use. Ms A did not engage with services offered and so there is little further detail about her difficulties at this time.

3.4 The traumatic event that has had such a big impact on Ms A in recent years occurred in March 2010. Ms A made a complaint (later in June 2013) that she was drugged and raped by three men, one of whom was an acquaintance. As a result of this Ms A became pregnant and had a termination in May. The period that followed was very difficult culminating in Ms C calling the Police 999, worried about her daughter's safety in terms of her self-harming. In the next 18 months there were a number of incidents involving the Police and alcohol, the most serious of which was Ms A crashing her car when under the influence of alcohol. Ms A presented to her GP and was referred to psychological services. At the time and subsequent to this there was a belief that Ms A was using alcohol as a way of coping with the trauma. Throughout this period her sister and Mother do appear to have had some presence in Ms A's life but Ms A has consistently reported that she does not have a close or easy relationship with either party.

3.5 The situation appears to have reached crisis point in June 2013, at the starting point of this review when, after another crisis that involved alcohol, Ms A disclosed to the Police for the first time about the incident in 2010.

3.6 It would seem that it was around this time that Ms A became pregnant. She has disclosed very little information about the father other then it was only a very brief relationship and that he was married with another family.

4. Chronology of significant events

Date	Detail	Comment
09.03.10	Ms A was victim of rape. Not reported to police until 2013	This was an incident after which Ms A made a complaint that she was drugged and raped. Criminal investigations are ongoing
May 2010	Termination of pregnancy which was result of rape	
28.05.10	Mrs C rings 999 expressing Ms A was not responding to calls, was very 'low' and had recently had a termination	Ms A tells police that she is 'fine'
23.01.11	Ms A arrested for drink driving having crashed her car	
07.02.11	Ms A referred to CMHT for assessment	Ms A reported as drinking heavily but no concerns re self-harm. The referral would appear to come from her GP at the time
October 2011	Ms A registers with GP1	
22.06.12	Ms A referred to CMHT by psychological services (Healthy Minds)	
10.12.12	Ms A seen by psychological services for initial assessment	This takes place after Ms A has missed a number of appointments
23.01.132	Ms A discharged from care of mental health services (CMHT)	This takes place after a number of further missed appointments
31.01.13	Ms B presented at the reception of the psychiatric unit expressing concerns about her sister's mental health and level of drinking	Staff advise Ms B to encourage Ms A to see her GP
02.06.13	**Review Period begins**	
02.06.13	Ms B calls Police concerned that her sister, Ms A, is going to 'slit her own throat'	When officers attend Ms A is under influence of alcohol. Ms A discloses that she had been raped on her birthday 3 years ago
03.06.13	Ms A attends GP1 with her sister saying she is desperate for help, drinking heavily and having panic attacks	Mental health services (CMHT) undertake emergency assessment later that day and they feel services could play valuable role if Ms A engages. Referred to psychological services.
12.06.13	Psychological services undertake screening. Ms A expresses wish to engage and is ready to address post trauma and alcohol issues	Ms A had been referred previously but not engaged. Belief that alcohol issues may need to be addressed first
10.07.13	Ms A met specially trained Police Officer re rape complaint	
05.08.13	Ms A attends psychological services in very distressed state	Further appointment made for week later that she does not keep

29.08.13	Ms A attends GP1 and reports possible pregnancy	Discloses past trauma and expresses desire to reduce heavy alcohol consumption
30.08.13	Scan reveals twin pregnancy	
16.09.13	Ms A seen at home (by request) for booking in appointment	Vulnerability recognised and placed under care of consultant. 9+5 weeks pregnant
18.09.13	Ms A seen by consultant psychologist	Consultant recognises Mother's vulnerability and feels she is 'at risk' – isolation, alcohol, complex PTSD, possible homelessness. CMHT asked to reopen case
18.09.13	Ms A referred to safeguarding midwife	
01.10.13	Following further missed appointments psychological services write to Ms A advising CMHT will be in touch	
02.10.13	Ms A attends police station and makes a statement re the alleged rape in 2010	This takes place after several attempts but on each of these occasions Ms A said that she was either not ready or missed the appointments
02.10.13	Ms A calls ambulance because of vaginal bleeding. Taken to local hospital but soon discharged	
October 2013	At some point in this month Ms A attended the drop in at SMART and disclosed that she was drinking 1 – 2 bottles of wine a day and has been doing so for some years	This information was not recorded or passed on to other professionals by the worker at SMART
11.10.13	Ms A discussed at CMHT team meeting and appointment made	
21.10.13	Social worker from CMHT meets Ms A for needs assessment	Ms A very positive about pregnancy. Main stressor is housing
25.10.13	Ms A calls police on 999 because of vaginal bleeding. Call passed on to ambulance service who attend	Ms A taken to hospital but soon discharged
01.11.13	Ms A met with a psychiatrist for an assessment	This assessment identifed the same risk factors as on 18.09.13. Ms A now 15 weeks pregnant. Notable that there was no referral to Children's Social Care at this point
05.11.13	Ms A missed ante-natal appointment	GP1 followed this up
06.11.13	Ms A informs CMHT worker during home visit that she is to be imminently evicted but re-housed by Chiltern Housing	Ms A reported to be low in mood an to have high anxiety during this meeting. She expressed concern about how she would cope with motherhood
15.11.13	Home visit by CPN to Ms A	It is agreed that Ms A will re-book missed scan. It is apparent that Ms A is very short of money and using a food bank
19.11.13	Further visit by CPN who refers to Bucks Floating Support	
25.11.13	Care Plan overview for Ms A with	Many areas identified that are

	CMHT	relevant to parenting capacity but there is no reference to possible Children's Social Care involvement
28.11.13	Ms A did not attend ante-natal appointment. Midwife attempts to make contact with Ms A	Midwife checks with Children's Social Care to ascertain whether case is known to them (it is not)
29.11.13	Ms A moves to new address	
03.12.13	Midwife visits Ms A at new address	Mother denied drinking since booking appointment. Mother now 19 weeks pregnant.
03.12.13	CPN and mental health social worker visit Ms A. Ms B also present	Ms A, when challenged by sister, admits she is drinking alcohol regularly
04.12.13	CMHT contact SMART to discuss CMHT encouraging Ms A to attend further drop in sessions	
05.12.13	Midwife makes referral to First Response in Children's Social Care	
06.12.13	Midwife refers to children's centre	Introductory meeting arranged but no CP or CIN concerns raised
09.12.13	Children's Social Care decide professionals meeting should be arranged and pre-birth assessment undertaken	
11.12.13	CMHT receive telephone call from SMART who say they are going to refer Ms A to another alcohol service OASIS	
13.12.13	Ms A sees consultant obstetrician who notes that Ms A is under care of psychiatrist. Ms A referred to midwife for vulnerable women	
17.12.13	Assessment closed in First Response	This was with a view to one of the longer term teams undertaking an assessment. Case allocated to appropriate team.
17.12.13	Midwife contacts CPN to arrange a multi-agency professional's meeting in early January	
17.12.13	Distressed call to mental health social worker by Ms A complaining of broken washing machine and social isolation	
19.12.13	Mental health social worker speaks to Ms B who agrees to support her sister	
30.12.13	Midwife contacts social care to find out what has happened to referral as she has had no response yet	Provided with name of social worker who has now been allocated
03.01.14	Midwife contacts health visitor to inform her of professionals meeting	Difficult to be clear from records but it would appear this meeting is being jointly organised by social worker and midwife
07.01.14	Although assessment has not taken place, social work records describe Ms A as being vulnerable mother who is overwhelmed by current difficulties	Summary by manager

08.01.14	Case allocated to children and families social worker	
08.01.14	Police interview Ms A as a witness	
10.01.14	Joint home visit by health midwife and children centre worker to introduce Ms A to children's centre activities	
13.01.14	Professionals meeting held	Good multi-agency representation and an agreement that social worker will undertake pre-birth assessment. Case discussed by social worker at her unit meeting (group supervision)
17.01.14	Ms A attends Parents Craft Group at the children's centre	
24.01.14	Ms A attends Parents Craft Group at the children's centre	
24.01.14	Social worker meets with Ms A and gathers some social history. Later that day the children centre worker also visits (separately)	During this visit children's centre worker hears about a social work visit but does not follow up and enquire as to the nature of Children's Social Care's involvement
28.01.14	Ms A discussed at joint midwifery / social care meeting at the hospital	Meeting advised that Ms A was unknown to Children's Social Care (untrue). Ms A now 27 weeks pregnant
04.02.14	Psychiatrist recommend to GP1 that he prescribe Imipramine for Ms A's fluctuating moods	
05.02.14	Social worker supervised and agrees to complete pre-birth assessment	Supervisor advised that she needs to explicitly address smoking and alcohol issues
7-24.02.14	Number of calls between social worker and Job Centre attempting to resolve benefits issue	There do not appear to be conversations about some other key issues in the assessment especially regarding alcohol consumption
28.02.14	Ms A seen at ante-natal clinic by safeguarding midwife and consultant	Discussion re delivery method. Ms A now 32 weeks pregnant
04.03.14	Social worker supervised by manager	Social worker reports that Ms A is no longer drinking, is smoking and is anxious. Nevertheless situation perceived to be positive. Manager advises pre-birth assessment needs completion and CIN meeting needs to be organised
11.03.14	Midwife called Children's Social Care to arrange further professional's meeting but was advised social worker was off sick	
13.03.14	Community midwife rang Children's Social Care expressing concern that initial assessment had not yet been carried out	Midwife rang the following day and was informed that a locum was covering the case
17.03.14	Allocated social worker (back from sick leave) visited Ms A with colleague who was going to chair CIN meeting	
19.03.14	Home visit by CPN. Ms A appeared to	

	be in good spirits	
25.03.14	Some correspondence between the children's centre and social worker as to what the children's centre could offer Ms A once the children were born	A number of areas of support identified. It appears that each party is now aware of each other's work
26.03.14	Psychological services informs Ms A that her case is being closed as she has not engaged since 09.01.14	
27.03.14	'pre-birth assessment summary' from Children's Social Care system describes support / agencies involved	It does not appear to include an assessment of Ms A's parenting capacity
27.03.14	Children in Need meeting held (as later described in social work records)	Significantly no minutes of this meeting were kept and some other agencies did not understand it to be a CIN meeting, simply a multi-agency network meeting
01.04.14	Home visit by CPN	Ms A describes progress of the Police inquiry which is a great source of stress. Ms A also worried about level of professional involvement re her capacity to parent
04.04.14	Twins born by elective Caesarean	Babies admitted to neonatal unit
08.04.14	Telephone conversation between neonatal nurse and children's social worker	Neonatal nurse expresses concern about Ms A's bonding and attachment to the babies
08.04.14	Further discussion takes place between neonatal nurse and CMHT	In these conversations nurse expresses concern that Ms A is 'flighty' and unreliable at present re feeding routines. Ms A has agreed to stay in hospital with the babies (although unhappy about this)
09.04.14	Series of phone conversations between children's social worker and health professionals	Neonatal nurse still expresses some concerns about how well Ms A is engaging with caring for her children. Also reported that Baby K has conjoined toes
09.04.14	Health visitor registers twins with GP2	
10.04.14	Twins discharged home	Social worker ascertains from neonatal unit that twins are medically fit for discharge, that Ms A has been more engaged in their care and that her mother, Mrs C, will stay with her
11.04.14	Children's social worker drops off 'red books' to Ms A and confirms babies are well (Mrs C also present)	
15.04.14	Home visit by CPN. Midwife was also present	Daily visits by midwifery service
17.04.14	New birth health visitor appointment took place at home	
22.04.14	Unannounced visit by social worker	Discussion about safety issues (routine), finances and how Ms A would cope without the support of her mother. Social worker reports in her records that Ms A is doing well with

		the babies. Social worker engages family support worker in her team in supporting Ms A
24.04.14	Family support worker takes Ms A to register the babies birth	
25.04.14	Children centre worker attends and helps Ms A with handling and feeding skills. Ms A also attends first baby massage class	Unclear as to whether there is any coordination with the family support worker from Children's Social Care. During this visit it became apparent that Ms A is stressed because she has run out of milk and cannot get to the surgery to pick this up. The Children's centre worker arranges this for her
28.04.14	Children's social worker visited Ms A	No concerns were expressed about the care of the babies. Ms A reported that she had medical appointments for Baby K the following week re her conjoined toes and a newly identified hip problem. Ms A reported that a number of other agencies would be visiting in the coming days
01.05.14	Children in Need meeting held	This is only referred to in maternity chronology and referred to as 'core group'. It is not clear what the decisions were although there were a high number of services being provided
01.05.14	Ms A and twins discharged from midwifery service and care transferred to health visiting service	
02.05.14	Suspect in rape investigation interviewed	Unclear as to whether Ms A was aware of this
07.05.14	Children's centre worker attended and met with Ms A	Ms A reported that she was now on anti-depressants and was finding caring for the babies stressful. Ms A thought Baby K was in pain when she massaged her so children's centre worker ensure she called the GP
09.05.14	Unannounced visit by CPN because Ms A had not responded to phone calls	Ms A appeared to be low in mood (not on anti-depressants according to their records). The CPN called social worker who agreed to speak to health visitor re extra support
12.05.14	Ms A visited by Bucks Floating Support worker and children's centre who reported her to be 'loving' towards the babies	
14.05.14	Baby K died	

5. Overview of case and Involvement of professionals

5.1 Prior to the review period, as described in section 3, Ms A did have some involvement with both universal services and specialist mental health services. In 2007 the GP reported that she had presented seeking treatment for her drinking (reported as 1 bottle of wine a day) and panic attacks. Ms A was referred to the CMHT a number of times but as there is no record of contact in the mental health report it is to be assumed that these referrals did not progress to Ms A engaging with services. The GP also records that Ms A attended Alcoholics Anonymous several times in this period.

5.2 The event which in many ways shaped the subsequent years for Ms A was the incident on 9th March 2010. Ms A later made a complaint that on this date she was raped by an acquaintance and two of his friends, after she had been drugged. This resulted in a pregnancy and a termination. The combined trauma of these events have been cited by Ms A as huge sources of ongoing distress in her life to which she has largely attributed the mental health difficulties that have affected her.

5.3 The first crisis, with regard to these difficulties, that came to the attention of professionals was when Ms C contacted the Police in May 2010, shortly after the termination, requesting their urgent assistance as she felt her daughter was going to harm herself. Police attended but Ms A reported that she was fine.

5.4 Over the next 18 months there was contact with several agencies that indicated that Ms A was struggling in terms of her mental health. In January 2011 she was arrested after crashing her car while under the influence of alcohol. The following month she presented at the GP requesting help with her alcohol consumption and panics attacks. Ms A was referred to CMHT who this time did undertake an assessment and referred her to psychological services. Ms A's engagement with these services however was only very partial and was not sustained. The Mental health IMR does express the view of professionals at the time that Ms A's alcohol use was a form of self-medication in response to the unresolved trauma of the complaint of rape.

5.5 The review period commenced on 2nd June 2013 with a call to Police from Ms B. She reported that her sister was threatening suicide and was going to "slit her own throat". Police officers responded immediately and attended Ms A's home. They found Ms A in an intoxicated, sleepy state with her sister still in attendance. In this state Ms A disclosed the complaints relating to the incident in March 2010. The officers offered to immediately refer Ms A for a mental health assessment but, as she posed no immediate risk of self-harm, they agreed with Ms B's proposal that she remain with her sister and she should take her to the GP the following morning.

5.6 The following day the officers recorded Ms A as a vulnerable adult under their own vulnerable adult procedures and referred the complaints of rape to CID and for further support and investigation by specially trained officers.

5.7 On that same day, 3rd June 2013 Ms A attended her GP and was referred to the CMHT. Ms A was seen the same day and was considered to meet the criteria for their service. In particular it was felt that Ms A would benefit from support from the psychological services. After an initial screening process Ms A was offered 7 face to face sessions between July and October. Of these, 3 took place with 3 being cancelled by Ms A and one by the psychologist. In these sessions Ms A was diagnosed with

having a complex post-traumatic stress disorder and work was undertaken to begin to treat this. In September, in the midst of this work, and having also recognised the impact of alcohol misuse, social isolation and possible homelessness, the psychologist referred the case back to the CMHT. From that point onward an Oxford Health social worker and community psychiatric nurse (CPN) were also involved.

5.8 On 28th August Ms A presented at her GP saying that she pregnant. It was confirmed very soon that she was expecting twins the following April. Therefore, unlike many situations where professionals are working with vulnerable mothers, the network became aware of the pregnancy at an early stage. Ms A was booked in by the maternity services two weeks later and, in recognition of her mental health difficulties was seen at home. From the outset the difficulties identified by the mental services were also clear, although Ms A denied that she was using alcohol.

5.9 As part of their work the CMHT did however refer Ms A to a community alcohol service, SMART at this time and she was seen once in October. Worryingly, Ms A disclosed to a SMART worker that she was drinking between one and two bottles of wine a day and had been doing so for the past two years. The SMART worker claims that this information was passed onto the CMHT, in an unrecorded telephone call, and who in turn, (the SMART worker claimed) said that they recognised the children's safeguarding concerns in relation to the unborn twins and that they would be taking the lead in referring to Children's Social Care. This does not correlate with the information in the mental health IMR, in which there was no such assertion that the CMHT would be taking such action in this period. Indeed there is no evidence that this important information was passed on to other professionals by SMART. This information was not recorded in any of SMART's recording systems and the assessment of which this conversation with Ms A was a part was not completed, or recorded.

5.10 Certainly in the October and November of 2013 there was a growing awareness of Ms A's vulnerability which had been captured so clearly in the psychologist's assessment of 18th Sept 2013. The CPN, and to a lesser degree the social worker, went to considerable lengths to keep Ms A engaged in their service even though she regularly missed appointments. Likewise the maternity services were also becoming aware of Ms A's vulnerability and from early on she was referred to the safeguarding midwife. Throughout this period Ms A was not easy to engage in respect of either service and she regularly missed appointments. Ms A acknowledged that she was not easy to engaged in this period when the author met with her in the course of this review.

5.11 During this period the ongoing rape complaint was having a significant impact on Ms A. Specially trained officers from July onward had been attempting to engage Ms A with a view to her making a formal statement. Great sensitivity and patience appear to have been shown by officers as Ms A again missed and cancelled several appointments. However on 2nd October 2013 Ms A finally felt able to make a statement which was the basis on which the Police were able to then formally take forward the criminal investigation with regard to the rape complaint.

5.12 Throughout September to November maternity services, the GP, adult mental health and the Police were all aware of the vulnerability of Ms A. Her isolation, the impact of PTSD and her precarious housing situation were all major stresses in her life. Certainly alcohol issues were identified as an ongoing concern, but it is surprising the weight that seems to have been given to Ms A's self-reported claims that she was not

using alcohol at all, or on some occasions only very minimally. Given that she had been receiving intermittent treatment for alcohol misuse since 2007, there should have perhaps been wider recognition that Ms A had an entrenched difficulty with alcohol. Moreover, when Ms A was visited by the CPN on 3rd December 2013, Ms B, who was also present, challenged her sister's assertion that she was not using alcohol.

5.13 The reason for this may have been that Ms A presented extremely plausibly. The adult mental health social worker is reported in the mental health IMR as feeling that Ms A could be manipulative and tended to say what she felt professionals wanted to hear. This is particularly the case with her self-reporting with regard to alcohol consumption. However it should be borne in mind that progress did appear to be positive in this period. On many occasions in the mental health and midwifery IMRs Ms A is reported to be cheerful and positive, especially with regard to her feelings about impending parenthood. Moreover there was some progress around practical issues such as housing. At the practitioners' event there was unanimity among the practitioners that Ms A was not by any means one of their more worrying cases and they were dealing with much more worrying situations on a daily basis.

5.14 Nevertheless the challenges facing Ms A were realistically understood by professionals and this lead to the community midwife deciding to refer to Children's Social Care at the end of November 2013. The reasons for this referral were well understood by the GP and mental health professionals in particular. It could be argued that all three of these agencies could have referred at an earlier point as all three explicitly reported concerns about how this vulnerable parent would cope as a parent. The difficulties facing Ms A were known by the professional network from the outset of her pregnancy and an earlier referral would have enabled Children's Social Care to being able to engage and assess Ms A at an earlier point.

5.15 Nevertheless this review does not believe that this delay ultimately compromised the welfare of either Ms A or the twins. The referral by midwifery was only made a week outside the 16 weeks BSCB's pre-birth guidelines. These guidelines are consistent with practice across the country and there is a case for not making early referrals in that until the pregnancy is confirmed and viable there can be a danger in potentially raising alarm and anxiety on the part of the mother.

5.16 The midwife therefore referred Ms A to the First Response team in children's services. This team recognised very quickly that this case would require an in depth assessment. However, as Children's Social Care have since acknowledged, the system for managing this transfer to a team who could undertake such an assessment was cumbersome and led to delay. That is, the team opened and formally began an assessment before almost immediately closing and transferring this case. This appears to have been a misguided mechanism for managing the work stream into the long term teams at this time. In this case therefore although the referral was made on 5.12.13 it was a further two weeks before the case was passed over to the Child in Need team who would undertake the assessment.

5.17 The children in need team was a small team of three social workers and a supervisor. These teams were the result of a service redesign that had taken place earlier that year in April 2013. This involved the much larger social work teams being reorganised into smaller "units" based on a model that had been favourably evaluated in Hackney. The rationale for this was that these smaller teams would work much more collaboratively with high levels of peer supervision.

5.18 Unfortunately this particular team was very inexperienced, with all three of the social workers being newly qualified and managed by a supervisor who was recognised as not offering strong professional leadership, ultimately leaving in March 2014. It was not till 8th January 2014 that the case was allocated to one of these newly qualified social workers.

5.19 Her first task was to attend a professionals meeting on 13th January 2014 which had been largely organised by the midwife. This meeting was very well attended and although there does not appear to have been a formal record taken, the reports in the IMRs suggest that it did very clearly identify the areas that needed further investigation and with which Ms A would need further support. That is around her mental health difficulties, her alcohol misuse, and her isolation, practical problems regarding money and helping with the pressures incumbent on being a first time single parent caring for twins. The main task that was agreed therefore was for the social worker to undertake an in depth pre-birth assessment. While not explicitly shared between agencies, it would appear from the social worker's subsequent supervision records that this could be on the basis that this was a children in need assessment.

5.20 This may well have been the appropriate way forward based on the information available to that meeting, although it could have been argued that there were already sufficient risk factors present to justify moving toward a pre- birth child protection conference. Nevertheless a child in need assessment was defendable practice if it was robust and had sufficiently analysed the risk factors in relation to the protective factors that were also apparent.

5.21 There were two notable absentees from this professionals meeting on 13th January 2014. Firstly, the midwife had, at the time of the referral to First Response, also referred Ms A to the local children's centre. They had accepted the referral and were beginning the process of engagement at the point this meeting took place. This meeting would have been ideal point at which to have discussed how their work, largely around parenting support and parenting skills, would be coordinated with the other professionals in Ms A's life. Unfortunately it was some months before other parts of the network, particularly the social worker, even became aware of their presence in the case.

5.22 Secondly, the Police were also absent as they were not invited. While it would not have been routine to invite investigating Police officers to such a meeting, they did have important information about the context in which Ms A was preparing for the birth of the twins. Namely she was still extremely stressed by the ongoing criminal investigation and the officers did have real insights into Ms A's emotional state at the time. At the practitioners' event that was part of this review, the specially trained officers did express a view that they would have been prepared to attend this meeting. However, even if an officer had not been present then at least their up to date information would have been very helpful at that meeting. This again partly reflects the lack of experience on the part of the social worker. However the review heard that this was also a cultural issue in that Children's Social Care often do not recognise the importance of involving Police officers who are not directly involved in child protection. Hence in this case the specially trained officers role (supporting adult victims) was not recognised.

5.23 Over the next two months agencies remained very involved in Ms A's life. The

children's centre successfully engaged Ms A and she attended some ante natal Parent Craft classes. This was not an easy process and the children's centre staff again like other professionals in this case showed persistence and commitment in engaging Ms A. Ms A continued to receive ante natal care from midwifery and her GP. In this period Ms A disengaged from psychological services and her care was closed with a view to the work restarting possibley after the birth of the twins. Nevertheless both the CPN and social worker from the CMHT remained actively involved in the case.

5.24 The Children's Services social worker was also actively involved although much of her work appeared to focus on practical issues around benefits. There is some evidence that she had some discussion about Ms A's background social history. However, there was no sense that there was a systematic attempt to gather historical information or to have the difficult conversations around sensitive issues such as alcohol use and how Ms A would cope with parenthood. This poor practice though was very understandable in the circumstances. She was a newly qualified social worker (she joined the team in November 2013) who only received supervision twice prior to the birth of the twins. She appeared to receive no clear guidance as to how to undertake a pre-birth assessment, how it should be recorded and how the plan should be progressed. Instead she used an out of date template and appeared to not understand timescales.

5.25 It was at the prompting of the midwife that a further pre-birth meeting was held on 27th March 2014. This was called a "children in need" meeting although not all agencies recorded it as such and there appeared to be no formal record of the meeting. Nevertheless it did serve as a forum in which agencies could share their ongoing concerns. They were hampered by the lack of an assessment and professional leadership from Children's Social Care that might have provided a more robust foundation for making a collective assessment in respect of Ms A's parenting capacity and how services could have been coordinated more effectively. It should be acknowledged that the social worker was off on sick leave around this period.

5.26 It is important to recognise though that Ms A was not "slipping under the radar". Many professionals were engaged in her life and she was receiving considerable support, something that Ms A herself told the review she valued. She did nevertheless say that the number of different agencies involved was confusing in terms of different practitioner's respective roles and this underlines the need for greater coordination.

5.27 A further week later on 4th April 2014 the twins were born by elective caesarean. There were no significant health concerns although Baby K did have 2 conjoined toes and a problem with her hip. They were initially cared for in the neonatal baby unit. At this point the staff in this unit did have some concerns about how well Ms A engaged with the babies and fed back to the community midwife and adult mental health that she appeared "flighty" and needed prompting around feeding routines. Ms A stayed in hospital with the twins and after 6 days they were discharged home. The Children's Services social worker was involved in this decision, ensuring support was in place from Ms C.

5.28 Over the next three weeks there was considerable professional activity around the family to the point where the new health visitor compiled a visiting matrix so Ms A was not overwhelmed. During this period Ms A said on several occasions she found it

very difficult caring for the twins. The children's centre were not formally informed of the birth but once they became informally aware they did visit regularly and provided important practical help, especially one day when Ms A ran out of baby formula.

5.29 Ms A had only moved house two months prior to the birth so the health visitor helped register her and the new babies with a GP more local to her new home, but this review did hear that there was lack of clarity about the transfer of medical records between practices which is addressed in the recommendations in the final section of this report. In particular the level of concern about how Ms A would cope with parenthood was not communicated between the practices.

5.30 The midwifery service was concerned about the apparent lack of a coordinated post birth plan so. at their prompting. a "children in need" meeting was held on 1st May 2014. Again there appears to be a lack of clarity around the purpose of this meeting and one professional described it as a "core group" which is perhaps indicative of their level of concern. As with the previous meetings there also appeared to be no formal record taken.

5.31 In the final two weeks of Baby K's life there were some signs that Ms A was under some stress and struggling with parenting two young babies alone. However, there were also some very positive reports in this period with, for example, the floating support worker reporting that she was cheerful and appeared to be managing well only 2 days before Baby K's death. Moreover most new parents of twins find it stressful regardless of the additional challenges Ms A had to manage.

6. Analysis and Learning

In this section there is an exploration of the terms of reference agreed by BSCB in terms of an analysis of the case and the learning that it provides.

6.1 To establish what assessments, including those relating to mother's mental health and alcohol dependency, were undertaken and the quality of those assessments

6.1.1 The key assessment that was undertaken in this case was the pre-birth assessment carried out by the Children's Services social worker from January 2014 onwards. The newly qualified social worker was provided with little guidance and support in this process and indeed she was unaware of the basic information that should be covered in such an assessment and how it should be recorded. The absence of a "present" child can lead, in the author's experience of undertaking reviews in such cases, to them not being seen as holding the same urgency as those when the child has been born. However, the result was that the pre-birth assessment undertaken by Children's Social Care was inadequate and therefore did not lead to a sufficiently robust plan of support for Ms A. There was, as reported by the social care IMR, a superficial social history and lack of coverage of the key safeguarding and safety issues. In particular there was a lack of an exploration as to the impact of how Ms A's mental health might affect her capacity to parent and also a lack of curiosity and challenge around Ms A's assertion that she was not using alcohol.

6.1.2 The pre-birth assessment should include the views of other professionals. While

the social worker needed to have gathered this information much more systematically, there was a recognition at the practitioners' event that the professional network tended to be too reliant on Children's Social Care in these circumstances and indeed some felt there was not enough clarity about the meaning and purpose of what a pre-birth assessment entails.

6.1.3 In terms of other agencies, there was attention given to issues around alcohol both in terms of assessment and treatment. However, from a children's safeguarding point of view it does appear that significant weight was given to Ms A's self-reporting to most professionals that she was alcohol free. Greater scepticism needed to be deployed in the context of caring and empathic interventions. This was particularly the case with practitioners from both adult mental health and the GP, as her primary care records did state that she had sought support regarding her alcohol use from as early as 2007.

6.1.4 It is of particular concern that Ms A told the SMART worker she was drinking 1-2 bottles a day in October but this was never communicated to anyone. The SMART report states that their own assessment procedures were not followed with it being neither completed nor recorded.

6.1.5 In terms of understanding why professionals did not challenge Ms A further regarding her alcohol use, at the practitioners' event there was a widely held view that Ms A presented very plausibly. She was never under the influence of alcohol and was always well-presented when she came into contact with professionals.

6.1.6 There was very good support around her mental health otherwise and great commitment shown by mental health professionals. They did address parenting issues but arguably needed to refer earlier to Children's Social Care and generally communicate their concerns more fully. Again Ms A's presentation may offer some explanation as to why professionals did not do so.

6.2 To establish what risk factors were identified in relation to the unborn babies and whether appropriate procedures were followed

6.2.1 A referral was made (almost) within timescales, and the midwife's practice was very good in this respect. She demonstrated professional leadership in the absence of a response from Children's Social Care and coordinated a multiagency professionals meeting (which did include Children's Social Care) in January 2014. This referral reflected a concern that was shared by colleagues in adult mental health that Ms A was at a very vulnerable point in her life and that she would struggle with parenting without support. The GP was aware of both Ms A's mental health difficulties and the pregnancy. Whilst the GP could have been more proactive with other agencies in raising these concerns, there is equally no evidence that the GP did not share or missed information in relation to potential risks to the babies. The GP did, for example, ensure that Ms A was receiving both ante-natal services and support for her mental health.

6.2.2 In terms of assessing the risk to the babies once the case was held by Children's Social Care there was not an appropriate assessment carried out. What was carried out was very superficial, with the work focusing on practical issues, not on the possible risk factors facing Ms A and the twins. The limitations of this assessment were

captured very well in the social care IMR. There was no analytical social history and no recognition of how the mental health issues and possible alcohol misuse difficulties would impact on her capacity to parent. Moreover caring for twins as a single parent is challenging for any new parent and this was exacerbated by Ms A's social isolation.

6.2.3 It is arguable whether this should have been subject to pre-birth Initial Child Protection Conference or a Children In Need meeting. What is inarguable however was that this was a very vulnerable mother who needed robust, well-coordinated multi agency support that addressed explicitly the impact of mental health and alcohol concerns including PTSD. Unless these issues were addressed the potential risk to the babies would clearly be present.

6.3 To establish what risk factors and needs were identified in relation to the twins after their birth

6.3.1 The absence of a pre-birth assessment meant that the plans for post birth were also poorly coordinated and somewhat ad hoc. Nevertheless, in the period following the birth Ms A did get considerable support with the children's centre, the social worker, midwifery and the health visitor all visiting regularly to the point that the latter drew up a visiting matrix. This was because the health visitor wanted to ensure that the visits were coordinated and did not overwhelm Ms A.

6.3.2 In the brief period of Baby K's life this review has not heard evidence that risk factors were underplayed or missed in this post birth period. On the contrary by this stage professionals were very present and focussed on Ms A and her and her children's needs.

6.4 To establish if plans were implemented and to what extent the plans addressed any risk factors identified in the assessments

6.4.1 There was some good practice in identifying risk factors by individual agencies, but the meaning of this information was not fully processed or understood by the multi-agency group in the pre-birth period. Each agency was tending to work within their own remit and it appeared to the reviewer to be the initiative of the midwife that led to there being a level of interagency information sharing and planning in the two multi agency meetings in March and May 2014. Each of these meetings appears to have been a "children in need" meeting although this was not the consistent label given to the meetings by all agencies. Neither of these meetings, like the earlier meeting in January, was formally recorded so the only record of these meetings was within some of the individual agencies. This clearly did not facilitate good planning and coordination.

6.4.2 The pre-birth assessment was never completed by the children's social worker. Therefore the plans that were made tended to be reactive and focus on practical issues. Important as these practical issues were, the plans did not therefore address some of the underlying risk factors sufficiently.

6.4.3 After the birth of the babies, all professionals including the social worker were aware of the level of support Ms A needed and indeed had to respond to unexpected developments. This included the departure of Ms A's mother who the professional network had assumed would be providing longer term support. This review did not hear

evidence that the lack of a formal plan impeded the delivery of services in this period.

6.5 To establish whether practitioners understood the thresholds for intervention – from Early Help through to Child Protection

6.5.1 This was a challenging case in terms of thresholds in that it could be argued legitimately either way as to whether it should have been progressed through either the children in need route or via formal child protection processes. Certainly if other professionals had known about the information shared with the SMART worker they may have perceived this to have been a more explicit case of child protection. Nevertheless this wasn't known and it was quite legitimate, in the view of the reviewer, for this to have been managed within a children in need framework. It is perhaps a good example of how debates about formal thresholds can obscure the fact that ultimately this family needed robust and well-coordinated support under whatever label was chosen.

6.5.2 At the practitioners event there was a strong consensus among the professionals who had worked with Ms A that *at the time* none of the professionals considered this to be a particularly "high risk" case. Indeed many talked of their profound sense of shock when Baby K died.

6.5.3 This review does believe that there needed to have been greater curiosity and challenge toward Ms A with regard to her alcohol use, both before and after the referral to Children's Social Care. However, this was not because of the case being wrongly identified in terms of threshold. In any case the midwife made an appropriate referral to Children's Social Care via First Response and so it is not the case that a misunderstanding of thresholds delayed the referral process.

6.5.4 Nevertheless, a lack of clarity around thresholds between agencies has been identified by both the BSCB and in last year's OFSTED inspection as an issue in Buckinghamshire. Subsequent to that, in September 2014, the Board published new threshold guidance[6]. The guidance stresses the importance of timely referrals and the focus on possible harm to children. In that sense therefore the referral to Children's Social Care met these criteria.

6.5.5 The more pertinent issue regarding thresholds was when the case was being managed within Children's Social Care. The Framework for the Assessment of children in need [7] remains relevant in this case in that it makes clear that children in need assessments and plans should be carried out as robustly as those given the formal label "child protection", including those involving unborn children.[8] Instead the children in need label would appear, from the evidence provided by members of the panel, the social care IMR and staff at the practitioners event, to have contributed to the case not being treated with the same rigour. This, it would appear, has been a general problem in Buckinghamshire in recent years and was identified in last year's OFSTED inspection.

6.5.6 Children therefore deemed to be only "children in need" and not also in need of protection or being looked after have, according to evidence received by this review, not always received sufficient services that were proportionate to their level of need. This family received the input of many agencies but sufficient services in this case meant a timely and robust assessment and plan undertaken and led by a well managed suitably experienced social worker.

6.5.7 The explanation that several of those who contributed to this review gave was that this was fundamentally a capacity issue and, in a context of limited resources, labelling all children in need as not being a priority in terms of allocation to an experienced social worker was one way of managing this demand. However, the dangers of such a crude mechanism are exposed by this case and have been recognised by children's services issuing new children in need procedures. It is a concern that other panel members were not aware of this guidance and clearly the Board will need to be reassured that this guidance is disseminated among partner agencies and does lead to improved practice.

6.6 To establish if agencies shared information appropriately and involved other professionals or agencies as necessary, including adult services

6.6.1 There was some good information sharing and the midwife in particular appears to have been very proactive. The good level of attendance at the January 2014 network meeting reflected a multi-agency network which was committed to supporting this vulnerable mother. Once this case was allocated to a social worker she needed to have demonstrated greater professional leadership in terms of coordinating multi agency work.

6.6.2 There were three specific areas where information sharing was poor and could have implications for other cases. Firstly SMART received the very worrying information directly from Ms A regarding her alcohol use. This was not communicated to other agencies. While this review does not believe it would have changed the overall way in which this case was managed if other professionals such as the adult mental health or the GP had known about the level of alcohol consumption, it would have raised the level of urgency and there would have been a clearer sense about possible risk of harm to the babies. It could also have alerted them to the degree to which Ms A was possibly concealing her drinking while appearing to be complying with professional advice. In other words "disguised compliance".

6.6.3 Secondly, in the period from January onwards both the social worker and children's centre worker were visiting Ms A and providing support, as well as, in the case of the social worker, undertaking an assessment. However, for several weeks neither worker was aware of the other's presence. The children's centre worker did not make further enquiries even when she heard that there was a social worker visiting. In cases such as these the interface between targeted and specialist services is crucial and may be an area the BSCB will seek to scrutinise further to ensure that this does not reflect wider systemic weaknesses.

6.6.4 Thirdly, Ms A changed GP after she moved to her new property. The process of transferring her records between the practices highlighted the limitations of some of the IT systems within this part of the NHS. While there are not straightforward solutions to these types of situations this case does underline the importance of proactive follow up when there are possible children's safeguarding concerns. Unfortunately the transfer of records is a national process but face to face and telephone handover is still important when concerns are raised.

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6 http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Thresholds_Guidance_Sept_2014.pdf
7 Department of Health (2000) Framework for the Assessment of Children in Need and their families
8 Hart, D (2009)

6.6.5 Adult mental health liaised with a number of other support agencies but perhaps not sufficiently with Children's Social Care in the period from January to April 2014. However, by this stage Ms A was disengaging from the therapeutic work which would have been quite appropriate given the point of the pregnancy. They, like other agencies represented at the practitioners' event, reported that this did reflect a tendency in Buckinghamshire to over-rely on Children's Social Care to provide case coordination in such cases. While Children's Social Care was clearly the lead professional in this case, there was nevertheless considerable experience in the professional network that could have been a great and invaluable support to this inexperienced social worker.

6.7 To establish if there were factors which enhanced or impeded working relationships with the parent/s

6.7.1 Ms A engaged well with professionals in that when she met with them she was not hostile and appeared to be very forthcoming with regard to the difficulties she was facing in her life. There was perhaps a degree of disguised compliance in that particularly workers in adult mental health felt that she tended to say what she felt professionals wanted to hear.

6.7.2 At the practitioners event there was a view that Ms A tended to present very differently depending on which professional she was engaging with. With some of the adult mental health practitioners for example she often appeared to be very vulnerable and expressed great anxiety about the future. In contrast with the others she was often much more optimistic. Some variation is not unusual, but there was a feeling among some practitioners that this reflected the degree to which Ms A could manipulate professionals on occasions.

6.7.3 Although Ms A did engage to a certain degree with professionals she did, as she acknowledged miss appointments on a very regular basis. However, the laudable tenacity of staff to follow up missed appointments, particularly in adult mental health tended to mask this.

6.7.4 It is important however to keep this in perspective. Again the view expressed by all of the professionals at the practitioners' event was that Ms A was not someone who they would describe as "hard to reach", "resistant" or "difficult to engage". On the contrary she was well known to the professional network throughout the review period.

6.8 To establish to what extent the parenting capacity of the parent/s was considered and addressed

6.8.1 To a large degree this area has been addressed in preceding passages of this report. In summary Ms A's vulnerability was well known to professionals in the network. There was however insufficient inter agency coordination, particularly in the period between January and April 2014. As a result the implications of this vulnerability were not gathered together into a single robust plan that would have provided more effective and coordinated support.

6.9 To establish if the diversity needs within the family were identified and addressed

6.9.1 There is some discrepancy in the information the agencies held about the ethnicity of the babies. In some of the agency records the babies are described as white British. Other agencies describe the father as being of "Asian" heritage in which case baby K and her sibling would therefore have been of mixed heritage if this was accurate.

6.9.2 The lack of clarity about the babies' heritage does reflect a broader theme that is common in serious case reviews. That is, that there was little attempt to find out more about the father and any possible role he might have had in the children's lives. Ms A's position that he was not interested and this pregnancy was the result of a brief relationship was accepted without question.

6.9.3 Clearly Ms A's wishes that the father should not be directly involved should have been respected at this stage of the work. However, any in depth pre-birth assessment should have contained a deeper exploration of his background and role.

6.10 To establish if there were any capacity issues within agencies that impacted on the quality of the services provided

6.10.1 This was a family who received a considerable range of services. Therefore capacity issues are not as obvious as in some other cases. Nevertheless, the belief among practitioners at the practitioners' event was that all of the agencies involved in this review were coping with tightening resources and increasing workloads and demands for their services during this period. This pressurised context served to create a challenging environment for practitioners in terms of thinking reflectively and critically about cases. This environment could also inhibit the capacity for offering challenge between agencies. Practitioners reported that it was tempting to assume information shared was information understood and that a referral made would inevitably lead to a certain level of professional involvement and activity in Children's Social Care.

6.10.2 The agency in which the resource issues were most apparent was Children's Social Care. This agency had been having some difficulties prior to the review period and, like all such departments across the country, was attempting to implement reforms in light of The Munro Review of Child Protection. In Buckinghamshire there had however been further instability. In April 2012 there had been major changes in the Senior Management group. This new leadership embarked on a process of local reform with the launch of the First Response Service in August 2012 and then the complete remodeling of the social work long term teams into smaller "units" in April 2013. This was along the lines of the "Hackney model" which was receiving much positive coverage at the time.

6.10.3 During the review period in June 2013 the implementation of both these aspects of this reorganisation were reviewed. It was then further reviewed between September and November 2013. These latter reviews came before a critical OFSTED inspection in August 2014[9]. This inspection found services for children in need and protection, and leadership, management and governance to be "inadequate".

6.10.4 The social care IMR specifically highlights the lack of sufficient resources in First Response that led to the protracted manner in which the referral from midwifery was progressed. Moreover the review panel highlighted the high numbers of staff vacancies in Children's Social Care in this period and the very high numbers of temporary agency staff. Representatives of Children's Social Care report that the situation is improved with increased investment (£4.8 million increase in Children's Services budget for 2014/15 and additional £1million from contingency to fund the improvement plan), measures to improve the strength and capacity of the workforce with a reduction in vacant posts, new procedures, additional staff resources and a new structure around the First Response service. Again the BSCB will want to be reassured that these changes are achieving the improvements that they sought.

6.10.5 Otherwise resources do not appear to have played a major role in this case. Indeed it is very positive that Chiltern District Council Housing was able to re-house Ms A and she received multiple sources of support over the 9 months of the review period.

6.11To establish if staff involved had the skills, knowledge and experience to address the issues within the family

6.11.1 The good practice that was evident in much of the work with this family reflects the fact that some experienced and apparently skilled staff were working with this family. In particular within midwifery, adult mental health services and the Police there is considerable evidence of this expertise.

6.11.2 However, crucially, the social worker was far too inexperienced to undertake such a complex pre-birth assessment. The fact that this was labelled "children in need" appeared to lead to the decision to allocate this complex piece of work to this newly qualified worker.

6.11.3 The newly qualified social worker was on the Assessed and Supported Year in Employment programme (ASYE) during the period of this review. The ASYE was a recommendation that emerged from the Social Work Reform Board. It is a scheme, implemented since September 2012 that should have ensured there was a framework of support and quality assurance regarding the practice of newly qualified social workers in every local authority. It replicated social care systems that have been operating within the NHS and education sectors for some years.

6.11.4 The social worker did not appear to get the support in terms of supervision that is part of that scheme. Nationally, Skills for Care recommend that supervision is provided weekly for newly qualified workers for the first three months and then two weekly till six months and then monthly thereafter. Locally the scheme in Buckinghamshire said that supervision should take place at least once a fortnight. The social worker in this case, however only received 3 supervisions in the whole review period. It is both unacceptable and unreasonable to expect a newly qualified worker to engage with complex case work (which this undoubtedly was) without such support. Even though this case would quite understandably not have been seen as the one of most "high risk" cases it did nevertheless raise some complex issues around pre-birth assessments and the impact of mental health difficulties and substance misuse on parenting capacity and, potentially, child development.

6.11.5 The belief among senior managers in the department at the time, and indeed

the “theory” behind this model was that the unit system promoted peer supervision and support and the belief of the review was that this was not adequate for two reasons. Firstly the “peers” in this situation were also newly qualified social workers and secondly there did not appear to be sufficiently robust quality assurance systems in the organisation that were monitoring the supervision staff were receiving.

6.12 To establish if staff within agencies co-operated to achieve the best outcomes for the children

6.12.1 This area has been largely addressed in preceding passages of this report. There is certainly no evidence of a lack of “cooperation” between agencies. Rather any deficits were due to poor coordination and case leadership. It is worth reiterating however that at the practitioners event professionals within the other agencies did recognise that there could have been greater support for the social worker and that there was an over reliance on her management of the multi-agency system.

6.13 To establish to what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies

6.13.1 Policies and procedures regarding the course of the assessment were not followed in Children’s Social Care. Some action has been taken to address this. The Board however will want to be assured that the action taken is addressing these difficulties.

6.13.2 Other agencies appear to have largely followed procedures although questions remain around whether concerns should have been escalated in January to March 2014. Indeed at the practitioners’ event there was a consensus that in situations such as these there can be an over reliance on the social worker as lead professional to identify safeguarding concerns and coordinate services. There was a widely held view that other professionals needed to more proactively pursue concerns about whether safeguarding concerns are being addressed.

6.13.3 The one agency where there appeared to be a serious breakdown in procedures was in SMART. In their report for this review they reported that both their assessment and safeguarding polices were not adhered to and steps are being taken to address this with the staff involved. The Board will want to be assured that such a breakdown in procedures was indeed down to individual error and did not reflect wider systemic weaknesses.

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[9] http://webarchive.nationalarchives.gov.uk/20141124154759/http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/buckinghamshire/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

6.14 To establish if staff directly involved had appropriate supervision and managerial guidance

6.14.1 Supervision has a different role and meaning within each agency. However the health visitor, the mental health practitioners, midwives and police officers all reported in their respective agency IMRs that they were receiving good supervision. For General Practitioners supervision is not organised in the same way but there is no evidence that their practice was impeded by inadequate clinical support or guidance.

6.14.2 However the social worker was only supervised three times in the five months in which she was employed. This is not within the guidelines locally set out for all workers (one a month) or especially newly qualified social workers on the Assessed and Supported Year in Employment. This stipulates that newly qualified social workers should be supervised on a bi-weekly basis.

6.14.3 This case however raises questions about the wider supervision structure within Children's Social Care at the time. If the supervisory systems had been functioning effectively then the weaknesses in the line manager's practice should have become apparent in her supervision and there appeared to be weaknesses in the quality assurance systems in this crucial part of the management structure.

7 Conclusions

7.1 It is not possible to say whether this 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.

7.2 The focus of a serious case review is the way that services were delivered to children and the 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.

7.3 It appears that much of this work was much 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 antenatally and postnatally was also of a good standard despite, in the case of the former, Ms A finding it difficult to engage with services on occasions.

7.4 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.

7.5 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.

7.6 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.

7.7 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. 7.8 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.

7.9 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's services and their partner agencies are leading to improved practice.

7.10 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.

7.11 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.

7.12 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.

8 Recommendations

As part of the methodology of this review it was agreed that each agency which provided an individual management review would also provide a set of recommendations for improving services and practice. Each of the individual agency recommendations below are therefore directly drawn from the individual management reviews and have already been agreed by senior managers within those agencies. The author will also conclude with some additional board level recommendations at the end of this section. However at the outset of this section it is important to recognise that this review has highlighted many of the systemic weaknesses in children's social care that were identified in the OFSTED inspection in 2014. The local authority has put in place a number of reforms to address these. This review does not wish to replicate these and add to what is already a comprehensive work plan. Nevertheless the Board will need to work with both children's social care and its partner agencies to ensure that this is leading to the improvements in practice that these reforms aimed to achieve.

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 NICHE[10] 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.