REPORT OF THE SERIOUS CASE REVIEW REGARDING

Baby N

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CONTENTS

Introduction and Background to the Review 3

The Terms of Reference 3

Review Process and Parallel Processes 3

Family input into the review 4

Summary of facts 4

Background history 6

Key points of intervention 7

Analysis 11

Lessons learned 18

Conclusions 21

Recommendations 23

Appendices 25

Appendix 1 – Terms of Reference for the Review

Appendix 2 – Temperatures in the caravan by month from September 2018 to December 2018

1 INTRODUCTION

Background to the review

1.1 This review was commissioned by Buckinghamshire Safeguarding Children Board (BSCB) as a Serious Case Review (SCR) following recommendations to the Board's Independent Chair that the circumstances met the statutory criteria for an SCR because a child had died, and the circumstances of the death indicated it to be the result of abuse or neglect. The criteria being:

(a) Abuse or neglect of a child is known or suspected; and
(b) The child has died[1]

1.2 Baby N's death and the circumstances of her siblings were reported to the National Panel on 20th January 2019. The recommendation to carry out a Serious Case Review had been confirmed by the Chair on 16th January 2019. The National Panel confirmed their agreement to the decision on the 19th February 2019

2 THE TERMS OF REFERENCE

2.1 The specific terms of reference are attached as Appendix 1. In addition to the requirements in the Terms of Reference, all agencies were asked to report on their work under the following headings. The author has also tried to capture the lived experience of each of the children based upon the environment they were living in and the comments made from contributing agencies' reports into this review.

The review was asked to consider the following specific questions:

- What would be a good practice version of services under a universal offer e.g. services that are available to all members of the public? Was this provided to the family? If not, what barriers prevented good practice and why?
- Were there any intra and inter agency communication barriers which prevented the provision of good services? If so, what were the causes of these?
- What was the impact of the family's movement between areas on sharing information, building an understanding of the family's needs and providing good specialist or universal services?
- How (if at all) did staff safety considerations impact on services offered?
- How were risk assessments completed, reviewed and shared in relation to visiting the children?
- Were there any additional or suspected additional needs identified in either, or both of the parents?
- Is there any other learning pertinent to the learning from this review?

2.2 The time frame of the review was from 1st January 2018 to the 26th December 2018. Agencies were also asked to provide a brief background of any significant events in respect of Baby N and her siblings, that took place prior to the timeframe.

3 REVIEW PROCESS

3.1 The review was conducted using a systems methodology that:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

[1] *Working Together to Safeguard Children, 2015 © Crown copyright 2015*

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. [2]

3.2 Information was received from the following sources:

- The Thames Valley Police
- Fire and Rescue Services
- 3 Schools
- Buckinghamshire Children's Services
- Southampton Children's Services
- Buckinghamshire Health Visiting Service
- Oxfordshire Midwifery Service
- A local hospital
- Northamptonshire Early Help Service
- Southampton schools and GPs
- The Aylesbury Vale District Council (AVDC)

3.3 The lead reviewer was Siobhan Burns, an independent social work consultant. She is an experienced senior manager in Children's Services, with over 20 years experience as a qualified social worker. She has held roles such as Head of Safeguarding and Head of Quality Assurance and Improvement. She is an experienced author.

3.4 She is independent of Buckinghamshire Safeguarding Children Board and the agencies that report into the Partnership.

4. PARALLEL PROCESSES

4.1 There were no parallel processes to this review.

5 FAMILY INPUT TO THE REVIEW

5.1 The mother and father chose to discuss the report after it was finished. They shared their views that they did not feel listened to by professionals that they came into contact with, during the period covered by this review. They described that when they asked for help, this was not responded to or taken seriously. The parents were asked about their views of what agencies could have done differently. They responded by saying that it would have been helpful if professionals from housing and the health visitors could have visited the caravan. They reflected that had this have happened, professionals would have known how bad it was for the family, living in the caravan.

[2] HM Government, (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*. London: Crown copyright 2015.

6 SUMMARY OF FACTS

6.1 Family composition

Family member	Relationship	Ethnicity	Age at the time of the child's death
Baby N	Baby girl that died	White British	Died aged 13 weeks
Z	Sister	White British	11 years
Y	Brother	White British	6 years
X	Brother	White British	5 years
W	Sister	White British	3 years
V	Brother	White British	2 years
PGM	Paternal Grandmother	White British	n/a
PGF	Paternal Grandfather	White British	n/a
MGM	Maternal grandmother	White British	n/a
Mother	Mother	White British	28 years
Father	Father	White British	32 years

6.2 In March 2018 the family moved to Buckinghamshire. The mother reported that she had left Southampton as she had experienced physical abuse at the hands of the MGM. Another reason given by the children's mother for the move was to be closer to the paternal family for support. Although their move had resulted in them being closer to the paternal family, they were not living in the same county.

6.3 They had secured a static caravan a short distance from the border of the county where the wider family lived.

6.4 X, Y and Z attended schools in a neighbouring county, Northamptonshire. Baby N and V were too young to attend school and remained at home with their mother. Child W was entitled to free nursery provision, but she was too young to be transported without a parent. She therefore did not access early education.

6.5 There were indications that the parents found managing their income a challenge.

6.6 All six children and their parents lived in the caravan which had three bedrooms, a small shower area, a toilet and a lounge/kitchen area. The three male children shared a room which had two single beds and the two female children shared another room with two single beds. Baby N was reported by the parents to have been sleeping in a Moses basket in their bedroom.

6.7 In August 2018 the father contacted the police. A neighbour's friend was reported to have taken a video of X whilst he was in the caravan. The caravan windows were open, and the curtains shut. X had been videoed whilst naked, playing with his penis. X was five years old at the time of this incident.

6.8 The neighbour's friend is reported to have then shared this video with two other people on the site. The father later called the police to tell them that he felt the matter had been resolved. This incident was reviewed as a low-level crime by the police and no further action was taken.

6.9 On the 26/12/2018 at 5.07am a call was received by the Police from the ambulance service reporting that a thirteen-week-old female child was in cardiac arrest. The mother told the ambulance staff that she had woken up in the night and went to check on the children. Baby N had been brought into the parent's bed due to the cold temperature in the caravan. At 6.53am paramedics confirmed that Baby N was dead.

6.10 Police door to door enquiries shortly after Baby N's death showed that the families' caravan and conditions were in stark contrast to those around it. The caravans in the surrounding plots were described as "well kept" and "warm", by the officers that attended.

6.11 The children's living conditions were observed in September 2018 by midwifery staff. No other professionals saw the children's home between October 2018 and the time of Baby N's death.

7. BACKGROUND HISTORY

7.1 Records show that the family lived in Southampton in 2011. Some support was offered to the family during this time due to Z's low school attendance, which was as a result of her suffering minor health issues. No other services were provided in this area prior to the first move to Northamptonshire.

7.2 School records show that the family moved to Northamptonshire in January 2013. Between July and September 2014, a children's services assessment was undertaken of the children's needs. This was triggered by concerns that Y had suffered a significant bruise to his face. Agencies were also concerned that no medical attention had been sought for Y at that time.

7.3 During this assessment the family informed the Northamptonshire social worker that they intended to move to Southampton, as they had "no support in the area" and they had to move out of their rented property.

7.4 The then social worker noted that there were "concerns regarding the poor home conditions which would have meant that there would have been on going involvement from the department (children's services) if the family had remained in the area".

7.5 The family were described as "isolated" in the area in which they lived in Northamptonshire. The father was working long hours and had not therefore been able to offer support to the mother in the home.

7.6 Z was described as having "additional needs and on the autistic spectrum" and her "attendance at school was good". Y was attending nursery and described as "being hyperactive and at times very aggressive". The parents were at this time, querying if Y also had additional needs.

7.7 The family moved from Northamptonshire to Southampton on the 7th December 2014. The assessing social worker referred the children to Southampton children's services, alerting them to the fact that Northamptonshire had intended to commence working with the family, due to the concerns prior to their departure from the area.

7.8 Between February 2017 and January 2018 there were two referrals made to Southampton children's services, one from a school and one from a nursery. These related to concerns about the multiple, minor injuries suffered by X in February 2017. He had gone to nursery with 12 different minor injuries in 4 months. He was then aged 2 years.

7.9 In January 2018, Y presented in school with a bruise to his lower lip, two red lines on his left cheek and a red line on his neck. Y's mother said that these injuries had happened by accident when Y was in a "rage". He was then aged 6 years. Both these referrals were received by Southampton children's services. No further action was taken.

7.10 The family moved to Buckinghamshire in March 2018.

8. KEY PERIOD OF INTERVENTION 1: Antenatal care: March 2018 to 20th September 2018

8. 1 The pregnancy was confirmed by a scan in March 2018. Soon after, the family moved to Buckinghamshire. The mother was not referred onto local midwifery services and there was therefore no handover between the two midwifery services.

8.2 In June 2018 the mother was offered two appointments by the health visitor for W and V's transfer in developmental checks, at a local Buckinghamshire health centre. She was unable to attend either as she did not have any transport and public transport links weren't available from the site.

8.3 On the 12th July 2018 W and V were brought to an appointment by their mother with health visitor 1. They were described as having a "good attachment" to their mother and that she "spoke to and about the children" in a caring manner. The mother told the health visitor that she believed she was in receipt of the benefits the family were entitled to. She also disclosed that she had moved from Southampton due to having a very difficult relationship with her own mother who had "physically abused" her. She told the Health Visitor 1 that her housing situation was temporary, and she hoped to move to Northamptonshire to be closer to the paternal family.

8.4 The mother was approximately 7 months pregnant on this visit, however the notes did not indicate this. The health visitor 1 had retired at the time of writing this report. It was therefore not possible to establish why the pregnancy had not been observed, prompting a response for her to receive ante natal care.

8.5 The mother called an ambulance on the 17th September when her waters had broken. She was taken by ambulance to the nearest hospital with available maternity services. Baby N was born in Oxfordshire.

9. KEY PERIOD OF INTERVENTION 2 - August 2018 – X filmed by a neighbour's friend.

9.1 On the 3rd of August 2018 Baby N's father made a telephone call to the police. He was concerned that a neighbour's friend had videoed X through the caravan window. X was playing with his penis. X, aged 5 years old, was naked as the weather was very warm. X's father told the police that the caravan got very hot. The caravan curtains were shut, and the windows open at the time the video was taken.

9.2 The father told the police that the neighbour's friend had sent the video to 2 other people on the site. The father feared that this video was taken for 'sexual reasons'.

9.3 Later the father made another call to the police providing the first name and address of the neighbour's friend.

9.4 He made a further call to the police on that day to report that X was videoed coming out of the caravan, naked. He said that this was reportedly for evidence to show that the child should not be naked outside of the caravan. The video had since been deleted and he said he was happy that the matter was now resolved. He also said that he did not want any action taken, as the people who took the video were "travellers".

9.5 This matter was reviewed by the police. It was decided that no further lines of enquiry needed to be taken.

10. KEY PERIOD OF INTERVENTION 3 - Baby N's birth and subsequent services: September 2018 to December 2018

10.1 Baby N was born on the 20th September 2018 in a hospital in Oxfordshire.

10.2 The hospital midwife that met the mother on the post-natal ward in Oxfordshire described the mother as "responsive and engaging".

10.3 The mother met her allocated community midwife the day after Baby N's birth, when they had returned to the caravan.

10.4 The Oxfordshire safeguarding midwife contacted the midwifery service in Southampton to gather information. The safeguarding midwife was told that there were:

- No alerts
- No children's services involvement
- On 4 occasions the mother had not attended appointments in previous pregnancies.

10.5 The children were seen in the caravan on three separate occasions by the midwifery service staff. Each visit was undertaken by a different midwife. They all reported that the children were "loved and nurtured". The caravan was described as "cluttered", but no safeguarding issues were identified. Cooking facilities were observed, there was space for the children to sleep and the midwifery staff were satisfied with the home conditions.

10.6 The midwife handed over to the Buckinghamshire health visiting service in October 2018. At this time, the midwifery assessment of need was that this family did not require any additional support. A referral to a local Children's Centre was not made, as the Oxfordshire based midwives did not have knowledge of local facilities.

10.7 There were 2 health visitors that worked with the family leading up to the death of Baby N.

10.8 Neither health visitors saw the children in their home. There was a risk assessment recommending that all "clients" be seen at a local health centre.

10.9 The risk assessment was compiled by the Trust in March 2016 and was interpreted locally to mean that visits should not be done on the site. The Trust's view of the risk was different to other agencies. Local midwives and social workers visited the site without issue. The midwives were not employed by the same Trust as the health visitors.

10.10 The Buckinghamshire health visitor did not receive the children's notes from the health visitor in Southampton. She was informed about the family moving into the area in June 2018. This date precedes the birth of Baby N as V and W were seen earlier for their transfer in contact.

10.11 Information was received from the previous health visitor in Southampton. However, this was not recorded in the correct part of RIO[3], so this was not seen by the Buckinghamshire health visitor 2 until after Baby N's death.

10.12 Health visitor 2 saw the mother and Baby N on 10th October 2018. She did not see the mother handling Baby N, but the mother was described as "speaking lovingly" about Baby N. The mother was advised about Safe

[3] RIO is the name of the Buckinghamshire Health Trust electronic recording system

Sleeping practices[4] and the benefits of tummy time[5]. The mother was advised about non-medical emergency services and parenting resources. She was also invited to a local post-natal group, which she declined as she didn't have any transport.

10.13 They discussed the support that she had in caring for the children. She said that the father was very supportive and he worked to support them financially. She stated that the paternal family in Northamptonshire were also supportive.

10.14 Health visitor 2 saw the mother and Baby N again on the 2nd November 2018. The mother told her that the father was working extra hours to pay for the heating and rent, but that the family felt at risk of eviction "at any moment". The health visitor 2 signposted her to the AVDC to assist with her finances and re-housing.

10.15 At this time Baby N's birth had still not been registered, as the mother had cancelled her scheduled appointment to register her birth. This was due to the family's fear of eviction. Normally births are required to be registered within 42 days. The 42nd day after Baby N's birth was the 1st November 2018.

10.16 Baby N was maintaining her weight and appeared to be developing well. The mother told the health visitor that Baby N was "mouthing and smiling". The notes indicate that this was reported by the mother rather than observed by the health visitor.

10.17 Health visitor 2 contacted Southampton children's services on the 13th November 2018 and was told that the family were known to children's services in the area. They had been "investigated" but the children had not been on child protection plans. It is not clear what prompted this contact by the health visitor.

10.18 On the same day the health visitor 2 reported that the mother contacted the AVDC. The family's contact with the housing department is covered in detail in Key Practice Episode 4.

10.19 At this time the mother had no transport and was caring for 3 children under the age of 5 years old. The father had increased his working hours and would not therefore have been able to transport the mother to any appointments.

10.20 On the 29th November 2018 the mother told the health visitor 2 that her mother in law had agreed to give the family some money for a deposit. The mother said they hoped to privately rent and to secure a property in the New Year. She also informed the health visitor 2 that the father had found a new job.

10.21 Leading up to Christmas the health visitor 2 provided a food parcel for the family and signposted the mother to access Christmas presents via a local charity.

10.22 The assessment of the family's needs was not reviewed during this key practice episode. It is clear however, that between September and December 2018 the family's levels of need were escalating due to the increasingly inadequate housing and dropping temperatures, financial difficulties, being at risk of eviction and the family's isolation.

[4] *Safe sleeping practices include; - Things to do: Always place your baby on their back to sleep. Keep your baby smoke free during pregnancy and after birth. Breastfeed your baby, if you can. Place your baby to sleep in a separate cot or Moses basket in the same room as you for the first 6 months. Use a firm, flat, waterproof mattress in good condition. Things to avoid: Never sleep on a sofa or in an armchair with your baby. Don't sleep in the same bed as your baby if you smoke, drink, take drugs or are extremely tired, or if your baby was born prematurely or was of low birth weight. Avoid letting your baby get too hot. Don't cover your baby's face or head while sleeping or use loose bedding.*

[5] *time spent by a baby lying on their stomach while awake, intended to help develop strength in the neck, arms, back, etc.*

11. KEY PERIOD OF INTERVENTION 4 - Emerging concerns and agency responses Sept 2018 – December 2018;

11.1 X, Y and Z all started at the primary school slightly late in the summer term, due to difficulties with transport. Both Y and X were achieving below their peers. Y was the further behind of the two boys, but he was making small steps in his progress. Since the children started at the school in June 2018, they often had colds and had nits.

11.2 Child W did not commence nursery when this was available. The family had no means to get her to the nursery and she was too young to be transported without a parent.

11.3 The primary school actively supported the mother and the children by supporting the application for Z's transfer to a secondary school. The school offered food vouchers, money, school uniforms and clothes. Local parents provided lifts to the GP for Baby N and her mother, transport to the local shops, transport to register Baby N's birth, blankets, food and money.

11.4 The primary schools' concerns began to increase in October 2018, when the mother told the school that the father had lost his job. Despite the father actively pursuing housing, no progress was being made. As a result of the increasing concerns the school attended an early help meeting hosted by Northamptonshire. The school was instructed to complete an early help assessment and send it to the Northamptonshire Early Help Service.

11.5 The early help assessment was completed between the primary school and the mother in October 2018. The Early Help Assessment set out the family's needs including:

- Loss of father's job
- No means of traveling off the site
- The site was described as unsafe due to recent arson attacks
- The family had no money to pay their rent and were dependent on donations for food, blankets and clothing
- The children were described as "generally unwell"
- Housing was depicted as damp and overcrowded
- The mother had shared concerns about drinking the water in the caravan due to the damp

11.6 The early help assessment was later logged by the Early Help Service in Northamptonshire. On submission of an early help assessment there is a prompt to contact the team if further help is required. In this case, the school reported that they were told that they were doing well in supporting the family and as a result, Northamptonshire Early Help Services would not be offering any further assistance. As part of this review, Northamptonshire early help stated that they do not have a record of this conversation.

11.7 On the 29th October 2018 the Aylesbury Vale District Council (AVDC) Office received a telephone call from Baby N's father. He made an application for housing which was graded as "requiring urgent action". He informed them that he, his wife and 6 children were facing an illegal eviction. The father informed the housing department that he had been told by his landlord that they needed to leave the caravan by the 31.10.18 if they failed to do so they would be "removed".

11.8 The mother contacted the AVDC later that day. She gave a description of the living conditions. She described levels of intimidation from the landlord and explained that the caravan was "unliveable cold in the cold weather and uncomfortably hot in summer[6]". She added that the family were having trouble getting access to electricity due to the meters being over full. The family were reliant on electricity for the microwave, boiler, washing machine and dryer. Due to the size of the caravan two children were having to share a bed.

[6] *Taken from a report from the records of Aylesbury Vale District Council*

11.9 She was concerned about the children's physical safety due to the incident in August with child Y. She was also worried that she and the children were experiencing skin problems and had been "ill" due to the local water being unclean.

11.10 She cited that there had been several fires close to the family's caravan. One fire was described as requiring 4 and a half hours to extinguish. The family experienced frequent loss of access to water and electricity and at one stage the family were without water for 2 days. She told them that she was very isolated and couldn't get any supermarkets to make food deliveries to the home and she didn't have any transport.

11.11 She referred to a wasp nest which had resulted in "20 to 30 wasps on a daily basis" in the caravan.

11.12 From October 2018 the weather began to get colder. The lowest day time temperatures that month were recorded as 6 and the lowest night time temperature was recorded as -5. A table of the temperatures from September 2018 to December 2018 is shown in Appendix 2.

11.13 On the 30th October Baby N's father made enquiries of his application. He was advised that he didn't need to take any further action but that he would need to attend the housing offices if the family were "made homeless and had no accommodation". He was told that if the family were to be offered housing, then this would be in another area which was between 47 and 60 miles from where the family lived. The father was informed that his application would soon be transferred to a housing advisor, who would be in touch.

11.14 In November 2018 the parents made three further contacts with the Aylesbury Vale District Council after they had found privately rented accommodation. There is evidence that steps were made by the Housing Advisor to secure this house for the family. The landlord subsequently withdrew the offer of the property.

11.15 The temperatures had fallen further. The lowest day time temperatures that month were recorded as 5 and the lowest night time temperature was recorded as -4.

11.16 On the 12th December 2018 a new housing advisor was allocated to the family. The housing advisor made a number of attempts to contact the family by telephone. These attempts were not successful prior to the death.

11.17 The primary school delivered Christmas presents for the children in mid- December 2018. The teacher recalls that she did not see all of the bedrooms, but that the living area appeared to be warm and uncluttered.

11.18 In December the lowest day time temperatures that month were recorded as 2 and the lowest night time temperature was recorded as -6.

12. ANALYSIS

12.1 What would be a good practice version of services under a universal offer[7]. Was this provided to the family? If not, what barriers prevented good practice and why?

12.2 *What would be a good practice version of services under a universal offer?*
Midwifery: Midwifery and health visiting services offer services described in the Healthy Child Programme[8]. This requires midwives and health visitors to assess family's needs focussing on the following areas:

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[7] *Universal services is a term used to describe services that any member of the public can access. These include services such as health visiting, GPs, police, fire and rescue, hospitals and schools.*

[8] *For further reading on the Healthy Child Programme visit http://healthychildprogramme.com*

- Development of the baby or child (0-5 years)
- Parents and carers
- Family and environment[9]

12.3 For families requiring a universal service, it is expected that the midwife informs any specialist services that may be required, due to additional needs, regarding safeguarding or mental health issues. It is also expected that the midwife refers the family to the local children's centre, unless a parent declines.

12.4 The midwife should share the information gathered from working with the family and provide the health visitor with an assessment, which informs the level of need of the family.

12.5 **Health visiting:** Approximately 2 weeks after the birth of a new-born child the health visitor normally undertakes a new birth visit in the home. On this visit, advice is usually shared about caring for the new baby, including feeding, safe sleeping, crying, immunisations, and any other health issues relating to the family.

12.6 When the baby is between 6 and 8 weeks old, the health visitor should contact the mother to discuss the baby's health, development, feeding, and sleeping patterns, or anything else that the mother may be concerned about.

12.7 Health visitors are expected to undertake a minimum of 5 mandated visits up until the child is aged 5 years old[10]. They should consider the health and development of the child alongside the wider environment of home and family.

12.8 The first two visits to a family are usually undertaken in the home[11].

12.9 Transfer in health visiting assessments are required for children under the age of 5 years who have moved into the area. These assessments are usually prioritised as important reviews due to known risks for children who experience multiple home moves or live in transient families.

12.10 The review should ensure that families are linked in with the right services and support, where additional help is needed or if there are any concerns. The child is weighed and measured, and parents can discuss immunisations and the various options for childcare and early years education.

12.11 **Education:** Not all 2-year-old children are eligible for free early years provision. All 3-year olds are universally entitled to early years provision. All school aged children are expected to be able to access full time education.

12.12 **Police:** A universal service from the police entails a response to public concerns and protection from harm.

12.13 **Housing:** A universal service provision from the AVDC would have entailed offering a timely response to the need for emergency housing.

12.14 *Was this provided to the family? If not, what barriers prevented good practice and why?*
Midwifery services: The mother was not provided with antenatal care as the first contact between the mother and midwifery services came when she called an ambulance after her waters had broken.

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[9] *Assessment criteria, section 3 http://www.healthychildprogramme.com/pathways/links-to-national-pathways*

[10] *For further reading see. Health Visiting: Giving Children the Best Start in Life. Local Government Association. March 2019*

[11] *https://ihv.org.uk/families/what-is-a-hv/*

12.15 She was allocated a community midwife on Baby N's birth who subsequently visited at the home. The midwife saw the children's home conditions and commented that they were "cluttered, a little bare" and "smelt of urine". The mother was described as "responsive and engaging".

12.16 Midwifery staff in the practitioner event shared that they would not expect a mother of 6 children, with a new born child to have a clean and tidy caravan. Midwifery staff visits took place three weeks after the birth. However, more professional curiosity could have been used to consider the impact on the children and Baby N if the family continued to live in the caravan into the winter months.

12.17 Where limited antenatal care has been accessed it is good practice for contact to be made with the midwifery services where the mother moved from, in this case, Southampton. This was done but the midwife was not provided with all the information.

12.18 The family were offered a "universal" level of service from the midwife however this was not aligned to the family's level of need given:

- There had been poor antenatal engagement.
- There had been prior children services involvement in 2014.
- There had been two referrals about the children in Southampton.

12.19 **Health visiting services:** On the 19th June 2018 the health visiting service were informed that the family had moved into the area in March 2018 with 2 children under the age of 5 years. This notification included information that the family had prior social care involvement. This information was recorded on the monthly planner. A monthly planner is a mechanism for ensuring tasks are allocating to health visitors and work is prioritised.

12.20 The mother was offered two appointments in a local health centre, which she could not attend due to not having transport. The health centre was 6 miles from the family home.

12.21 W and V's transfer in "visit" was done on the 12th July 2018 at the local health centre. The mother told the health visitor that she believed she was in receipt of all her entitlement of benefits and that she hoped to live in Northamptonshire, closer to the paternal family. She described her housing as "temporary".

12.22 The mother was described as having a "good attachment"[12] to W and V and was considered "receptive" to the advice given.

12.23 Baby N's new birth visit occurred at 20 days, which is later than required. The new birth visit also took place in the local health centre. The mother was not observed handling Baby N. Health prevention information was given in respect of safe sleeping, accident prevention and tummy time[13]. The mother was also given details of basic national resources such as 111 and was invited to join a post-natal group. She described the father as helpful with the children and said that he works to financially support the family. This health promotion information was in line with that expected of a universal service.

12.24 The mother was seen again on the 2nd November 2018 at the health centre for a maternal mood assessment. The mother informed the health visitor that her husband was working additional hours to earn extra money

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[12] *Attachment is the emotional bond that typically forms between infant and caregiver, and it is the means by which the helpless infant gets primary needs met. It then becomes an engine of subsequent social, emotional, and cognitive development. The early social experience of the infant stimulates growth of the brain and can have an enduring influence on the ability to form stable relationships with others.*

[13] *Tummy time is time spent on the baby's stomach to promote development*

to pay the heating bills and rent but the parents felt under threat of eviction "at any moment". The health visitor sign posted the mother to the AVDC.

12.25 The health visitor also noted on this appointment that Baby N's birth had not yet been registered and this had exceeded the normal time limit of 42 days post birth. The mother told the health visitor that she did make an appointment to register the birth, but she had to cancel this due to financial difficulties. Despite the family's fears of eviction, the concerns about finances and failure to register the baby's birth this did not prompt a review of the assessed levels of need for the family.

12.26 Baby N and her siblings were not offered a "good practice version of services under a universal offer". The children's home was not seen and therefore it was not possible to assess the development of the baby, form a view about both parents and consider the family and environment.

12.27 The children's need for adequate beds, bedding, space to play, heating, food, clean water and clothing and readiness for school were not identified and as a result they were not offered the enhanced levels of service which would have been more aligned to the family's levels of need. The barrier to this appears to be the risk assessment which recommended the use of a local health centre rather than visiting children on the site. Another barrier was a sense of unconscious bias about the perceived risks on the site, due to it being predominately populated by members of the travelling community.

12.28 Supervision "is central to safe and effective practice"[14] . In this case the health visitor did not recall accessing supervision, although records show that she attended 4 child protection supervision sessions. This impacted upon the ability to reflect and review the family's levels of need and continually re-evaluate the impact of the risk assessment on both her and the children's safety.

12.29 **Schools:** X, Y and Z all attended schools in Northamptonshire. Their start in school was delayed due to the need to secure transport to get the children to school. The mother was expected to secure transport from Buckinghamshire County Council as the children resided in that area. This made the application complex, so the school assisted, to ensure the children could start the school term as soon as possible.

12.30 When transport was secured for the children their attendance was good and the mother had regular contact with the school.

12.31 The school and the local parents provided the family with transport to appointments, clothing, school uniforms, food and money. The school undertook an early help assessment with the mother and attended an early help meeting. They worked with a neighbouring school to manage Z's move to secondary school and secured transport for her to attend. The primary school therefore offered a service which exceeded expectations of a universal service.

12.32 **Police services:** The family did not receive a good universal service from the police. The barrier to this was due to the grading of the referral and what information was recorded. When the father contacted the police, this was dealt with by a triage team. They did not recognise that the referral should be treated as a potential child protection concern and refer the matter to the MASH[15]. As a result, the referral was not reviewed by an officer with sufficient seniority and child protection experience. Details of the child were not recorded on the police system and details of the suspect were not taken. Therefore, insufficient information was collected to enable this to be fully investigated.

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[14] *Buckinghamshire Healthcare NHS Trust. Clinical Supervision Protocol. Dated February 2019*

[15] *Multi Agency Safeguarding Hub*

12.33 **Housing services:** The mother and father made repeated contact with the Aylesbury Vale District Council (AVDC) requesting alternative accommodation. They described living conditions which were not suitable or safe for children. This should have triggered the completion of a personal housing plan and the offer of temporary accommodation. Furthermore, the family were told that if they were to be placed in temporary accommodation this would entail a temporary move to either Slough or High Wycombe[16]. The parents feared that such a move would have necessitated moving the children's school and the subsequent loss of the support offered. On the day that the family requested alternative accommodation there was none available close enough to ensure continuity of schooling for the children in Northamptonshire.

12.34 An independent investigation commissioned by the AVDC as part of this review has shown a range of operational causes as to why the family's first contacts didn't result in alternative temporary accommodation being offered. These included:

- Procedures regarding how to manage priority cases were not followed
- The allocation of cases to officers on leave
- Routine monitoring of cases did not detect the delays experienced by this family
- Experienced officers did not take appropriate action to progress the case
- The personnel doing the triage of cases and the housing officers were placed in separate teams

12.35 In addition, there were some wider systemic issues that acted as a barrier to providing a good service. In October 2018 the AVDC were experiencing high levels of homelessness presentations[17] and this was due to a recent change in legislation which came into force in April 2018[18]. AVDC had recruited a large number of staff to meet the additional demands. Some agency staff did not follow procedures.

12.36 The barriers to resolving the family's housing needs after the initial contact on the 30th October were due to individual staff errors, coupled with multiple staff changes, without clear individual accountability for managing the family's application and driving forward progress.

12.37 Given that there were barriers to resolving the family's situation and the children continued to live in unsanitary and a potentially dangerous situation, officers dealing with this case should have made a referral to children's services. Although it is recognised that the parents weren't choosing to remain in the caravan, the children were still impacted upon by the continued poor housing conditions and neglectful circumstances.

12.38 Were there any intra or inter agency communication barriers which prevented the provision of good services? If so, what were the causes of these?

12.39 As cited in paragraph 12.32 there was an intra communication issue in the police in response to the father's call in August 2018. There were issues in how the referral was graded and recorded. The police accepted that there were training needs as part of this review and have provided the team with feedback and training.

12.40 The intra agency communication between agencies working with the family were impacted upon by cross border issues where the children lived in one area and went to school in another. This meant that professionals working with the family were not aware of the existence of one another and this was a barrier to effective communication and information sharing.

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[16] The average time families spent living outside of the area in temporary accommodation in October 2018 was 26 days. The longest period of time was 62 days and the shortest length of time 2 days.

[17] Those at risk of homelessness in the AVDC area had increased by up to 50%.

[18] Homelessness Reduction Act 2017

12.41 Despite the family's Buckinghamshire address being clearly recorded on the front of the early help assessment, this was not picked up when it was logged. Northamptonshire did not forward the assessment to Buckinghamshire or inform the school that they should contact Buckinghamshire.

12.42 There were clear intra agency communication issues within AVDC. There were multiple "hand offs" between triage staff and housing officers. There was also evidence that where advice and expertise was sought by triage staff from more qualified officers, this was not always forthcoming. Structurally these issues have been ameliorated by the co-location of the triage staff and housing officers.

12.43 What was the impact of the family's movement between areas on sharing information, building an understanding of the family's needs and providing good specialist or universal services?

12.44 Northamptonshire children's services actively shared information with Southampton children's services which was excellent practice and exceeds what would ordinarily be expected. Southampton community midwifery service were not aware of the pregnancy and did not know to forward on the information they held about the family. Oxfordshire midwifery contacted Southampton, but they were not informed that the family had historically met the threshold for services from children services. The midwife in the practitioner event reflected that, had she known about the previous concerns she would have automatically made a referral to children's services in Buckinghamshire. It has not been possible to establish why this information was not shared from the information submitted to this review.

12.45 Based on the information available the midwife did not assess the family as having additional needs and this assessment was handed over to the health visitor. This, in turn influenced the health visitor's initial assessment of the children's needs.

12.46 The health visitor in Buckinghamshire did not receive any records from Southampton. The Buckinghamshire health visiting service was informed of the previous children's services involvement in June 2018, however this was recorded on the planner. She later contacted children's services in Southampton in November 2018, where partial information on the family history was shared. In this review it has not been possible to establish the reason for the delay in contacting Southampton children's services.

12.47 The health visitor contacted Southampton children's service to gather information, which was good practice. She experienced some reluctance in the part of Southampton children's services, to share information. On reflection in the practitioner event, it was agreed that information might been more forthcoming from the Southampton health visiting service.

12.48 The school received a child protection file and information from the previous school. Although the information in the file was not outside of what would normally be expected, the practitioner's view was there was insufficient information shared to fully understand the family history and the children's needs.

12.49 The full family history did become apparent to the practitioners in the practitioner event. The group formed an understanding of how the family's moves had impact on the understanding of the family's needs. They agreed that had they known the full history, they would have made a referral to the local children's services when they encountered the family. The information being: -

- The Z, Y and X had been assessed by Northamptonshire in 2014 and were deemed to be children in need due to concerns about the basic care and supervision of the children and the family's housing issues.
- 1 referral was made to Southampton in February 2017 due to X having multiple minor injuries, there was concerns about the levels of supervision of the children.
- 1 referral was made to Southampton children services in January 2018 regarding Y who had injuries to his face and neck.
- The father contacted the police in August 2018 due to a neighbour's friend taking a video of X.

12.50 Despite attempts by practitioners to gather information, the family's movement between 3 local authorities resulted in the following:

- a loss of understanding of the family's history
- an inaccurate assessment of the level of the family's needs
- support services for the family were not appropriately identified

12.51 How (if at all) did staff safety considerations impact on services offered?

12.52 Safety considerations did not affect services from the midwifery staff, schools, police or AVDC.

12.53 The children's home was not seen by the health visitors between June and December 2018. This was due to a Trust risk assessment, which recommended that the children could be seen at a local health centre.

12.54 Staff safety considerations inhibited the health visitor's ability to fully assess the children's needs and provide services to meet those needs. The recommendation not to visit the site also meant the deterioration in the children's living circumstances between September and December were not detected or responded to.

12.55 The health visitor assessment was based on:

- information handed over from the midwifery service
- what was observed at the health centre
- what the mother told the health visitor
- information from previous authorities indicating that there were no child protection concerns.

12.56 As a result of the staff safety considerations the health visitor was unable to assess the family and environment, parents understanding and ability to apply the "safe sleeping" guidance, to provide adequate food and nutrition and to meet the wider needs of the children.

12.57 How were risk assessments completed, reviewed and shared in relation to visiting the children?

There were no risks assessments held for midwifery, children services, schools, AVDC and police staff. The Fire and Rescue service did require that their officers were accompanied by the police following assaults in November 2018.

12.58 There was a risk assessment compiled by the Buckinghamshire Health Trust in March 2016. The risk assessment was triggered after a notification from the Northamptonshire early help service. This alert was in respect of an individual living on the site who had an NHS marker for aggression against a member of staff employed by the Trust. Following this the Trust recommended that all clients would be seen off site.

12.59 The risk assessment was not directly linked to any aggression or threat from members of the Baby N family. Neither parent had presented as aggressive or angry during the scope period of this review.

12.60 The risk assessment itself did not provide any analysis of the risk in respect to either the worker or the children concerned. There was no evidence of the required level of management oversight and it had not been reviewed since the original creation in 2016. The risk assessment was not shared with any of the other agencies or the parents.

12.61 The Trust's risk assessment appeared to be incomplete, there was no evidence of management oversight and it appears to be informed by unconscious bias associated with perceived risks from the Traveller Community.

12.62 Were there any additional or suspected additional needs identified in either or both of the parents?

Neither of the parents had assessed additional needs in respect of their cognitive capacity, mental health or substance misuse. The father reported to AVDC that he had Asperger's syndrome and Dyspraxia. This was self-reported and there was no known recent diagnosis of these conditions.

12.63 Identified good practice

This review has shown some good practice. The primary school showed a great deal of persistence and tenacity in providing support for the family. The school and the local parents provided clothing, uniforms, blankets, food, food vouchers and money. They worked closely with the secondary school that Z moved to. The secondary school exceeded class sizes in order to accommodate Z.

12.64 Children's services in Northamptonshire shared their assessment with children's services in Southampton. There is a requirement to share information of children on child protection plans but not for children in need. Z, Y and X were assessed as children in need[19]. Therefore, it is good practice that steps were taken to share this information with Southampton after the family had moved.

12.65 The health visitor and the safeguarding midwife followed good practice guidance by contacting Southampton to gather further information about the children.

12.66 Finally, there is evidence that the triage officer that managed the family's contact with the AVDC on the 29th October identified that this was a complex case that would require immediate action. Unfortunately, this officer didn't receive the required expert guidance which acted as a barrier to the family being assisted.

13 LESSONS LEARNT FOR THE WIDER SAFEGUARDING PARTNERSHIP

13.1 The importance of understanding the family history

The issue of not taking sufficient account of family history or failing to grasp the impact of neglect on children were found in almost half of assessments in the 124 neglect cases scrutinised in an Ofsted report in 2014.[20]

13.2 In these children's case, the understanding of the family's history became fractured, as the family moved between Southampton, Northamptonshire and Buckinghamshire. Despite the efforts of Northamptonshire children's services, the information shared about the family's needs in 2014, did not follow the family and inform assessments. It has not been possible to establish the reason for this in this review.

13.3 Northamptonshire children's services, Southampton schools, the midwife and health visitor all made attempts to share information and to gain an understanding of the family's history.

13.4 The loss of the family history resulted in the children's needs being understood through the lens of poverty, as opposed to the full context which was a combination of child neglect and poverty.

13.5 Assessing the holistic needs of children

Health visiting and midwifery services are the two services that see pre-school children in their homes. They therefore hold a key position to assess this vulnerable group of child/ren's needs in a holistic manner.

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[19] *Under **Section 17 Children Act 1989**, a child will be considered in need if: they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority; their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority; they have a disability.*

[20] *Office for Standards in Education (2014) in the child's time: professional responses to neglect, www.ofsted.gov.uk/resources/140059.*

13.6 An NSPCC report 2015[21] highlighted the increased vulnerability of younger children and shows the critical role of neonatal professionals in identifying neglect[22].

13.7 Non-verbal children's needs cannot be assessed in isolation from their home environment and this became especially important for these three children under 5 years old. The living conditions for the children were unsanitary, cold and overcrowded.

13.8 The housing situation became more unsuitable as the winter months approached. There were signs that the family's circumstances were becoming more difficult from early November when they feared that they would be evicted. As a result of the children not being seen in their home, these increasingly difficult living conditions of the children were not detected.

13.9 This case has similar themes to that of recent research[23]. This research showed the "majority of neglect related deaths of very young children involved accidental deaths and sudden unexpected deaths in infancy where there are pre-existing concerns about poor quality parenting and poor supervision and dangerous, sometimes unsanitary, living circumstances which compromise the children's safety" (Brandon et al, 2013; Sidebotham et al, 2011). These issues included the risks of accidents such as fires and the dangers of co-sleeping with a baby, although this was mainly in relation to parents with substance and/or alcohol misuse problems (Brandon et al. 2013, p.59).

13.10 It is therefore critical that children's living conditions are seen, and these observations are used to continually review the assessment of need.

13.11 Schools do not have a mandate to undertake home visits where there are no concerns about the children's behaviour or attendance. Therefore, it is important that the voices of school age children are heard to inform professionals views about the care they receive.

13.12 School professionals that took part in the review reflected the importance of understanding the lived experience of the child. They felt if this was understood for Baby N's siblings, it would have enabled them to build a picture of what the living conditions were like for the children. This echoes findings from an Ofsted report in 2014[24], where failure to consider the child's lived experience or understand the child's world was a common finding in child maltreatment research.

13.13 **Cross border issues**

The understanding of the children's needs was impacted upon by the cross-border issues in this case. When the family moved to Buckinghamshire in March 2018, they had managed to move closer to the extended family, but weren't living in the same county as them.

13.14 The family's home was on the border of Northamptonshire and Buckinghamshire. This made the identification of needs and securing services very complex for the family and the practitioners that sought to support the family.

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[21] *Neglect: learning from case reviews. Summary of risk factors and learning for improved practice around neglect. September 2015, NSPCC*

[22] *Cited in Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report November 2014 Department of Education*

[23] *DFE. Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report May Peter Sidebotham et al 2016*

[24] *Office for Standards in Education (2014) In the child's time: professional responses to neglect, www.ofsted.gov.uk/resources/140059.*

13.15 The cross border issues contributed to the children's needs remaining undetected, due to fractures between midwifery and health visiting services that were being offered across 'borders'. This fracture resulted in the family's history and needs remaining unrecognised. It also limited the amount of community support that was offered to the family. The nearest children's centre to the family was across the border in Northamptonshire, which would have necessitated a referral from a Northamptonshire professional.

13.16 The cross border issues proved to frustrate the parents own attempts to meet their children's needs in respect of finding a school nearby, transport to school and seeking housing closer to the paternal family.

13.17 The children's emerging needs were identified by the primary school in Northamptonshire, which prompted the early help assessment. The head teacher was not signposted to Buckinghamshire early help, which would have been the area responsible for the provision of these services.

13.18 The early help assessment was completed and was logged. However, despite the Buckinghamshire home address being shown on the front of the assessment, the head teacher was not informed that she needed to make a referral to Buckinghamshire early help. Northamptonshire early help also did not send the completed assessment to Buckinghamshire early help services. This resulted in the request for help falling between the two areas and the family not receiving the much needed, co-ordinated support.

13.19 Practitioner feedback from Northamptonshire early help services suggested that if this referral had been made to the Northamptonshire MASH[25] in August 2019, it would have very likely met the threshold for an assessment by Northamptonshire children's services.

13.20 The practitioners at the event reflected that they tried to secure early help rather than refer to Northamptonshire MASH due to their experience of this service. They felt that the threshold for intervention for children's services in Northamptonshire was extremely high. They had pre-empted that their referral would not be accepted. This echoes the findings of Brandon et al 2015[26] where it was found that resource constraints influenced professional behaviour.

13.21 **Assessing risks to staff whilst meeting the needs of those living in disadvantaged areas**

Safety of staff is important, and employers have a duty to ensure that the workforce is appropriately safeguarded from harm.

13.22 When responding to a risk there are a range of steps that agencies can take if they feel their staff may be at risk such as:

- Joint visiting from staff in the same organisation
- Joint visiting with partner organisations
- Requesting police assistance in carrying out visits

13.23 There was evidence of criminal activity on the site, there had been caravan fires and an assault on Fire and Rescue staff. However, the actual risk to staff and/or families living on the site had not been quantified at the time of this review.

13.24 The issue of risk to staff was explored in the practitioner event. The group reflected that it can be challenging working with risk. However, if the risk to staff is perceived to be high enough to prohibit staff from visiting a place, then this would indicate that the children living in that place are also likely to be at risk. They reflected that, in such an instance, risk to children should be carefully assessed and the vehicle for this would be a

[25] *Multi agency safeguarding hub*

[26] *Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report November 2014 Department of Education*

strategy discussion[27] . The purpose of a strategy discussion is to share information, assess risk and formulate plans to keep children safe, where required.

13.25 However, in this case the level of risk does not appear to have met that threshold and appears to have been influenced by perceived risk and unconscious bias. This was exacerbated by a lack of management oversight and review of the assessment or risk.

13.26 Responding to urgent and emergency housing needs of children living in neglectful circumstances

13.27 It is important that the needs of children are fully considered when parents present as homeless or being at risk of becoming homeless. Baby N's parents articulated very well their concerns about their living conditions and were persistent in trying to get housing from October 2018 onwards.

13.28 In this case the AVDC had sufficient information to form a view that the family required emergency temporary accommodation and this should have been responded to in a timely manner. An independent investigation commissioned by the AVDC has shown the operational and system failures in response to the parent's efforts to acquire alternative housing.

13.29 The housing issues for this family were more complex than simply the provision of a home. The family were living in the north of the County and the older children were attending school in the south of the bordering County. As the family feared, at the time of their application there was no available temporary accommodation in an area that would have enabled the children to continue to attend school. The children then being 12, 6 and 5 years old. The support from the school was invaluable to the parents and indeed was the only form of support the parents were receiving. The parents were therefore placed in an unenviable position of choosing between staying in their accommodation with the support from the school or moving away, losing the established support, interrupting the schooling of the three eldest children and distancing themselves from the only family support in the area.

13.30 In instances where family's housing situations cannot be resolved in a timely manner and the children are at risk of neglect and/or from adults in the area, a referral to children's services should be made to trigger an assessment of need.

13.31 An important lesson from this review is the need for housing providers to consider the needs of the whole family and consider the impact of temporarily moving the family from their local area on support available for families that are in acute difficulties. A recommendation has been made as part of this review to address this issue.

14. CONCLUSIONS

14.1 The loss of Baby N was tragic, but cannot be directly attributed to the actions of any one agency or the parents.

14.2 This family were viewed by agencies as living in poverty, this was the cause of the poor living conditions, lack of clothing, heating, blankets and food for the children.

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[27] *A strategy discussion Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care (including the residential or fostering service, if the child is looked-after), the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case.*

14.3 The area the children were living in does overall have higher levels of deprivation than the other three Districts in Buckinghamshire[28]. Practitioners that took part in the review felt they worked with many families that were experiencing poverty. Ongoing exposure to families living in poor conditions can result in a level of desensitisation, which can contribute to the reduced recognition of child neglect.

14.4 There were indications that the parents found managing their income to provide for their family, a challenge. The condition of the family caravan in late December 2018 was in stark contrast to the other caravans in the surrounding plots, which were described as “well kept” and “warm”.

14.5 The family history shows indicators of neglect which predated Baby N’s death. These included:

- Children’s services assessment in 2014 showed concerns about the home conditions.
- Frequent movement between areas
- A history of multiple injuries in 2017 when X was aged 2
- Concerns about Z and Y’s presentation in school where additional needs were queried
- Not accessing antenatal care

14.6 These, amongst others, are recognised in the Brandon et al 2014 research[29] as indicators of neglect and should prompt professional curiosity.

14.7 There were some recurring themes in the family functioning. The family moved from Northamptonshire in 2014 to Southampton due to “not having any support” in the area. The family were described as isolated and the father could offer limited support to the mother due to working long hours. This is not a very different picture from that of 2018.

14.8 The complex task of deciphering what was child neglect and the effects of poverty were exacerbated by the frequent family moves. The themes in the family functioning were not detected due to the fragmented picture of the family history.

14.9 Cross-border issues also made it extremely difficult to undertake any assessment of the children’s needs and offer early help. This was a large sibling group with diverse needs. Effective early help would have needed to involve professionals from early help, health, education and housing across two Local Authority boundaries. It is not realistic for this task to be led by a small, although very able, primary school.

14.10 Other than direct feedback from children, observations of a child’s home is the best form of information gathering to assess the lived experience of a child. In this case, the Buckinghamshire Health Trust recommended that all Trust staff see these children away from their home. This contrasts with accepted good practice and inhibited the health visitor’s ability to form an assessment of the children’s needs.

14.11 The recommendation in the Trust risk assessment was not evidence based, lacked regular management oversight and there was a sense of unconscious bias about the perceived risks on the site.

14.12 Health practitioners appeared to place strength on the fact that the mother had a good attachment to her children. The emphasis on the mother’s attachment and lack of home visits skewed the assessment of need.

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[28] *The Buckinghamshire’s JSNA 2016 to 2020 found at http://www.healthandwellbeingbucks.org/s4s/WhereILive/Council?pageId=2098*

[29] *Brandon et al (2014) Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report November 2014 Department of Education*

14.13 This review has shown that without the help from the primary school, the family would have experienced even more extreme hardship. However, these generous provisions also “masked” the actual level of need and very likely prevented the family’s situation from worsening, resulting in the intervention of statutory services.

14.14 School participants in the practitioner event felt that, given the right tools and training, they would have been in a strong position to have gathered information from the children to understand what life was like for them at home. This would have enabled them to know what the living conditions were like without visiting the caravan and help disentangle what was the effects of poverty and what was neglect.

14.15 There was an opportunity to intervene in October 2018. The early help assessment ably set out the needs of the older children. If the early help assessment had been read and triaged rather than being “logged”, this would have likely resulted in a referral to the Northamptonshire MASH, which would have triggered a referral to Buckinghamshire children’s services.

14.16 The father’s concerns in August 2018 did not receive the correct level of response from the police. This review does highlight learning for the police. However, it is unlikely that this could have prevented Baby N’s death or highlighted the neglectful conditions the children were to later experience.

14.17 The parent’s efforts to secure alternative accommodation were thwarted due to operational and wider issues as set out earlier in the report.

14.18 The parents who already had been identified as needing support were isolated, a distance from any family support, the mother was caring for the 6 children whilst the father worked long hours to make sure the family were financially stable. The mother had no transport to get her to the health visitor appointments or get food. Local supermarkets did not deliver to the family home. The parents weren’t integrated into the community on the site and there was some suggestion that the parents were at times experiencing intimidation from other adults on the site. These environmental factors will have made successful parenting extremely challenging for any parent.

14.19 In addition to these very practical issues, the services that were designed to aide parenting did not all assist in the way that they were designed to. The complex interplay of a fragmented understanding of the family history, cross border issues, the lack of sight of the home conditions, the challenges of providing early help for a diverse age range of children, unconscious bias and access to suitable temporary accommodation meant that meeting the needs of these children became almost impossible for these parents.

14.20 Ultimately, the care of these children was impacted upon partly by neglect and partly the combined complexities of working with large sibling groups of children, the number of moves the family experienced and the challenge of working with a family who were living in one area and accessing services across local authority borders.

15 RECOMMENDATIONS

Recommendation 1

Buckinghamshire Healthcare Trust to review risk assessment process to ensure risk assessments:

a) are evidenced based and timely
b) contain a clear analysis of how any risk may impact upon the safety or wellbeing of a child or children as well as staff
c) have regular reviews and management oversight
d) should be shared with other agencies coming into contact with risk individuals
e) do not impinge upon the ability to offer equality of access to health services.

Recommendation 2

Buckinghamshire Healthcare Trust to strengthen the provision of supervision for health visitors to ensure that good quality, regular supervision is offered, in line with the supervision protocol.

Recommendation 3

Buckinghamshire Healthcare Trust to roll out the planned Unconscious Bias and Professional Curiosity training.

Recommendation 4

The Buckinghamshire Safeguarding Children Partnership Independent Chair to write to the Independent Chair of the Northamptonshire Safeguarding Children Partnership to ensure that lessons learnt in this review are shared.

Recommendation 5

AVDC to work with neighbouring Northamptonshire housing authorities to develop a common cross-border understanding regarding the placement of vulnerable families in temporary accommodation.

Recommendation 6

Following the AVDC becoming part of a new unitary authority[30], the AVDC to share the audit findings regarding the progress of implementing the actions identified by their internal investigation, with the appropriate Safeguarding Children Partnership.

Recommendation 7

The Partnership to consider the use and effectiveness of existing tools, to support professionals in the wider children's workforce, to understand the impact of neglect on the lived experience of children.

[30] *On 1st April 2020 the new Unitary Authority for Buckinghamshire (Buckinghamshire Council) will be responsible for all services that were previously provided by the individual District Councils and Buckinghamshire County Council*

Appendix 1 – Terms of reference for the review

1. Introduction:

1.1 This Serious Case Review (SCR) has been commissioned by Buckinghamshire Safeguarding Children Board because the child has suffered serious harm as a result of abuse or neglect.

2. Legal Framework:

2.1 SCRs and other case reviews should be conducted in a way that:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

3. Methodology:

3.1 This review will be conducted using a systems approach, which reflects on multi-agency work systemically and aims to answer the question why things happened. This approach recognises practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The model engages frontline practitioners and their managers in the review of the case, focussing on why events happened and avoiding "hindsight". It is a collaborative and analytical process which combines written agency reports with practitioner events.

3.2 The review model adheres to the principles of:

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of SCR:

4.1 Timescale of the review from: 01.01.2018 to 26.12.2018 when child N died and to include information in this timeframe for all 6 children in the family. In addition, agencies are asked to provide a brief background of any significant events involving the family. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Buckinghamshire, Northamptonshire & Southampton Social Care
- All schools the children attended within the scope of the timeframe
- Buckinghamshire and Northamptonshire Fire and Rescue Services
- Buckinghamshire, Northamptonshire and Oxfordshire health services
- P3 and Bucks Floating Support voluntary housing support organisations

- Any other agency identified during the course of the review

5.2 Agencies are requested to use the Buckinghamshire Agency Involvement Template.

6. Areas for consideration:

6.1 Agency report authors should consider the following:

- How and when the agency became involved with Child N, including contacts with the family, services offered and endings of services.
- What would be a good practice version of services under a universal offer e.g. services that are available to all members of the public. Was this provided to the family? If not what barriers prevented good practice and why?
- Were there any intra and inter agency communication barriers which prevented the provision of good services? If so what were the causes of these?
- What was the impact of the family's movement between areas on sharing information, building an understanding of the family's needs and providing good specialist or universal services?
- How (if at all) did staff safety considerations impact on services offered?
- How were risk assessments completed, reviewed and shared in relation to visiting the children?
- Were there any additional or suspected additional needs identified in either or both of the parents?
- Any other learning pertinent to the learning from this review?

7. Engagement with the family

7.1 A key element of any review is engagement with family members, in order that their views can be sought and integrated into the learning. The Buckinghamshire Safeguarding Board will inform the family that this review is being undertaken and will offer Child N's parents the opportunity to meet with the independent author and the Board manager.

7.2 Their contributions will be included in the Overview Report and they will be offered feedback at the end of the process.

Appendix 2 – Temperature report between September 2018 to December 2019

	Sept 18	Oct 18	Nov 18	Dec 18
Highest day time	24	23	15	14
Lowest day time	15	6	5	2
Highest night-time temp	16	15	10	10
Lowest Night-time temperature	-2	-5	-4	-6
Mean night-time temp	7.3	4.09	4.26	2.7

Weather data reference link

https://www.accuweather.com/en/gb/buckingham/mk18-1/december-weather/327000?year=2018