Serious Case Review
Child S

November 2016

1. INTRODUCTION

1.1 In October 2015 child S, aged 8 weeks, was taken to hospital following a cardiac arrest. Her mother had fallen asleep on the sofa with child S and awoken to find that she was unresponsive. She was placed on life support in a specialist paediatric intensive care unit; following deterioration in her condition, life support was withdrawn three days later when she died. The post mortem report gave the cause of death as natural causes. At the time of writing this report, the coroner's inquest has not taken place. Child S was subject to an interim supervision order and a child protection plan at the time of her death.

1.2 This matter was referred to the Local Safeguarding Children Board in Swindon where child S lived. On 5 November 2015, the Case Review Group (CRG) of the Swindon Local Safeguarding Children Board (SLSCB) met to consider whether the criteria for a serious case review were met.

1.3 There is a legal requirement, as defined in statutory Guidance, Working Together to Safeguard Children 2015, to undertake a serious case review when abuse or neglect of a child is known or suspected and

- either a child has died, or
- a child has been seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.4 At its November meeting, the CRG concluded that the criteria for a serious case review (SCR) were met, whilst recognising similar issues/potential overlap and learning with another current SCR. The Independent Chair undertook to discuss with the Lead Reviewer for the other SCR and undertake a peer challenge with another experienced LSCB Chair. Following these processes, she decided on 27 November 2015 that the SCR criteria were met, as the child was subject to a child protection plan and interim supervision order, and neglect was a factor in the decision to issue care proceedings, but that the SCR needed to be proportionate.

1.5 The purpose of a serious case review, as set out in statutory Guidance, Working Together 2015, is to identify improvements which are needed and to consolidate good practice in order to prevent similar deaths or serious harm.

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2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 The SLSCB decided that its Case Review Group would be the reference group for this review. It was chaired by Alex Walters, the Independent Chair of the Board. Its function was to manage and oversee the conduct of the review. The membership of the CRG is set out at Appendix A. The Board appointed an independent reviewer, Helen Davies, to lead the review and to write this overview report. She was assisted by Lesley Boorman, SLSCB Business Manager, and Fiona Francis, Swindon Borough Council (SBC) Service Manager, Quality Assurance and Review (SCR Champion). Further details are at Appendix B

2.2 Seven Individual Management Reviews (IMRs) were requested from the following agencies which had substantial contact with child S and her family:

- Great Western Hospitals NHS Foundation Trust
- Local Clinical Commissioning Group (Swindon general practitioners)
- Swindon Borough Council Children, Families and Community Health including Heath Visiting and Social Work
- Wiltshire Police
- Swindon Borough Council Legal Services
- CAFCASS (Children and Family Court Advisory and Support Service)

2.3 In addition, background reports were requested from agencies with less significant or less recent information:

- Swindon Borough Council Housing Services
- NSPCC
- Coram Voice
- Wiltshire Probation Trust
- Swindon Borough Council Education Service

2.4 This report was written in anticipation that it will be published. Consequently, the information in the report is limited so as to;

1) take reasonable precautions not to disclose the identity of the child or family

2) protect the right to an appropriate degree of privacy of family members

2.5 Terms of Reference for this SCR are at Appendix C. Child S was the main subject of the review and its principal focus was from 1 April 2015 (when her mother's pregnancy with child S became known to agencies) until 15 October 2015 (when child S died). However, all agencies were asked to provide a summary of all significant events and relevant family history outside the specific timescale and to consider any safeguarding issues for child S's older siblings.

2.6 All individual management reviews addressed the terms of reference. All the authors of the individual reviews were independent of the case management,

and all conducted interviews with staff involved with child S and her family. At least 17 members of staff were interviewed.

2.7 Following consideration of the combined chronology of events and the individual reviews, the independent reviewer and the SCR Champion met at a learning event with thirteen professionals who had worked with child S and/or her family. They included a midwife, health visitor, social worker and her manager, and staff from the nursery and school attended by child S's siblings. This provided a valuable opportunity to gain their perspectives of their work with child S's family and to consider lessons learned.

2.8 Immediately afterwards, a smaller meeting was held with a social worker and her manager, a SBC solicitor and the Children's Guardian to consider legal processes relevant to child S and her siblings.

2.9 After the first draft of this report had been compiled, the independent reviewer and the SCR Champion met with IMR authors and key professionals in order to seek their views on preliminary findings and on recommendations. Five IMR authors attended this meeting along with eight of the professionals who had attended the earlier learning event. A GP also attended this meeting.

2.10 A letter was also sent to the District Family Judge requesting her to consider if the review raised any issues from the perspective of the family court. To date, no reply has been received

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This overview report relies on:

- the agency IMRs and background reports
- subsequent discussions with the CRSG reference group
- dialogue with the IMR authors
- discussion at the learning event in April 2015
- discussion at the follow up meeting in June 2015
- the views of Child S's parents and grandmother, discussed in section 5

3.2 This report consists of:

- a factual context and chronology
- commentary on the family's input to the SCR
- analysis of the part played by each agency
- closer analysis of key issues arising from the review
- conclusions and recommendations

3.3 The conduct of the review has not been determined by any particular theoretical model. However, the review has been carried out in keeping with the underlying principles of the statutory Guidance, set out in Working Together 2015. These are at Appendix D.

4. BRIEF CHRONOLOGY OF KEY EVENTS

4.1 This section of the report briefly describes key events from the birth of child S's oldest sibling. Further detail is then provided at appropriate points throughout the report.

4.2 Child S lived with her mother and her three older siblings, all of whom are white British. The father of the children was not supposed to have any contact with the mother, but had some contact with the children (supervised by a family member). During her pregnancy, the mother told health professionals that child S had a different father, but after her birth it was confirmed that she had the same father as her three older siblings. The mother also has two other children, one of whom (now an adult) was brought up by her grandmother; the other is in foster care. As neither had been part of the household for many years, this report only refers to child S's three siblings that lived with her.

4.3 The family had a considerable history of involvement with SBC Children and Families Service prior to the time frame of this review – for at least 20 years. The children spent several periods subject to child protection plans as well as children in need plans. The concerns were parental misuse of drugs and alcohol, domestic abuse witnessed by the children, and neglect of the children.

4.4 At the start of the time frame for this review, the Children and Families Service had no involvement with the family, the case having been closed at the end of January 2015 and stepped down to Team Around the Child (TAC).

4.5 In March 2015, the mother had her first contact with a midwife for her pregnancy with child S. The midwife rightly identified safeguarding concerns, given the past history, and notified these to the safeguarding midwife.

4.6 In April 2015 the mother was admitted to hospital suffering from a life threatening illness. Her three children were looked after by members of their extended family. During this period of hospitalisation, a grandmother and the children's school made a referral to the Children and Families Service expressing concerns about the state of the family home and how the mother would cope after her discharge from hospital.

4.7 Later in April 2015 a strategy meeting was held attended by social work staff, the police and staff from the children's school/nursery. The mother was due for discharge, but the meeting recommended that the children should remain with their grandmother until the family home had been cleaned up and that a safety agreement should be drawn up with the mother. If she did not comply, the children would be made subject to police protection.

4.8 By the end of April 2015, the condition of the family home had improved following input from friends of the mother. She signed an agreement in which she agreed to cooperate with a parenting assessment as well as maintain the house in a reasonable state, only allow the children to have supervised contact with their father (supervised by his mother) and to ensure that the children attended school/nursery. The children then returned home.

4.9 In May 2015, an initial child protection conference was convened, which concluded that the three children and the unborn child S should be made

subject to child protection plans under the category of neglect. A core group meeting was held 2 weeks later, when it was noted that the house was in a poor state again.

4.10 By June 2015 the state of the family home had deteriorated and the mother had failed appointments to progress the parenting assessment. Therefore, service manager approval was given for a legal planning meeting, which duly took place in early July 2015, when it was agreed to hold meetings under the Public Law Outline (PLO) with both parents.

4.11 In early July 2015, the first review child protection conference took place. All children, including unborn child S, remained subject to child protection plans under the category of neglect. Virtually, all concerns remained from the initial conference apart from improved school attendance, as a neighbour was taking the children to school.

4.12 The PLO meeting with both parents was held in mid July; the outcome was that the local authority would be applying for care orders on the children because the conditions in the home remained unacceptable and the social worker had been unable to progress the parenting assessment due the mother's lack of cooperation. A few days later another core group meeting took place, which focused mainly on the arrangements when the mother went into hospital to have child S.

4.13 Child S was born in August 2015 and the hospital agreed that the mother and baby could remain in hospital until the outcome of the local authority's application for interim care orders on child S and her siblings. The initial application for interim care orders/emergency protection orders before magistrates was referred to a judge later the same day. She agreed, as did the Children's Guardian, with the extended family's proposal to supervise the care of the children by the mother and made no orders. The mother and child S were duly discharged from hospital, subject to an extensive written agreement, which included the requirement that child S slept on her own.

4.14 Another court hearing took place before the same judge four days later. She did not consider that there was a trigger event (in the context of chronic neglect over an extended period) to justify interim care orders and the immediate removal of the four children from their mother. This was also the view of the Children's Guardian. Interim supervision orders were made on the four children and assessments of the mother were commissioned. A contested interim care order hearing was scheduled for the end of October.

4.15 Another core group meeting was held early in September, when there were no particular concerns about child S. During September and early October, there was massive input from core group members to support the mother and children and improve the home conditions. This included an outreach support worker and visits at weekends. However, the cleanliness of the kitchen and bathroom continued to be of great concern.

4.16 The next core group meeting was held in the family home on 28 September 2015. There was considerable focus on sleeping arrangements, and the mother was reminded repeatedly about the risks of co sleeping, as it was unclear whether she was sleeping on the sofa in the lounge, close to child S who slept in a moses basket, or in her bedroom. During the meeting the health

visitor was concerned about child S who did not appear to be feeding well (she was breast fed) and seemed drowsy. After the meeting she weighed child S and was concerned about a drop in her weight. She made an appointment for the baby to be seen by a GP later that day. The GP was concerned about child S, but the baby was not dehydrated. He spoke with the health visitor by phone and understood that the family was having an assessment by their social worker later that day, so he did not refer for an immediate assessment; instead he referred her for a paediatric assessment. This had not taken place before her death.

4.17 On 12 October 2015, the mother woke early on the sofa to find child S lying beside her unresponsive. Child S was admitted to a children's hospital and placed on life support. Sadly, her condition deteriorated and she died on 15 October after the support was withdrawn. Her mother explained that she must have fallen asleep while breast feeding her. No criminal charges were brought.

4.18 On 15 October 2015, child S's three older siblings were made subject to interim care orders and placed in foster care. They were subsequently made subject to care orders and now live with a member of their extended family

5. THE FAMILY

Child S's mother

5.1 Child S's mother agreed to speak with the author by phone. She was very positive about the health visitor, community midwife and all the staff at the specialist children's hospital, all of whom she described as 'amazing'. She felt that they all did their best to help her. She was also positive about the outreach support worker and the staff at the older children's school. She was critical of the social workers as she considered that she did all they asked of her but it was never enough. She wished she had received more professional help (and help from her family) after her discharge from hospital in April 2015 when she was very weak.

5.2 Understandably, her main preoccupation was the loss of her three older children, which compounded the loss of child S. She did not believe that they should have been removed from her care, and she was unhappy with the current contact arrangements. In her view, the family member looking after them receives far more support than she did.

Child S's father

5.3 The father also agreed to speak with the author by phone. He did not feel able to comment on the agencies working with the mother and his children, as he was not involved with them. He took the same view as the mother that she needed more help after her serious illness, that she did everything that was asked of her by Children and Families, and the older children should not have been removed, and that the family member looking after them receives more support that the mother did.

Child S's grandmothers

5.4 The maternal and paternal grandmothers were also invited to contribute to the review. They both had considerable involvement with child S's siblings and had, between them, looked after them on three occasions during the time frame of this review. The paternal grandmother agreed to speak with the author by phone. She praised the input from the nurses at the children's hospital and from Wiltshire Police at the time of child S's hospitalisation and death. The family was given contact details of five different bereavement services; she herself had benefited from contact with the Lullaby Trust, which had put her in touch with another bereaved grandmother.

5.5 The paternal grandmother also commented that the mother had valued her health visitor and appreciated the continuity, as she had known her for seven years. In her view the key issue was the state of the home and the mother would have benefitted from more help with cleaning. She also commented that the mother was very tired due to her recent illness and breast feeding; she was not getting enough sleep.

5.6 Her main criticism was the decision to move child S's three siblings into foster care many miles from home on the day that child S died. In her view, this was not in their best interests and compounded the feelings of loss experienced by all family members. She felt that the process of securing the older children's future should have been slowed down and options explored within the family. (They now live with a family member). In response, Children's Services

explained the complexity of assessing family members and that placement so far away was in order to keep the three children together.

5.7 Despite several attempts to contact her, the author has not been able to speak with the maternal grandmother.

6. THE AGENCIES

6.1 Wiltshire Police

6.1.1 Wiltshire police had previous involvement with child S's family recorded on their systems which relate to concerns around domestic abuse, child protection and drug/alcohol abuse. There was involvement with child S's family on four occasions during the time frame of the review. The first was an investigation into child neglect in April 2015 following a referral from the siblings' school about the state of the family home. The detective constable (DC), leading the investigation, worked closely with the allocated social worker. They advised that the family home was not in a fit state for the children to return following the mother's discharge from hospital, and the DC advised that the children would be made subject to police protection if they returned before improvements had been made. On a later date, the DC and social worker checked the state of the house, which had improved dramatically following assistance from family and friends. A detective sergeant subsequently reviewed the evidence and decided that no further action was necessary. Her rationale was that, although the house had been in a very bad condition, the mother's poor health meant that it was not proportionate to caution her. Following police and social work intervention, the situation had improved significantly; therefore, it was not in the public interest to seek a prosecution. Police involvement continued in the initial child protection conference.

6.1.2 The second involvement was in August 2015 when a strategy discussion was undertaken by the Multi Agency Safeguarding Hub (MASH) following a concern that the older siblings might be staying with someone who posed a risk to children while their mother was in hospital giving birth to child S. Social workers tracked the children's whereabouts and it was established that they were safe. No further action was taken by the police.

6.1.3 The next involvement was the following day when further concerns were raised about the older children's care while their mother was in hospital. The children's services emergency duty service (EDS) requested that the police check on the children's whereabouts as it was believed that their father was caring for them. Police officers visited the paternal grandmother, who confirmed that she was caring for the children. The officers saw the children. They then contacted the father, who confirmed that he had no contact with the children. No further action was necessary, apart from updating EDS.

6.1.4 The final involvement was on 12 October 2015 when the ambulance service notified police that child S was in cardiac arrest, and rapid response procedures were carried out. Two officers attended the family home, one of whom was the DS who had reviewed the child neglect investigation in April 2015 to allow continuity. This DS was in contact with children's services and the specialist hospital during the next two days. She also took a statement from the mother and went to the hospital after she had heard about the baby's death.

6.1.5 The IMR author concludes that the practice of the Wiltshire police officers and staff was entirely appropriate. While the decision not to caution the mother in April 2015 might be seen as controversial as there was sufficient

evidence to do so, the author is satisfied that the poor state of the house was part of a much bigger child protection concern in which the focus was intervention and support to rectify the problem. The lead reviewer agrees with her conclusion.

6.1.6 The IMR author also notes that the response officers went beyond the minimum requirements when checking on the children's safety in August 2015. As well as seeing the children at the grandmother's home, they additionally contacted the father independently, showing respectful uncertainty. She particularly commends the DS involved at time of child S's hospitalisation and death for showing levels of compassion and support to the mother (and extended family) that went beyond what was expected of her in her role.

6.1.7 While the IMR author notes the generally good communication between Wiltshire police and children's services in this case, she also notes learning in the circumstances when a child is critically ill but has not yet died, as it appears that, at times, the communication between the two agencies was disjointed. She, therefore, recommends that, in such circumstances, meetings/discussions should take place every 24 hours between the relevant DS and social worker to ensure that each is fully up to date with the other's actions and intentions for that day. The lead reviewer endorses this recommendation

6.2 The General Practitioners

6.2.1 Two of child S's older siblings, the mother and the father were all registered at the same GP practice, which has a very high caseload of vulnerable families. The third sibling had not been registered despite reminders, resulting in a delay in immunisations. However, both this sibling and child S had been registered by the time of her death. The practice was aware of the family background of domestic abuse and parental substance misuse, along with the mother's history of significant medical issues as well as a history of depression. The practice was concerned about the welfare of the children in the family. Despite her history of several life threatening illnesses, the mother (and her three children) was an infrequent user of primary care services and frequently did not attend appointments in secondary and tertiary care.

6.2.2 During the timeframe of this review, the practice's involvement was around the mother's pregnancy. She was only seen once with child S on 28 September 2015 because of the health visitor's concerns about child S's weight. The GP who saw her was contacted by the health visitor by phone before the consultation; she updated him about her concerns about the baby's weight loss and demeanour. He then rang the health visitor after the consultation to tell her that he did not think an immediate paediatric assessment was necessary that day. The GP believed that the family had a social work visit later that day; had this not been the case, he would have arranged for child S to be seen by the hospital paediatric team later that day. Although concerned about the baby's weight, after examining the baby, he was content to make a referral to the community paediatric team.

6.2.3 The IMR author concludes that the GP's involvement with child S was appropriate from a medical point of view. However, she notes that overall information sharing would have been much stronger if the practice had been more involved in the child protection process; for example, analysis of the risks to the children of incomplete immunisations and poor hygiene in the home, alongside the effects of the mother's medical history and depression on her ability to parent may have enhanced the application for care proceedings. The practice had no record on file of invitations to child protection conferences or minutes of conferences during the timeframe of this review, and was not aware of the care proceedings application. (Subsequent enquiries revealed that the practice had been invited to some of the conferences and sent minutes). The practice works closely with both health visitors and midwives, and the health visitor is used as a conduit of information sharing with children's services. Good practice suggests that GPs should be more involved themselves. While noting that this GP practice has been proactive in its take up of safeguarding training with almost all GPs trained to level 3 intercollegiate competencies, the IMR author makes suggestions about how they could be more involved in child protection processes. The lead reviewer endorses the recommendation that as a minimum the practice should provide a report to child protection conferences, providing holistic information about a family, as suggested in the GP Safeguarding Toolkit.

6.3 Great Western Hospitals NHS Foundation Trust

6.3.1 The community midwifery service provided by the local hospital was involved with child S's mother during her pregnancy with her. The first involvement was in March 2015 when a community midwife booked her for pregnancy care and reviewed the past history. She recognised the safeguarding concerns and passed them onto the safeguarding midwife for review. The safeguarding midwife did not contact Children's Services Family Contact Point (FCP) until 3 weeks later. A referral to children's services was requested but this was not made for a further three weeks. The delays were due to workload issues and lack of cover of the safeguarding midwife's responsibilities when she was on leave.

6.3.2 Early in April 2015, the mother contacted the GP surgery as she was unwell. The community midwife phoned her back and was so concerned that she decided to visit her between her morning and afternoon clinics. On arrival at the family home, it was clear that the mother was very unwell, so the midwife rang immediately for an ambulance to take her to hospital, where she spent eleven days in the intensive care unit (ICU)

6.3.3 Following her discharge home after nearly three weeks in hospital, the community midwife went out of her way to see the mother at home for her appointments (most appointments are held at GP surgery or hospital). She was very sensitive to the needs of the mother for support but also involved in child protection processes, working closely with the social workers to address the safeguarding concerns. She saw child S on several occasions after her birth and had no specific concerns about her health and wellbeing during this four weeks period. The IMR author commends the community midwife for her exceptional care of the mother, alongside her alertness to child protection

concerns, including her potentially lifesaving action to ensure that the mother received urgent medical treatment in April 2015. She was supported in her work by the safeguarding midwife, who, despite her limited capacity, persistently monitored the actions in relation to this family.

6.3.4 The IMR author helpfully includes in her report information from the Society of Critical Medicine about the effects of a stay in ICU. Specifically, recovery can be lengthy, and up to 50% of all patients who stay in ICU for a week or longer develop muscle weakness which makes the activities of daily living difficult and the patient may take more than a year to recover. The author rightly queries whether the agencies working with the mother appreciated the impact of her poor health on parenting. She identifies important learning that, following a stay in ICU, there should be greater consideration given to assessing the ability of a parent to be able to care for their children, particularly those that are lone parents or have limited support.

6.3.5 The author also identifies the lack of communication around ICU/hospital discharge to midwifery and obstetrics; the discharge letter was only sent to the mother's GP. She makes a number of recommendations to improve sharing of information and the quality of records within the Trust.

6.4 Swindon Borough Children, Families and Community Health

Health Visiting

6.4.1 The health visitor had worked with the family since 2007, so had delivered a service to child S's three older siblings. In the past she had made a number of referrals to children's social care because of her concerns for the health and emotional wellbeing of the children. She was particularly concerned about the mother's persistent low mood and tried to encourage her to go to her GP to enable her mental health to be assessed.

6.4.2 During the time frame of the review, the health visitor conducted a developmental assessment of child S's youngest sibling in April 2015 and visited again in July 2015 to review development and weight. She visited child S on four occasions during August and September, two of which coincided with core group meetings in the family home. She discussed sleeping arrangements for child S and gave the mother the leaflet from the Lullaby Trust about safer sleeping, pointing out the important aspects and mentioning sudden infant death. She also focussed on persuading the mother to register child S and her youngest sibling with the GP.

6.4.3 The health visitor had no serious concerns about child S until her last visit on 28 September 2015. Her weight had dropped by between 2 – 3 centiles. Her weight gain since birth was so small that this is deemed a significant loss in NICE guidance. The guidance to professionals is that they should action urgent follow up. The health visitor also observed how quiet child S was. She gave her a small amount of formula feed in a bottle but noted that the baby needed encouragement to be kept awake and to continue to feed. The health visitor rang the GP practice to organise an appointment for child S and her mother later that day. She spoke to the GP to explain her concern about the baby's demeanour and the significance of the drop by 2 – 3 centiles. She also told him that she herself had fed the baby some formula during the morning

and that this would impact on the baby's alertness at the time of the GP appointment.

6.4.4 Later, the GP rang the health visitor when the mother and baby were with him to inform her that, in his view, child S was well and was alert at the visit and he did not think immediate assessment by a paediatrician was required. The health visitor recalls checking that the GP remembered that she had fed child S some formula which would have influenced her presentation. She also recalls offering to contact the social worker to explain that an immediate referral to the hospital paediatrician should take precedence over the scheduled meeting with her to start the parenting assessment. She remembers the GP telling her that he would refer child S to the paediatrician as a matter of urgency. The health visitor did not challenge this decision but considers that her representations above constituted a professional challenge to the GP's thinking. The health visitor was about to go on two weeks' leave so made sure that the mother had contact details of her colleague health visitors and alerted them in case of contact during her absence. She assumed that the paediatric assessment would take place during her two weeks' absence, so she did not ask her colleagues to weigh child S during her leave. She reflected that if she had thought the assessment was not going to happen quickly, she would herself have referred child S by ringing the consultant paediatrician on call, which is established health visitor practice. The health visitor acknowledges that this level of detail about the events of 28 September 2015 is not recorded in the case notes.

6.4.5 The IMR author concludes that the service offered to this family was in line with what is agreed good practice for families where babies and young children have safeguarding needs. There was evidence of good practice in ensuring that child S was seen quickly by a GP following the health visitor's observed concerns. The health visitor herself, at the learning event, reflected whether she should have challenged the GP's decision that an urgent referral to a paediatrician was not necessary, and possibly have escalated the matter. The lead reviewer, while commending the health visitor for her prompt action, queries why no arrangement was made for a health visitor colleague to check that the paediatric assessment had happened, and to weigh and monitor child S during her two weeks' absence, given the significance of the small weight gain and the baby's status subject to a child protection plan and interim supervision order.

Social Work

6.4.6This service had considerable involvement with the mother and her children for many years because of concerns about parental alcohol and drug misuse, the unhygienic state of the home, domestic abuse witnessed by the children, and very poor school attendance by child S's two oldest siblings. The children lived in a home that was chaotic, untidy and filthy, at times, and had been subject to child protection and children in need plans over several years. Nevertheless, at the start of the timeframe for this review, the case was closed to Children and Families due to an apparent improvement in the condition of the home by January 2015.

6.4.7 The brief chronology in section four outlines key details of Children and Families involvement between April – October 2015 so they will not be

repeated here. The IMR author concludes that during the period of the review, social work practice was good in relation to the work undertaken with the children and their parents. Social workers clearly explained their concerns to both parents and outlined what might happen if things did not improve. Attempts were made to involve the father and to get to know him. They made clear efforts to get to know the older children and build a relationship with them; they were seen both on their own and with their mother. Practical help was offered to clear up the house that was initially rejected, but then accepted once the care proceedings had commenced. Safeguarding procedures were used appropriately and timescales adhered to. The multi-agency group of professionals appeared to function well with good attendance at core group meetings and good information sharing in between. Care proceedings were initiated in a timely manner. The lead author endorses this conclusion.

6.4.8 The author highlights that the key issue in this case was difficulty in presenting evidence to the courts to justify immediate removal of children in cases of chronic neglect. She therefore recommends:

- workshop between staff from Children and Families Service and Legal Team to consider research on neglect and form a shared view of the effects on children
- training made available to staff about the effects of long term drug use on the brains of those who misuse drugs
- further training in court work for social workers with particular emphasis on the PLO and writing of statements for court

The lead reviewer endorses these recommendations.

6.5 Swindon Borough Council Law and Democratic Services Department

6.5.1 This case was open to the Legal Department from June 2015 to January 2016, when care proceedings were concluded on child S's siblings. During the first period up to mid-August 2015, legal advice was provided on the grounds to proceed to a pre proceeding meeting and then to make an application to court. The IMR author concludes that the actions taken by the Legal Department and the legal advice provided were appropriate. The lead reviewer, based on her discussions with the assistant team manager and child care lawyer, at the learning event, concurs with this view.

6.5.2 The second period was in mid-August, covering the care proceedings application for Emergency Protection Order (EPO)/Interim/Care Orders in respect of the three older siblings, up to the initial hearing, which also included an application for an EPO in respect of child S. After discussions at court, the case was transferred on the same day from the magistrates court to a district judge to hear EPO applications on all four children. After further discussions and agreement between the parties, no order was made and the case was adjourned for an interim care order application three days later. The agreement was based on a temporary arrangement whereby the paternal grandmother would supervise the care of the children and the father signed an agreement not to go to the family home. The legal services IMR author explains that the case of X Council v B established that separation under an

EPO is only to be contemplated if immediate separation is essential to secure the child's safety – i.e. imminent danger must actually be established. Given this case law, he concludes that the agreement reached by Children's Services, with legal advice, for there to be no order appears to be reasonable.

6.5.3 The most significant event was the interim care order hearing before the same district judge. During pre-hearing discussions, the mother indicated that she would not agree to interim care orders. The Children's Guardian did not feel that there was enough to justify interim removal without a fuller hearing or a contested case. When the parties went before the district judge she indicated that her view was that there was not enough evidence for her to separate the four children from their mother under an interim care order. The parties then had more discussions and an agreement was reached by all that there should be interim supervision orders on all four children supported by a tight written agreement which set out requirements as to the mother's care of the children and also provided that the father's contact must be supervised. Further assessments were ordered, including a viability assessment of a relative as possible carer for the children. A date was fixed for a contested hearing and case management at the end of October. If the mother breached the written agreement, there was court permission for the local authority to return to court for removal of the children.

6.5.4 The IMR author explains that relevant case law (Re L – A,2010) requires a judge, when deciding whether to make an interim care order, to test whether a child's safety demands immediate separation, as well as considering the statutory grounds set out in Section 38(1) of the Children Act 1989. This means that cases of longer term neglect are difficult to prove at an interim stage. The author notes that the social worker's statement for the hearing provides an analysis of harm and the impact on the children and an analysis of parenting capability, but the statement could have been clearer as to why the children's safety demanded immediate separation at an interim stage, which would have assisted the judge. Having read the statement, the lead reviewer agrees.

6.5.5 The IMR author concludes that the child care lawyer's practice was reasonable in advising the social worker and her manager not to pursue an application for interim care orders, as the judge had indicated her view, the Children's Guardian had indicated his view that there was not enough evidence to justify immediate removal, and there was the possibility of an agreement with the mother and the father on key actions to reduce risks pending a final hearing. During discussion at the learning event, the social worker and her manager, child care lawyer and Children's Guardian all accepted that, given that there was no specific event (apart from the birth of child S) to warrant immediate removal and the social worker's statement focussed primarily on chronic neglect over many years, the actions were reasonable.

6.5.6 Finally, the IMR author notes that, following child S's admission to hospital in October 2012, swift action was taken to secure the removal of the three surviving children on interim care orders, a key factor being the evidence that the mother had breached the written agreement by sleeping with child S.

6.5.7 There are two similar recommendations to those made by the author of the Children and Families IMR:

- that the format for the first social worker statement is reviewed to include a section heading as to why the child's safety demands immediate separation at an interim stage
- that there is further training by the Legal Department of Children's Services staff on the preparation of statements and the evidence needed to satisfy the grounds for an interim care order.

At the learning event, relevant staff agreed that these were key learning points from this review.

6.6 Cafcass

6.6.1 An experienced Children's Guardian was involved in the public law proceedings in relation to the three older siblings from mid-August 2015 and was involved with child S following her birth until her death on 15 October 2015. By the time of the first court hearing, he had not had time to read the application. At the learning event, he explained this was due to annual leave. However, he was involved in the negotiation of the safety plan to protect the children during the four day period until the adjourned hearing. On that morning, having read the initial papers, he visited the family home in order to meet the mother and all four children, and make an initial observation, and inform his views for the court hearing. He did not support immediate removal of the children, and the children's solicitor advised that the threshold for immediate removal was not met. He recognised that there were serious concerns but was focussed on the longer term picture, informed by the proceedings. He next had contact with the family and key professionals when he attended the core group meeting on 28 September 2015.

6.6.2 Significantly, in this case, the initial Case Management Hearing (CMH) took place before the Children's Guardian was ready to prepare an initial analysis report. The district judge set the second CMH (and a contested hearing) to start on 29 October 2015, because there was insufficient court time for her to hear it earlier. However, the late setting of this CMH influenced the work of the Children's Guardian. It is usual for the Guardian to prepare an initial analysis report for the CMH. Its main purpose is to identify gaps in evidence and provide advice on behalf of the child about what might be needed and by when. In order to prepare such a report Children's Guardians need to frontload their work and quickly understand the issues in the case. If the second CMH had been scheduled earlier, the Guardian would have prepared an initial analysis report, which would have facilitated a systematic analysis of the issues relating to each child at that point. At the learning event in April 2016, the Children's Guardian explained that, while he did not consider that there was a specific event to justify immediate removal in August, his view might have been different if he had undertaken an initial analysis report shortly afterwards. He also noted that the local authority case was weakened by there being no social worker present in court who knew the family. The social worker that had written the statement had just left the country and was unavailable, and the new social worker had just taken over.

6.6.3 The IMR author notes some learning for the practitioner in this case. The broader learning relates to identifying and managing the risks associated with neglect. She highlights on line learning material available to CAFCASS Guardians which could assist them in being more systematic and bringing a child's lived experience to the fore. She also helpfully notes that CAFCASS is currently working with the NSPCC who have been commissioned to develop a tool in Spring 2016 to support analysis in neglect cases. The Children's Guardian's manager is signed up to becoming a trainer for this tool and will deliver training to her team. She has also volunteered her team to participate in a six month follow up to provide feedback and contribute to any changes that may be required. Thus, local Children's Guardians will be benefitting from a specific focus on neglect.

6.7 Wiltshire Probation Trust

6.7.1 The father was sentenced to a community order of twenty four months in March 2014 for common assault, which prevented contact with the victim, the mother of his children, unless approved by his supervising officer. During the time of the order, the probation officer had contact with Children's Services in September 2014 when the father had sanctioned contact with his children in order to assist during the mother's serious illness.

6.7.2 During the time frame of this review, the probation officer attended the initial child protection conference in May 2015 and had telephone contact with the children's social workers sharing information and risk assessments.

6.8 Swindon Borough Council Education Service

6.8.1 Child S's older siblings attended the same primary school/nursery. The school had many concerns and a considerable involvement with the family over many years. A family support worker had been involved as was the school nurse. During the time frame of this review, members of the school staff were appropriately involved in attending child protection conferences and core group meetings. It was clear from discussion at the learning event in April 2016 with the head teacher, school nurse and family support adviser that they were all committed to meeting the children's needs both educational, and emotional and social. The children were provided with a range of support in school.

6.9 Swindon Borough Council Housing Services

6.9.1 The council was the mother's landlord. Its only significant involvement during the period of this review was to arrange a property inspection following a report from the social worker that the home was in a very poor state of repair. The mother was not at home at the time of the pre-arranged property inspection and subsequently advised in a telephone call the she had no outstanding repairs. The author of the briefing report notes that, with the benefit of hindsight, it might have been appropriate for a follow up on the condition of the house despite the tenant cancelling the appointment.

6.10 Coram Voice

6.10.1 The children's social worker arranged for the two oldest siblings to have their own advocate, which is good practice. They were seen by the advocate at school on five occasions, and their wishes and feelings were represented by the advocate at the review child protection conference and a core group meeting.

6.11 NSPCC

6.11.1 The NSPCC submitted a briefing report but their involvement with the family had ended in 2011 so was not relevant to this review.

7. KEY ISSUES

7.1 Communication

7.1.1 Generally, communication between agencies about this family was good. This is clear from the analysis in IMRs and from the discussion at the learning event.

7.1.2 Three significant gaps were identified. The first pertained to the mother's admission to ICU in April 2015. Sharing of information between Health organisations was not adequate; the youngest child's health visitor was not formally notified of the mother's serious illness, while the discharge summary was only sent to the family GP. Even though the mother was pregnant, her midwife and obstetrician were not given copies. Most importantly, information about the time taken to recover from such serious illness and the ongoing debilitating effects was not made available to key professionals, including social workers, which was particularly relevant for a pregnant lone mother of three children, with limited support.

7.1.3 The second gap pertained to GP involvement in child protection processes. Although the family's GP practice had good communication between GPs and community midwives and health visitors about many vulnerable families through minuted meetings, it appears that they expected health visitors to pass this information onto conferences and core group meetings, without this being explicitly agreed. The GP explained that this was due to limited capacity. In this case, the GP was not aware that care proceedings had been initiated.

7.1.4 The third was during the difficult time when child S was critically ill in hospital when communication between Children's Services and the Police about their intentions was not always clear.

7.2 Professional Standards

7.2.1During the period of the review, there were generally good professional standards in relation to the quality of assessment, identification of neglect, and decision making. However, in previous years, it appeared that opportunities had been missed to take positive action to protect child S's siblings from the impact of chronic neglect. A detailed analysis is beyond the scope of this review.

Assessment

7.2.2 It is to the credit of the children's social workers, and assistant team manager, supported by more senior managers, that they quickly assessed in the Spring of 2015 that the pattern of chronic neglect, interspersed with short lived improvements, was having an adverse effect on the older children and would be repeated with the expected baby. They acted quickly to assess the mother's parenting capacity, and when she failed to cooperate, sought legal advice and initiated care proceedings. While the social worker's statement for court could have been more specific about the immediate harm the children were likely to suffer, it is positive that the long term risks had been identified.

7.2.3 The community midwife immediately identified safeguarding concerns when she met the mother at her first ante natal appointment and passed them on appropriately. The head teacher and staff at the children's school were attuned to possible indicators of a deteriorating situation and were involved in conveying to Children's Services the grandmother's concerns about the state of the family home in April 2015.

7.2.4 The police officer and social worker collaborated positively in assessing the state of the family home together in April 2015 and the police officer was assertive in threatening legal action in respect of the children if it did not improve. The health visitor identified rapidly that child S required urgent assessment by her GP on 28 September and ensured that it happened. However, it is a cause for concern that no paediatric assessment of whether the slow weight gain was due to neglect had taken place by the time the baby was admitted to hospital two weeks later. The Swindon Clinical Commissioning Group reports that action is now being taken to improve the Failure to Thrive pathway and address waiting times for community paediatric services.

7.2.5 Gaps in assessment were about the mother's mental health and the possible impact on her functioning of long term drug use. These were due to her failure to attend GP appointments when encouraged to do, and until care proceedings were initiated, there was no legal mandate to compel her to cooperate.

7.2.6 Another gap was accuracy about the father's involvement with the mother and the children. Despite efforts to engage him by the probation officer and the social worker, it is clear that he had more involvement than either he or the mother admitted.

Identification of neglect

7.2.7 The nub of this case is timely identification of neglect and its pernicious effects on children. Despite possible failures to act assertively in the past to protect the children, in 2015 all agencies were collaborating effectively and were alert to the neglect suffered by the children. The key issue in 2015 was preparation of evidence to satisfy a judge that the risks from ongoing neglect were so serious that immediate removal of the children from their mother was justified. The assistant team manager considered that the birth of a fourth child increased the risk significantly. However, the case law with regard to interim care orders requires clear evidence of immediate harm to warrant immediate separation, and the judge, Children's Guardian and the children's solicitor did not consider that this threshold had been met.

7.2.8 There is learning for Children's Services and legal services about the effective drafting of court statements when immediate removal of children is deemed necessary in the context of chronic neglect. Legal services report that changes have already been made to the social worker template for court reports. It is encouraging that the local CAFCASS team will be involved in piloting a new assessment toolkit around neglect. It could be helpful to take the debate to the local judges, as this is a notoriously difficult area.

The children's voices

7.2.9 Child S was only eight weeks old when she died. She was seen on numerous occasions by the community midwife, health visitor, social worker and outreach support worker. Throughout the last four weeks of her life she was seen by a professional several times each week, as a massive package of support, coordinated by the core group, was in place to support her mother and monitor the children's wellbeing. Overall, there were positive observations of her development and interaction with her mother. There was some concern about her grubby appearance and about her slow weight gain, which became more concerning on 28 September.

7.2.10 The older children had improved attendance at nursery and school so were observed and spoken with on each school day. The school nurse was supporting the oldest child with one to one sessions.

7.2.11 The children's social workers made strenuous efforts to communicate with the two oldest children and regularly saw them on their own. These two also had an advocate from a voluntary organisation, who saw them several times. Their experiences, wishes and feelings were communicated to the core group and in the court statement.

Decision making and risk analysis

7.2.12 From April 2015 onwards, safeguarding procedures worked effectively for the older children and subsequently for child S. She had been identified as a child at risk of neglect before her birth. There was a core group of professionals collaborating proactively to safeguard her and oversee the written agreement in place through the care proceedings. The only gap was the delay in obtaining a paediatric assessment of her slow weight gain and whether neglect was a factor. This was due to her GP assessing that an immediate referral to a paediatrician was not required when he examined her on 28 September 2015, and delays in securing an appointment with a community paediatrician. A further concern was the failure to weigh child S in the subsequent two weeks. Her health visitor was on annual leave, but no arrangement was made to weigh the baby in her absence.

7.2.13 All the professionals working with child S and her mother were well aware the risks of co sleeping. The mother had been given written information by the community midwife when she left hospital after child S's birth. The health visitor had given her written and pictorial information and spoken with her about the risks during her new birth visit. The social worker had ensured that it was addressed in the written agreement. No one had any reason to believe that the mother had slept with any of the older children when they were babies, but some professionals believed that mother was sleeping on the sofa. All the literature and oral advice given to the mother addressed the specific risks of co sleeping on a sofa. Child S had a moses basket where she was to sleep at night; she often slept in a small pram in the living room during the day. At the learning event in April, all members of the core group were clear that they reminded the mother regularly of the risks of co sleeping, including sleeping on a sofa, especially the outreach support worker who saw her frequently. The Children's Guardian confirmed that it was a topic for

discussion at the core group meeting on 28 September, when the mother was present. It was reported that the mother's attitude was that this was her sixth baby and she knew the risks.

Effective professional practice

7.2.14 There were many examples of effective professional practice, including staff, notably the community midwife and the detective sergeant, involved at the time of child S's death, going beyond the call of duty to promote the mother's health and wellbeing.

7.2.15 There were some very good examples of inter-agency communication, cooperation and coordination. The hospital allowed the mother and baby to remain there for a few days while court hearings took place; the police and social workers generally collaborated well together. There was a huge level of coordinated support to the mother and children from August 2015, with a clear focus on safeguarding the children. All staff involved with the family were committed to doing their best for the children.

7.2.16 The social workers engaged well with the older children and ensured that they had independent advocates. School staff ensured that the children received additional support. The health visitor ensured that child S was seen quickly by a GP.

7.3 Organisational Issues

7.3.1 Effective preparation of evidence for court, especially in complex cases of chronic neglect, has been addressed above. Both Children's Services and Legal team would benefit from considering together ways to improve understanding of case law and practice before and during court hearings. Ideally, the judiciary should be involved.

7.3.2 The workload of the safeguarding midwife was highlighted in this case, given the significant delay in making a referral to Children's Services. While it made no difference to the safeguarding of the children, it needs to be addressed.

7.3.3 The capacity of GPs to be involved appropriately in child protection processes, ensuring that all relevant information is shared with child protection conferences and core groups, was also an issue, which is not confined to this family's GP.

7.3.4 It is concerning that no arrangements were put in place to check the progress of the paediatric assessment and monitor the weight of such a vulnerable baby during the health visitor's absence.

7.3.5 There are lengthy delays for appointments with community paediatricians. It is concerning that there did not appear to be any means of expediting the assessment of this vulnerable baby, subject to a child protection plan and an interim supervision order. As indicated in paragraph 7.2.4, this matter is being addressed by the clinical commissioning group.

7.4 Safe sleeping

7.4.1 The professionals working with child S ensured that her mother was aware of latest NICE Guidance on co-sleeping and sudden infant death syndrome (SIDS). The public health message recommends that parents are informed that there is an association between co-sleeping (parents sleeping on a bed or sofa or chair with an infant) and SIDS. The association is likely to be greater when they or their partner smoke. The association may be greater with:

- parental recent alcohol consumption, or
- parental drug use

7.4.2 They regularly reinforced these messages. The mother said that she smoked outside the family home, and there was no evidence to the contrary. The mother had a longstanding pattern of alcohol and drug misuse, but all professionals working with her stated at the learning event that they saw no evidence of misuse during the period after child S's birth.

7.4.3 The author reviewed eight SCRs from other LSCBs where co-sleeping had played a part in an infant's death. The key themes were that co-sleeping occurred in the context of neglect and substance misuse. In most cases, the parent had consumed alcohol and/or drugs before sleeping with the infant.

7.4.4 One review noted that while health professionals had a good knowledge of the risks associated with co-sleeping, social workers did not. This was not the case with child S.

7.4.5 Recommendations relevant to co-sleeping included:

- reviewing the information about safe sleeping given to parents;
- health professionals to undertake a safe sleeping assessment to embed the information
- safe sleeping to be built into child protection plans

For child S, the information given was of a good standard, a safe sleeping assessment had taken place, and safe sleeping was built into the safety plan drawn up after the court hearings.

7.4.6 Research by Brandon et al into neglect and serious case reviews notes that, while maltreatment accounts for a very small proportion of SIDS, SIDS features in one in six of all death related SCRs. They also note that professionals can be falsely reassured about a baby's safety, even when the infant is subject to a child protection plan for neglect, saying that a good relationship between a baby and parent cannot keep the infant safe; for example, when co-sleeping with a parent who has consumed drugs or alcohol.

8. CONCLUSIONS AND LESSONS LEARNED

8.1 At the time of her death, child S was only 8 weeks old. The potential risks of significant harm through neglect were recognised before her birth; therefore, she was made subject to a child protection plan before birth. The social workers involved with the family assessed that the birth of a fourth child into a household where the mother was struggling to ensure hygienic conditions and adequate levels of care would increase the levels of neglect for all the children. They, therefore, applied for an emergency protection order in respect of child S shortly after her birth in August 2015. The order was not granted because the judge did not consider that the grounds for immediate separation of the baby from her mother were met. This was because her grandmother agreed to supervise the care of the baby and her siblings, subject to a written safety plan, for a four day period.

8.2 The social workers persisted in their application to separate child S and her siblings from their mother at a hearing for interim care orders four days later. Again, the judge did not consider that there was sufficient evidence to meet the case law test of immediate harm, which would justify immediate separation of the children from their mother. They were all made subject to interim supervision orders and a detailed written agreement was signed by the mother, which included that child S must sleep in her moses basket.

8.3 Thereafter, child S was seen very regularly by a number of different professionals each week, who reminded the mother about the risks of co sleeping, including on a sofa. Although her weight gain was slow, there were no significant concerns about the care of child S until the end of September 2015, when her weight gain was so slow and her presentation so drowsy that her health visitor made sure that she was seen by a GP within hours. The GP, after examining her, did not consider that immediate assessment by a paediatrician was necessary. Therefore, she was referred to a community paediatrician, but had not been seen by the time of her death two weeks later.

8.4 Wiltshire police accepted the mother's explanation that she had fallen asleep on the sofa with child S while breast feeding and concluded that her death was a tragic accident. No criminal charges have been brought.

8.5 All agencies working with child S and her family were alert to the risks of neglect and to the risks of co sleeping. It was considered that child S could only be protected from the chronic neglect suffered by her three older siblings if she were removed from her mother's care. However, they were not able to provide sufficient evidence to the judge to meet the legal threshold for immediate separation. This is notoriously difficult in cases of neglect, where a 'trigger' event is often missing. In this case, the local authority statement could not identify a trigger, apart from the stress caused by a new baby.

8.6 During her short life, there was no opportunity to present further information to the court which might have justified removal. (The next court hearing within the care proceedings was scheduled for two weeks after child S's death). It might have been helpful if child S had been weighed in the last two weeks of her life and if a paediatrician had assessed speedily whether her slow weight gain was due to neglect. Also, it might have been helpful if the contested interim care order hearing had been scheduled earlier in the proceedings,

thereby requiring the Children's Guardian to analyse potential risks to all four children. Any of these options may have provided additional evidence to present to the judge, but, obviously, this is mere supposition.

8.7 This review has revealed much good practice by the professionals working with child S and her siblings. In particular, after many years of neglectful parenting, its impact on the children was recognised, and positive action was taken to improve the quality of the lives of child S's siblings. The nub of this case is the difficulty in meeting the legal threshold for removal under an interim care order in cases of neglect. Swindon Children's Services and Legal team have already identified lessons from this case, while CAFCASS, nationally and locally, is involved in a project to sharpen practice in cases of neglect. This case has already been discussed by the Chair of Swindon Safeguarding Children Board with the local senior judge, with a view to considering lessons learned.

8.8 Other learning from this case has been the need for greater understanding of the impact of very serious illness, notably time in intensive care, on parents' subsequent functioning and their physical ability to provide day to day care for their children.

8.9 This review has also identified possible gaps in resources, notably workload of the safeguarding midwife in Swindon, GPs' capacity to be involved in child protection processes, and significant wait for community paediatric assessment.

9. RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW

9.1 Introduction

9.1.1 These recommendations reflect the key issues arising from this review. Agencies have not awaited the completion of this review in order to address issues arising from this case. Some of these recommendations, or aspects of them, have been identified and addressed already. Individual agencies have made recommendations following their own reviews, not all of which are listed here.

9.2 Recommendations to the Swindon Safeguarding Children Board

9.2.1 The Board should ensure that expectations about minimum requirements of GPs' involvement in child protection processes are agreed with the Clinical Commissioning Group and that their implementation is monitored

9.2.2 The Board should satisfy itself that there is sufficient capacity to fulfil the requirements of the safeguarding midwife role

9.2.3 The Board should clarify the processes for vulnerable children being assessed speedily by community paediatricians and consider whether any changes are necessary

9.2.4 The Board should engage with local Family Justice Board to consider any lessons learned from this SCR

9.2.5 The Board should make representations to the Department for Education and the Ministry of Justice, requesting that the judiciary be required to participate in serious case reviews when they have had recent involvement with the child and family

9.3 Recommendations to Swindon Borough Council

9.3.1 The health visiting service should review its procedures on escalation of concerns and on cover arrangements for vulnerable children in the absence of their health visitor

9.3.2 The Children and Families Service and Legal team should consider positively in which circumstances a statement from a GP might be helpful in care proceedings.

9.3.3 These recommendations from the individual reviews are endorsed:

- the format of the first social worker statement is reviewed to include a section heading as to why the child's safety demands immediate separation at an interim stage
- there is further training by the legal department of children's services staff on the preparation of statements and the evidence needed to satisfy the grounds for removal under an interim care order

- workshop to be held between staff from Children and Families Service and legal team, including Children's Guardians, to consider research on neglect and form a shared view of the effects on children
- training to be made available to Children and Families staff about the effects of long term drug use on the brains of those who misuse drugs

9.4 Recommendation to Swindon Borough Council and Wiltshire Police

9.4.1 This recommendation from the Police individual review is endorsed:

- in periods of 'limbo' when a child is critically ill, meetings should be held every 24 hours, by phone or in person, between the detective sergeant and social worker to ensure that they are fully up to date with the agencies' actions and intentions for that day

9.5 Recommendation to Great Western Hospitals NHS Foundation Trust

9.5.1 The Trust should consider how individuals, their families and professionals working with them can develop a greater understanding of the impact on patients after discharge from intensive care, notably the impact on the ability of the patient to be able to care for their children effectively

9.5.2 The Trust should ensure that all relevant health professionals are notified of the discharge of vulnerable patients

9.6 Recommendation to CAFCASS

9.6.1 CAFCASS should consider how Children's Guardians can be involved in workshop with social workers and local authority legal services to consider research on neglect

Appendix A Composition of Case Review Group

Alex Walters, Independent Panel Chair

Designated Doctor, Swindon Clinical Commissioning Group

Head of Children, Families and Community Health, Swindon Borough Council

Service Manager, Early Help, Children, Families and Community Health, Swindon Borough Council

Service Manager, Quality Assurance and Review, Children, Families and Community Health, Swindon Borough Council (SCR Champion)

Area Manager, Gloucestershire/Wiltshire Probation Trust

Continuous Improvement and Strategic Support, Public Protection Unit, Wiltshire Police

Service Manager, Swindon NSPCC

LSCB Strategic Manager

LSCB Quality Assurance and Training Manager

Divisional Director of Nursing, Women and Children's Division, Great Western Hospitals NHS Foundation Trust

In attendance

Helen Davies, Independent Lead Reviewer

Appendix B: Details of the independent lead reviewer/author of this report.

Helen Davies trained in social work and worked in local government in a range of social work and management positions, including thirteen years as an assistant/deputy director of children's services. Since 2011, she has worked as an independent consultant and been involved in a number of reviews in respect of children and adults. She has never worked in any of the agencies involved in this review.

Appendix C: Terms of Reference for this Serious Case Review

The serious case review primarily considered events in the period from April 2015, when the mother's pregnancy with child P became known to Children's Services until mid October 2015 when child P died. However, all agencies were requested to include relevant background information about her three older siblings. Child P is the main subject of this review but the circumstances in relation to any safeguarding issues for her siblings needed to be fully considered.

The agencies were asked to draw up their individual management reviews around the following issues:

- Did agencies communicate effectively and work together to safeguard and promote the children's welfare?
- Was the level and extent of agency engagement and intervention with the family appropriate? Were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and historical information?
- Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental anti social behaviours or concerns re neglect? If so, was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?
- Were the decisions and actions that followed assessments appropriate and were detailed plans recorded and reviewed?
- Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of young non verbal children being fully considered?
- Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?
- Did events and the information available appropriately inform the application for care proceedings?
- Was information on co-sleeping provided and were the risks understood?
- Were there any organisational or resource factors which may have impacted on practice in this case?
- Were appropriate management/clinical oversight(supervision) arrangements in place for professionals making judgments in this case?
- The lead reviewer to consider national research and findings from other SCRs and make recommendations as appropriate

Appendix D: Principles Underlying this Serious Case Review

The conduct of this review has not been determined by any particular theoretical model. It has been carried out in keeping with the underlying principles, set out in the statutory Guidance, Working Together to Safeguard Children 2015:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections;
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did;

Appendix E: References

This report has been generally informed by the following publications

- Working Together to Safeguard Children (Department for Education 2015)
- In the Child's Time: professional responses to neglect (Ofsted 2014)
- Missed Opportunities: Indicators of Neglect – What is ignored, why, and what can be done Brandon et al (DfE Research Report 2014)
- Neglect and Serious Case Reviews, Brandon et al (University of East Anglia/NSPCC 2013)
- Repository of Serious Case Reviews, NSPCC
- National Institute for Health and Care Excellence (NICE) Guidance on co-sleeping and sudden infant death syndrome (updated 2014)