Buckinghamshire

Safeguarding Children Partnership

Serious Case Review
Independent Overview Report:

Family T

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1 Introduction

1.1 In July 2018 Buckinghamshire Safeguarding Children Board (now Partnership) decided to undertake a Serious Case Review in respect of female twin siblings aged 14 weeks who sustained significant non-accidental physical injuries. When the injuries were identified the twins were living in a foster placement[1] due to concerns about the ability of parents to meet the needs of the twins, domestic abuse, and parental drug misuse.

1.2 Mother was 17 when she gave birth to the twins and had been in the care of the local authority[2] since the age of 14. A multi-agency Learning Review was completed to identify opportunities for practice learning during the period Mother was in care. This Serious Case Review will focus on the involvement of agencies with the twins, the potential to learn lessons about multi-agency practice to safeguard vulnerable babies in Buckinghamshire was recognised.

1.3 There was consensus within the SCR Steering Group that separating the Reviews in this way would maximise opportunities for practice learning. It is important to acknowledge, however, that the two Reviews are inextricably linked. Mother's experience prior to and whilst in care will have had a significant impact on her ability to parent vulnerable twins.

1.4 Key learning and actions from the Review will be monitored by the strategic leadership board with responsibility for the improvement of multi-agency practice to safeguard children in Buckinghamshire.

2 Methodology

2.1 The purpose of this Review was to identify whether improvements were needed in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice. The Terms of Reference considered throughout this Review are included at Appendix i.

2.2 The Review considered agency chronologies and practitioners who were involved at the time were invited to participate in events to explore practice and identify opportunities for single and multi-agency learning[3]. The SCR Steering Group contributed to the findings and recommendations to ensure that actions resulting from this Review complemented the improvement activities of the Safeguarding Partnership and avoided duplication.

2.3 It has not been possible to involve Mother or Father in the Review due to ongoing criminal proceedings.

[1] The initial plan was for Mother to move into the foster placement with the twins however she became too distressed to do so. It was subsequently agreed in court that Father could move into the foster placement to care for the twins

[2] Subject to a Full Care Order

[3] At the Learning Event there was an opportunity to explore practice and identify opportunities for single and multi-agency learning. At the recall event practitioners discussed the analysis and key findings of the Review.

3 The Family and Background Information

3.1 The twins were born by emergency caesarean section at 30 weeks gestation. Twin 1 weighed 1.24kg, twin 2 1.37kg. Both twins were admitted to the Neonatal Unit (NNU). Twin 1 required ventilation.

3.2 Mother became a looked after child at 14 and was 17 when she gave birth to the twins (Twin 1 and Twin 2). Father was 25 when the twins were born. Mother and Father had been in a relationship for approximately one month when pregnancy was confirmed.

3.3 The parents of Mother will be referred to as MGM and MGF[4]. Mother and Father received no support from extended family members during the timeline of this Review.

Background

3.4 Father's parents were known to misuse substances and he was subject to domestic abuse and experienced neglect from a very young age. Father was excluded from school at 13 years of age. Children's Social Care received concerns about the care provided to Father and deteriorating behaviour when Father was 14.

3.5 Mother was known to Children's Social Care from 3 years of age due to lack of supervision, concerns about domestic abuse, parental substance misuse and mental health problems. At 12 years old Mother was frequently missing from home and presented with anxiety, depression, and thoughts of self-harm. There were also reports of risky behaviour (drinking and drug use), socialising with older males and shoplifting. Referrals were made to CAMHS and RU Safe[5].

3.6 Mother was accommodated at 14 after being taken into police protection and became subject to a full care order. Mother experienced frequent moves due to placement breakdown and moved into semi-independent living at 16 years old. There was a domestic incident involving Father immediately prior to Mother's pregnancy.

4 Agency Involvement

4.1 The Review will start from September 2017 when Mother was known to be pregnant, until June 2018 when the twins were found to have non-accidental injuries.

[4] Maternal Grandmother and Maternal Grandfather

[5] A Barnardo's Project working with children at risk of child sexual exploitation

Pregnancy Until the Injury to the Twins

Month	Action	Agency
September 2017	Pregnancy with twins confirmed. Mother informed her Support Worker that if CSC attempted to give the unborn baby a Social Worker or make demands on her she would disappear with Father. Referral made to Family Nurse Partnership[6].	CSC K2 FNP
October	Mother and Father were advised to seek legal advice regarding the involvement of CSC with the twins[7]. Police report of an alleged assault by Father in a dispute over money.	CSC Police
November	Mother was seen by CAMHS 3 times and reported feeling isolated, aggressive, and anxious. Mother said that she was worried this would continue once the babies were born and concerned about how her relationship with Father was progressing. Mother received a six-month Youth Referral Order and a £50 fine[8]. At the 6 weekly placement review[9] Mother was advised that her Social Worker and PA were leaving and that the Social Worker had made a referral for a Pre-Birth Assessment to be carried out by CSC.	CAMHS YOS CSC
December	Child and Family Assessment was completed within 4 weeks and Mother was informed that no concerns were identified, and CSC planned to close the case. A sibling of Mother's informed her Support Worker that Mother kept asking to borrow	CSC K2

[6] FNP provides intensive support for vulnerable first-time young mothers and their families, including those from highly disadvantaged areas and backgrounds (for example looked after children who are young parents).
[7] At a meeting with the Support Worker, advocate, SOCIAL WORKER, and midwife
[8] Mother was convicted of Beating with Intent - assault occurred in May 2017
[9] Child Looked After

	money. Mother denied the allegation and asked for no more calls to be taken from her sibling.	
January 2018	A new Social Worker was allocated to Mother. CAMHS recorded that Mother's relationship with Father was difficult at times and that on occasions the worker had noticed *controlling elements* to his attitude; and that when this happened Mother had difficulty managing the situation resulting in her feeling stressed. Mother asked the Support Worker to take her to a Genito-Urinary Clinic and said that she would *kill her ex-partner if she saw him*.	CSC CAMHS K2
February	Mother was seen later in the month by CAMHS and reported that her mood had fluctuated recently. Mother said that the relationship with Father was currently stable and that she felt let down by CSC as her Social Worker had left and she had not been allocated new one. Mother attended a maternity appointment with the Support Worker and stated that she was feeling unwell, tired, vulnerable, and unsupported by CSC as her Social Worker and PA left and had not been replaced. FNP informed CSC about Mother's lack of engagement, their lack of involvement in the Pre-Birth Assessment and concerns about the decision that had been made. Mother was allocated a new Social Worker and PA. The SOCIAL WORKER and FNP met with Mother and Father to discuss non-engagement with services. Police report by Mother regarding threats by Father's ex-landlord relating to a debt. Referral to CSC by community midwife due to smell of cannabis during home visit. Child and Family Assessment to be completed.	CAMHS K2 FNP CSC Police BHT
March	The twins were born by emergency caesarean section at 30 weeks gestation. Twin 1 weighed 1.24kg, twin 2 1.37kg. Both twins were admitted to the Neonatal Unit (NNU). Twin 1 required ventilation. Maternity advised that the twins would	BHT

	require care above and beyond that required by full term infants. Mother discharged herself from hospital against medical advice two days after giving birth. Mother and Father continued to attend the hospital daily aided by Mother's Support Workers. The twins' Social Worker made a home visit, the house smelt strongly of cannabis and Father was present. Mother and Father informed that second Child and Family Assessment would be completed due to concerns about substance misuse. The FNP nurse visited both parents in hospital to deliver the FNP programme on three occasions prior to the twins' discharge. Staff at the hospital raised several positive observations about Mother's care of the babies but observed Father to be controlling and wondered about the power imbalance in the relationship. Mother and Father continued to visit the babies daily and Mother made significant progress with breastfeeding both twins. Father raised concerns that Mother may have postnatal depression and asked about rooming in. At a Multi-Disciplinary Meeting it was decided that it was not suitable for Mother to room in at that time. During routine contact with the NNU, the twins' Social Worker was informed that Father had been seen watching inappropriate images [10] on his phone. A Strategy Meeting was held when the twins were four weeks old. Recorded actions included; a Legal Planning Meeting (LPM) to be requested, an ICPC to be arranged, a Discharge Planning Meeting to be held, a genogram to be completed for both parents and the Social Worker to inform parents of the outcome of the meeting.	CSC FNP BHT BHT BHT BHT CSC CSC
April	The Social Worker for the twins advised Mother and Father that the twins were being escalated to	CSC

[10] A member of staff at the NNU alleged to have seen father watching pornography however this was not addressed directly with Father and there was a delay in informing the Social Worker

	Child Protection. The Social Worker informed that he was seeking to identify a mother and baby placement. Mother refused this as she didn't want to be separated from Father.	
	Mother contacted CAMHS and requested she be discharged from their service.	CAMHS
	Mother advised of local authority plans re. mother and baby unit and consequences that twins may be removed if Mother did not accept.	CSC
	IRO for Mother sought clarification regarding plans for Mother, Father and the twins following discharge of the twins from hospital.	
	The twins' imminent discharge from hospital was discussed at a Multi-Disciplinary Team Meeting. It was agreed that Mother should room in and a discharge planning meeting take place.	BHT
	The Court granted a six-month Interim Supervision Order in relation to the twins who were discharged from hospital and taken home by Mother and Father on the same day.	CSC
	An ICPC was held in relation to the twins and outcome was that a Child Protection Plan was not required although the vulnerability of the twins was noted, and an assessment of parenting was required. The twins were identified as CiN.	CSC
May	A new Social Worker was allocated to the twins (their third).	CSC
	Father made a report to the Police regarding damage to his car and ongoing issues with his previous landlord relating to unpaid rent.	Police
	Mother's Support Worker was commissioned to provide 6 hours a day.	K2
	Mother informed CAMHS that she and Father had been arguing and she was feeling tired and frustrated. A couple of days later Mother told her Support Worker that she and Father had rowed, and she had asked him to leave.	CAMHS
	At the second CiN meeting the twins were reported to be gaining weight and meeting developmental milestones although they had	CSC

	reflux which was causing some difficulties with feeding and their general management. Mother was upset and told the Support Worker that she and Father were rowing about the overnight feeds and the fact that Father was having to do them and then go to work. There was a punch mark on the door. A welfare check was carried out by Support Worker 2 in the afternoon. Mother was referred to Addaction.	CSC K2
June	Application by the local authority for an Interim Care Order, the court date was postponed to enable Mother to attend. Father was assaulted in the town centre by his ex-landlord in relation to unpaid rent. The twins and Mother were present during this altercation. Mother was unable to attend the Case Management Hearing due to childcare issues and Father attended. Mother was offered a mother and baby foster placement and was stressed as Father would be homeless but appeared to have accepted foster care as an option. An Interim Care Order was granted to the local authority. Mother agreed within the court room to attend a mother and baby foster placement however once outside became very distressed. Mother returned home via A&E and was found to be dehydrated, anxious and post-natal depression was queried. The twins went into foster care over the weekend and Father joined them when the decision was ratified in court. The Support Worker and CAMHS provided additional support to Mother. Father found caring for the twins at night stressful and the foster carers intervened by taking Twin 1 so that he only had to look after Twin 2. On the second day Father told the foster carers that he thought he may have held Twin 2 too tightly as she had some bruising. Father was distressed and informed the carers and the Supervising Social Worker that he wasn't cut out to look after the twins on his own, but worried if he didn't that they would be adopted.	CSC CSC CSC CSC CSC CSC

	Following A CP Medical and a Strategy Meeting both twins were admitted to hospital overnight. Twin 2 began fitting following admission and a CT scan showed a left-sided subdural bleed[11]. After a second seizure Twin 2 was transferred to a specialist unit and a skeletal scan highlighted a healing rib fracture. A skeletal scan of Twin 1 showed healing of six/seven fractured ribs. Twin 1 was discharged to local authority foster carers[12] Mother and Father were arrested and interviewed by the police in respect of the injuries and bail conditions included not contacting the twins unless directed by CSC. Twin 2 was placed with the same foster carers when discharged from hospital.	CSC

5 Analysis

5.1 Mother had many different Social Workers whilst in care including three changes of Social Worker during the time considered by this Review. The rapid turnover of professionals involved made it difficult for Mother to establish trusting relationships and will have had a direct impact on the effective implementation of multi-agency work to safeguard the twins.

5.2 Mother's view about the support received whilst in care was included in a LAC Review in September 2015 and is summarised below:

> *Since I have been in care, I have had 5*[13] *Social Workers and I have not felt listened to by any of them. They are difficult to contact and can never answer my questions. I have never seen my Social Workers regularly and have never been made aware of changes to Social Workers until it had already happened. At the moment, I have been told that I have a new Social Worker again, yet nobody can tell me who they are. I am very unhappy about being in care and feel that I am kept completely in the dark about all things in direct relation to my life..... The only people I feel genuinely care about me are the ones that cannot make decisions.....How can I feel safe and secure and try and be happy when I am so mistrusting of all the people who decide what happens in my life? I*

[11] The most common cause of subdural haemorrhage is Shaken Baby Syndrome. Clinical presentations include seizures, retinal haemorrhage, and consciousness disturbance.
[12] As there were no current injuries
[13] Mother had been in care for just over 12 months at this time

have no power, so why in my life. I have no power, so why should I go along with the plans they make for me?

5.3 Whilst the above statement was made twelve months prior to the time considered by this Review it is relevant and significant as it places into context the challenges experienced by agencies involved with safeguarding the twins and supporting Mother and Father as new parents. Mother was very anxious that the twins would be removed and informed professionals that she would disappear with Father if CSC attempted to give the unborn twins a SOCIAL WORKER or make demands on her. It was clear from this Review that management of the relationship between Mother and professionals was fraught, time-consuming and, at times, removed the focus of practice from the twins.

5.4 Key themes emerged during the analysis and were agreed by the Steering Group to provide opportunities for improvement in multi-agency practice. It is important to note that each theme impacted on the others in a systematic and dynamic way. For example, omission to complete a thorough Pre-Birth Assessment influenced the understanding of risk and vulnerabilities regarding the twins. In addition, lack of effective multi-agency cooperation impacted on information sharing and the ability of practitioners to appreciate and understand the potential importance of emerging concerns.

5.5 The themes identified were;

- Effectiveness of assessment
- Response to emerging concerns
- Support to parents during care planning for vulnerable babies
- Multi-agency cooperation and information sharing
- Professional understanding of the twins' lived experience
- Escalation of professional concerns
- Response to non-accidental injuries in babies

Effectiveness of Assessment

5.6 During the timeline of this Review two Child and Family Assessments were completed, one before the birth of the twins and the second when they were four weeks old.

5.7 The initial assessment was completed in response to a multi-agency referral form (MARF)[14] submitted by Mother's Social Worker to advise that Mother was pregnant with twins. The MARF noted that: *Mother has a long history of Social Care involvement and has a history of risky behaviours including CSE, threatening behaviour, alcohol and drug abuse and self-harm.* The assessment was completed two months before the birth of the twins and resulted in closure of the case to CSC as no concerns had been identified. At this time CSC was experiencing significant staffing challenges, there was reliance on agency staff and managerial oversight and supervision was inconsistent.

5.8 This assessment was wholly inadequate and did not provide sufficient information or analysis to effectively safeguard the unborn twins. The author of the CSC chronology noted that it would have been expected practice given the history and ongoing risks, to arrange a Legal Planning Meeting to consider Public Law Outline[15] (PLO) as part of the pre-birth procedures. Omission to complete a comprehensive Pre-Birth Assessment was a significant omission. Pre-Birth Assessments have been identified as an area for practice learning in previous BSCP SCRs[16]. Multi-agency training has been provided and practitioners at the Learning Event said that there is increased awareness and monitoring of Pre-Birth Assessments and there was a view that process and procedures have since improved.

5.9 During completion of the second Child and Family Assessment the twins were born prematurely and remained in hospital for four weeks. Whilst in hospital a Strategy Meeting took place in response to further concerns about parental

[14] Reporting a Concern - Buckinghamshire Safeguarding Children Partnership (buckssafeguarding.org.uk)
[15] The Public Law Outline sets out streamlined case management procedures for dealing with public law children's cases.
[16] Baby K, L and M.

cannabis misuse and the ability of Mother and Father to care for the twins, care proceedings were started.

5.10 The second assessment also contained significant limitations which influenced subsequent decisions and impacted on practice to safeguard the twins;

- There was insufficient evidence for the local authority to obtain an Interim Care Order and the twins were discharged from hospital to the care of Mother and Father under an Interim Supervision Order[17].
- The outcome of the ICPC was that the twins be supported under a Child in Need Plan.

5.11 It was noted in the chronology from CSC that: *There is an Interim Supervision Order in place which needs to be supported by a robust Child Protection Plan*. The assessment was not sufficient to evidence the vulnerabilities of the twins, the potential risks or the ability of Mother and Father to provide good enough parenting. Subsequent decision making at the ICPC did not result in a robust Child Protection Plan and was not adequate to safeguard the twins. Record of the ICPC noted that: *All professionals present agreed that the support plan in place can be managed under a Child in Need Plan with the court oversight.* This suggests that professionals may have been falsely reassured that the oversight of the court would provide sufficient protection for the twins, however at this time the power of the local authority was limited and the application for an Interim Care Order had not progressed due to insufficient evidence.

5.12 Specific shortcomings within the assessment process included lack of information about Father's limited multi-agency contribution, lack of understanding about the relationship between Mother and Father and lack of historical information about the parents.

[17] A Supervision Order gives the local authority the legal power to monitor the child's needs and progress while the child lives at home or somewhere else.

Lack of Information About Fathers

5.13 Omission to include Fathers in assessments has been highlighted as a consistent finding within Serious Case Reviews[18]. There was a significant gap in understanding amongst practitioners about Father's background and experience. There was lack of clarity about how he could contribute to the care of the twins. Given the lack of information it was not possible for any practitioner to be confident about the capacity of Father to support the twins. At the Learning Event practitioners acknowledged that their understanding and appreciation of Father's involvement and ability to care for the twins was limited. Historical information was available to CSC however this was not explored or included within the assessment. Practitioners only became aware of Father's history during the course of this Review, although this was of direct relevance to work of all agencies involved with the family and should have been shared earlier.

Limited Multi-Agency Contribution

5.14 Practitioners at the Learning Event said that key agencies working with the family did not contribute to the initial Child and Family Assessment[19]. Whilst agencies completed their own assessments and support plans there was no systematic multi-agency analysis or agreed coherent multi-agency action plan to support the twins.

5.15 Practitioners spoke about frequent turnover of staff within CSC, poor information sharing and lack of clarity about the roles and responsibilities of specific agencies as contributory factors which impacted on the effectiveness of multi-agency assessment. It has long been recognised that thorough, comprehensive assessments contribute to effective decision making and action to protect children. It is important that all partners share responsibility for contributing to a multi-agency assessment and that professionals are proactive within the assessment process.

[18] Hidden Men: Learning from Serious Case reviews. NSPCC, 2015

[19] CAMHS, FNP and the Support Worker were not involved in the assessment process

5.16 Practitioners noted that one assessment inaccurately indicated that there had been a contribution from CAMHS. It is important that systems and processes to support multi-agency assessments are robust and completed assessments are shared with all agencies who have contributed.

Lack of Understanding About the Relationship Between Mother and Father

5.17 It was a significant omission that the relationship between Mother and Father was not effectively explored within assessments prior to the twins being placed in their care. Whilst some agency records reflected that Father provided support and Mother appeared more settled there were other reports regarding controlling behaviour, lack of interest in the twins and strain within the relationship following birth of the twins. It was acknowledged within the report of the Independent Reviewing Officer at the ICPC that: *There are concerns that Mother may find looking after the twins challenging, it is a lot of responsibility. Mother has Father by her side to look after the twins, but we do not know as much as we could do about how they function as a team.*

5.18 Agency records contained details of incidents which gave practitioners cause for concern however these were not included within an assessment. Specific incidents included:

- Mother discharged herself from hospital against medical advice two days post-caesarean. Mother had tried to leave hospital immediately after the birth and was persuaded to stay. Father's perspective about the care of Mother is not known and there was no evidence that professionals explored whether mother was being coerced to go home. This was a missed opportunity to understand the reasons behind Mother's desire to leave the new-born twins. There was no evidence that the impact of giving birth had been considered or that the local authority as a corporate parent supported Mother to bond with the twins during their first days of life.
- Medical records indicated that Father appeared disinterested and was mostly on the phone during hospital visits. Father also queried the need

for Mother to continue to express breast milk. There was lack of understanding across agencies about how the birth of the twins impacted on Father.

- CAMHS records identified that Mother's relationship with Father was difficult at times and that on occasions the worker had noticed controlling elements to his attitude; it was recorded that when this happened Mother had difficulty managing the situation resulting in her feeling stressed.
- Nursing practitioners said that Father was observed to be controlling at times in the hospital and they had wondered about whether there was a power imbalance in the relationship. This was not recorded in the hospital records but was shared with CSC.
- Father was reported to be controlling of Mother and disruptive in some meetings. Practitioners arranged meetings with Mother when Father was not present.
- Father requested that there was reduced involvement of professionals with the family.
- The Housing Support Worker was contacted by Mother following arguments with Father about feeding of the twins. The parents were experiencing increasing stress and strain within their relationship however this was not assessed and the risks to the twins were not recognised.

5.19 It was known that Mother was a looked after child with significant vulnerabilities, in a relationship with an older man and expecting twins. The nature of the relationship should have been thoroughly questioned and explored by professionals specifically in the light of Mother's history of CSE. The lack of professional understanding about the relationship between Mother and Father, together with the desire among practitioners (expressed at the Learning Event) for parents to succeed contributed to professional optimism and the vulnerabilities of the twins were not consistently prioritised or fully addressed.

5.20 It is important to note that concerns about Mother being controlled within the relationship were shared by the CAMHS practitioner with the Social Worker at

the time, and other professionals. The frequent change in Social Worker, lack of chronology and assessment and limited multi-agency coordination impacted on the effectiveness of multi-agency practice to monitor, review, and assess the relationship.

Lack of Historical Information About Parents

5.21 Mother and Father did not experience positive parenting and their childhood experience of neglect and abuse will have had a significant impact on their ability to care for the twins. It was highly unlikely, given their own childhood experiences that Mother and Father would be able to provide a stable and nurturing environment in which the twins could thrive without extensive support.

5.22 Information about the past experience of Mother and Father was available at the time of assessment though not sought in a meaningful way to contribute to the assessments. There was substantial information regarding Mother within the LAC records and whilst there was limited information about Father this was available. Both parents experienced trauma as children and there was no evidence that either had experienced positive attachments or maintained a meaningful relationship with a supportive adult who could assist them to develop parenting skills. Both parents were isolated and there was no network of family support that they could draw on for support.

5.23 There was no evidence of a discussion with parents about their own childhood experiences and the potential impact of these on their ability to care for the twins. This would have been expected practice and could have informed discussions about the support Mother and Father needed to assist them to parent effectively and develop positive attachments with the twins.

5.24 There was agreement among practitioners at the Learning Event and within the Steering Group for this Review that; it was not appropriate to close the case to CSC prior to the birth of the twins and the ICPC should have concluded with the twins being made subject to Child Protection Plans. Had the Child and Family Assessment included systematic analysis of information that was available at the time it is highly likely that different decisions would have been made.

5.25 It is important that learning from this Review informs practice improvements regarding the assessment process for unborn and new-born babies to reduce the risk of repetition of similar practice limitations. It is essential that there are improvements to multi-agency collaboration to improve the quality of all assessments, specifically those relating to vulnerable babies.

Response to Emerging Concerns

5.26 There were emerging concerns about parental substance misuse and alleged debts involving Father which should have informed and updated the assessment of risks and vulnerabilities of the twins. Information about these concerns was not shared with agencies and there was no evidence that consideration had been given to the impact of these emerging concerns on the welfare of the twins. Each concern is discussed below:

Substance Misuse

5.27 During the timeline of this Review there were regular references to the cannabis use of Mother and Father. Father was signposted to substance misuse services although he did not attend. Mother was referred to services and engagement was limited.

5.28 Concerns about parental use of cannabis were the trigger for the second Child and Family Assessment and a contributory factor in the decision of the local authority to commence care proceedings. Practitioners acknowledged that Mother did not smoke cannabis during pregnancy although there was an extensive history of substance misuse prior to pregnancy. Given the available information about the substance misuse of both Mother and Father it was a concern that the potential risk to the twins was not recognised or reflected in the outcome of the assessments. Information provided by parents about current non-usage was taken at face value at the booking for antenatal care and at the ICPC.

5.29 It was clear that Mother and Father found it increasingly challenging and exhausting to care for the twins. Six weeks after the twins had been discharged home there was an argument between the parents about overnight feeds and

Mother called the Support Worker in distress. Both parents said they had smoked cannabis and a hole was noticed in an internal door. It was recorded that parents minimised the incident and did not accept that cannabis misuse, loud arguments and violence would have a negative impact on the twins.

5.30 The extent of parental substance misuse was not understood or explored at any time. There was a missed opportunity to explore the concerns of Mother's sibling who told the Support Worker that Mother was asking for money regularly and she was worried it may be for drugs. There is significant evidence about the negative impact of substance misuse on babies and the difficulties for drug misusing parents to provide safe and loving care[20]. It was not clear that Mother and Father were helped to understand the risks of substance misuse when caring for the twins.

5.31 It was known that Mother and Father had misused cannabis prior to the birth of the twins. It could have been anticipated that the emotional strain and physical challenge of caring for vulnerable twins may have triggered further use as the Mother and Father struggled to cope with the demands of parenting. This should have been identified as a high-risk factor within assessments and it was a significant omission not to do so. Poor assessment, high turnover of Social Workers and lack effective multi-agency cooperation contributed to the potential risks of substance misuse on the twins being overlooked.

Disputes Over Alleged Debts

5.32 There were at least four occasions during the timeline covered by this Review when Father was involved in physical and verbal altercations regarding alleged debts. The twins were present during one incident when Father was assaulted by his ex-landlord in relation to unpaid rent. This was at least the fourth incident relating to the alleged debt and should have resulted in proactive consideration about the potential risk to the twins, additional stress on parents due to alleged debt and exploration of any link between the debts and substance misuse.

[20] https://learning.nspcc.org.uk/children-and-families-at-risk/parental-substance-misuse/#heading-top

5.33 Limitations of assessments and missed opportunities to monitor, record and share emerging concerns as they arose had a significant influence on the key decisions made to care and protect the twins. Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family[21]. Many of the assessments and judgements made in relation to Mother and the twins were based on the presentation at the time with little consideration of past incidents and concerns.

Support to Parents During Care Planning for Vulnerable Babies

5.34 There was little evidence that Mother and Father had been effectively consulted about the support they required to meet the needs of the twins. Records indicated that Mother and Father were informed of decisions regarding the care of the twins and did not contribute to any plans. This was in contrast to the Strengthening Families Approach [22] adopted in Buckinghamshire which is collaborative, strengths-based and relationship focussed.

5.35 Father was not present or involved with the discussion between the Social Worker and Mother about a mother and baby placement. This was poor practice as Father should have been fully informed about ongoing concerns and proposed plans. Efforts to support Mother and Father to participate effectively in safeguarding practice and procedures were limited. There was lack of consideration given to whether the parents needed support to attend and participate in the ICPC which took place two days after the discharge of the twins from hospital[23].

5.36 It was acknowledged by practitioners and managers involved in this Review that the support provided to Mother during the court proceedings was not good

[21] Working Together to Safeguard Children 2018 p24

[22] https://www.proceduresonline.com/buckinghamshire/chservices/values.html#5.-our-model-of-practice

[23] Mother had to leave the meeting early so she could breastfeed the twins. Father had been caring for the twins for the first time alone and there was no opportunity for either parent to read any of the documents for the meeting.

enough[24]. Court proceedings had a significant impact on Mother and Father and resulted in heightened levels of fear and anxiety and increased mistrust between parents and professionals, particularly CSC. Mother's Social Worker did not attend court to offer support and it was recorded that Mother was unable to attend the Case Management Hearing due to childcare issues. There was no planning regarding the provision of childcare to allow Mother to participate in the court process. There appeared to be a lack of appreciation that Mother was reliant on the local authority as a corporate parent and had no additional support from family or friends. It is understandable that Mother reported feeling isolated, distressed, and anxious

5.37 Frequent change of Social Worker for both Mother and the twins did not enable the development of trusting relationships and had a significant impact on the level of compassion, understanding, care and support provided. Mother told practitioners on more than one occasion that she felt let down by CSC as her Social Worker and PA had left and she had not been allocated new one.

5.38 At the Learning Event practitioners discussed the fact that all agencies wanted Mother and Father to succeed in caring for the twins. Efforts were made to provide support (mother and baby unit) however given the lack of trust between Mother and professionals this was viewed as punitive and there was a lack of understanding about the value and purpose of support provided. Had Mother been able to speak to someone who could have explained the purpose of the mother and baby foster placement it is possible that her anxiety and distress about being separated from Father would have reduced.

5.39 Following a Child Looked After Review for Mother[25] the IRO sought clarity from the Social Worker for the twins regarding plans for Mother and the twins, and how Father would be involved in parenting as part of the family unit. Lack of timely and effective collaboration between agencies supporting Mother as a

[24] Lack of basic care to ensure that Mother had access to food and drink whilst in court was a significant omission. Mother became unwell and required rehydration in hospital immediately after the twins were taken into care

[25] Immediately prior to the discharge of the twins

looked after child, and those with responsibility for the twins, resulted in confusion and distress for both Mother and Father.

5.40 Practitioners said that Mother was treated as an adult during the court process rather than a vulnerable looked after child who had given birth, was experiencing extreme distress, and needed extra care and support. Practice lacked compassion and there appeared to be little understanding of the stress and anxiety experienced by parents.

5.41 Practitioners shared the view that Mother and Father were working hard to do all they could to care for the twins. However, communication between practitioners and parents about what constituted satisfactory care of the twins was not clear. Mother and Father were not provided with an opportunity to respond to the concerns of professionals or identify the support required to enable them to care for the twins.

Multi-Agency Cooperation and Information Sharing

5.42 Rapid turnover of Social Workers had a significant negative impact on multi-agency collaboration and cooperation. The twins had three different Social Workers in three months and difficulties were compounded as the Social Worker for Mother changed at the same time.

5.43 There was very little evidence of information sharing or collaboration between the Social Worker for the twins and the Social Worker for Mother during the period considered by this Review. At the Practitioners Event it was evident that that there was confusion among partner agencies about the respective roles and responsibilities of each Social Worker. In addition, there were occasions when information regarding the twins was shared with the Social Worker for Mother and not shared with the twins' Social Worker.

5.44 There was a missed opportunity for Mother to be supported by her own Social Worker with decisions and plans regarding care for the twins. This fell below the standard of expected practice outlined in the Buckinghamshire Safeguarding Children Partnership Procedures which states:

Where one or both parents who is a Child in Need in their own right (i.e. subject to a CiN Plan, a Child Protection Plan, is a child in care or a care leaver) there will be dual responsibilities of Social Care. The separate Social Workers involved will be responsible for information sharing and liaison across the different Social Work teams and ensuring all agencies involved with the unborn child and expectant mother/parents are aware of their dual responsibilities across the different planning processes.
https://bscb.procedures.org.uk/ykqhp/assessing-need-and-providing-help/pre-birth-procedures-and-guidance/#s2635

5.45 Whilst many agencies were involved with the family there was little multi-agency cooperation and lack of a coherent risk assessment and plan to safeguard the twins. Practitioners were working hard to support the family however without a shared understanding of the vulnerabilities, needs and risks, intervention lacked coordination and had limited impact. Multi-agency cooperation was impaired when dates of meetings changed at short notice. The first CiN meeting following the ICPC was changed[26] which resulted in many key practitioners not attending. Whilst many agencies were involved with the family, at no point was there a meeting with Father, Mother and the professionals involved to streamline them, avoid duplication, and ensure the right person was supporting Mother at the right time. This could have avoided some cancellations and ensured that appointments were prioritised.

5.46 Lack of communication between the Social Worker for Mother and Social Worker for the twins impacted on the effectiveness of intervention and transparency of decisions. Frequent change of Social Workers contributed to the challenge of developing a coherent multi-agency plan with mother and Father to safeguard the twins. There was a lack of trust between Mother, Father and the Social Workers which increased as decisions and plans were imposed rather than developed in partnership with Mother, Father, and practitioners they could trust.

[26] There had been a change in Social Worker and the new Social Worker could not attend on the date that was set with agencies at the ICPC.

5.47 Omission to organise a Multi-Agency Discharge Planning Meeting prior to the twins leaving hospital fell below what would be expected as effective safeguarding practice for all agencies concerned and has been highlighted in previous BSCP Reviews. There was no evidence that consideration had been given to how the twins would be safeguarded in the care of Mother and Father at home. There was significant confusion amongst agencies at this time and it was the understanding of medical practitioners that the twins would be placed in a mother and baby unit from hospital.

5.48 Father's request to room in at the hospital with Mother to care for the twins was initially declined however the rationale for this decision was not clear. This was a missed opportunity to assess the ability of Mother and Father to care for the twins within a supported environment. Mother and Father did room in immediately prior to the twins discharge however the twins were kept in a separate room and the parents woken for feeding due to concerns about absconding. This demonstrated a significant lack of trust between medical practitioners and the parents which was further evidenced as practitioners contacted the police regarding possible absconding and a (Unique Reference Number) URN[27] being raised. It was an omission that the concerns held by medical staff were not communicated through the escalation process with Children's Social Care.

5.49 The twins were subject to an Interim Supervision Order which provided the local authority with the legal power to monitor their needs and progress. It was acknowledged at the Learning Event that the Supervision Order was put in place with no clear information about whether Mother and Father could parent effectively. The absence of a clear plan and lack of effective multi-agency support was a further missed opportunity to safeguard the twins. Given the concerns highlighted and the limited understanding amongst professionals about whether Mother and Father could safely meet the needs of the twins, such lack of planning

[27] This would have provided the NNU with an immediate response should Mother and Father have attempted to abscond with the twins

resulted in the twins being exposed to unnecessary risk. Lack of understanding of the risks to children within plans was a concern also highlighted by Ofsted (2018).

5.50 At times, support and intervention focussed on issues regarding Mother and Father and the needs of the twins were not prioritised. There was no shared understanding between agencies or with parents about the needs of the twins and how parents could be supported to reduce risks and address vulnerabilities. Poor information sharing within and between agencies was a key theme through the Review. At the Learning Event practitioners expressed frustration about the impact on their practice due to limited information sharing. Key examples include;

- The midwife and Social Worker for Mother were not aware that Mother had attended a Genito-Urinary Clinic and stated that she would kill her ex-partner if she saw him
- Information transferred to the Neo-Natal Unit with the twins only stated that Mother was a looked after child. There was no information about social concerns although the post-natal ward was aware.
- The FNP nurse contacted the NNU and provided information relating to Mother, i.e. that she was a teenager and also a looked after child. Baby Narrative records including risk factor forms for each twin were started, however the social issues section was rarely completed. This impacted on the ability to document and assesses risk in relation to the twins whilst patients on the NNU.
- There was confusion among agencies about the CSC Care Plan for the twins. CAMHS were unaware that a second assessment had taken place until Mother contacted them in distress stating that she could not understand how Social Care had changed from closing the case before the twins were born to having a Child Protection Conference four weeks later. The decision to progress to Child Protection was made at a Strategy Meeting which was not attended by CAMHS, the Support Worker or the Social Worker.

5.51 Lack of information sharing between agencies impacted on decisions made at the ICPC. Practitioners stated that there was limited information provided by the Support Worker and Social Worker. The only comment regarding risk was that Father had been seen watching inappropriate videos. There was no information from the NNU to inform the ICPC and little information was known about Father. At the time of the ICPC there was a significant amount of information available to different agencies however there was a failure to pull this together to form a clear picture with regards to the risk and vulnerabilities of the twins.

5.52 Practitioners were clear that the parents, particularly Mother, were working hard to meet the needs of the twins. It was acknowledged at the Learning Event that the ICPC was limited due to lack of information sharing and decision making was influenced by positive reports of Mother doing all she could. There was a significant lack of information regarding Father and what was known was not analysed or assessed. Gut feelings of practitioners were not evidenced and assessments on the twins were incomplete as significant information was missing which resulted in inappropriate decisions and missed opportunities to effectively safeguard the twins.

5.53 Not all agencies attended key meetings and notably the CAMHS practitioner, Mother's Social Worker and the Support Worker were not included in a Strategy Meeting therefore information sharing was limited. Key partners were not fully informed of decisions which resulted in misunderstanding between agencies, practitioners, and the parents.

5.54 RU Safe and CAMHS had an informal meeting with Mother's Support Worker to consider the best way to enable Mother to access support. Whilst this was good practice it would have been more appropriate to hold a Professionals Meeting involving all agencies to agree a way forward in the best interests of the twins. Efforts by these agencies to hold a wider Professionals Meeting did not succeed mainly due to the lack of stability within CSC and the frequent change in Social Worker.

5.55 It was acknowledged at the Learning Event that a consequence of Mother not receiving effective support from her Social Worker was that other professionals, namely the Support Worker, provided support which at times appeared to blur the boundaries between professional support and personal involvement. Whilst the Support Worker did everything possible to provide practical support and care it would have been more appropriate for a Social Worker to have attended at times of crisis to ensure that the relationship between Mother and Father was subject to ongoing assessment and the potential risks to the twins were effectively monitored.

5.56 Practitioners spoke about working hard to maintain communication with other agencies. There was a shared view that it would have been useful to have a Professionals Meeting to clarify what each other was doing. It is not clear why a Professionals Meeting did not take place and it is likely that agencies were waiting for CSC to take the lead. It was clear that supporting the family created a lot of professional anxiety. Practitioners spoke about ongoing difficulties communicating with Social Workers and challenges when not informed that a Social Worker had changed. All these factors impacted on the ability of agencies to work effectively together and one practitioner stated there was not a cohesive multi-agency team effort to safeguard the twins and support Mother and Father. Ensuring the safety and protection of the twins was a multi-agency responsibility and there is learning for all those involved with the care of the twins at this time.

Professional Understanding of the Twins' Lived Experience

5.57 It was evident that the twins would have additional vulnerabilities, born by emergency caesarean section at 30 weeks gestation, Twin 1 weighed 1.24kg, Twin 2 1.37kg. Both twins were admitted to the NNU. Twin 1 required ventilation. It was known that the twins would require care above and beyond that required by full term infants. Caring for premature twins would challenge most mature and experienced parents. Mother and Father were not experienced and had no access to support or advice from family or friends. There was limited consideration to how the new-born twins would adjust to the transition of care from a supported hospital setting to being at home with Mother and Father.

5.58 The twins were known to have reflux which is painful. Infants with reflux may cry constantly, refuse to eat, posset frequently and sleep poorly. It can be exhausting for any parents to manage[28]. There was limited evidence that Mother and Father received support or advice to improve their ability to make the twins comfortable and reduce their distress.

5.59 The twins were present during adult arguments both in public and at home. It is likely that being subject to raised voices caused them anxiety and distress. There was limited evidence that the potential impact on the twins was reflected in professional supervision and little consideration was given to reducing the risk of repercussions prior to the twins being taken into foster care.

5.60 There were at least two occasions when professionals reported a strong smell of cannabis during home visits. Whilst the twins were not present at the time there was no evidence of robust conversations with Mother and Father about the significant risk to the twins should they misuse substances. This was a known risk which was not adequately addressed.

5.61 At the Learning Event professionals stated that everyone wanted Mother and Father to succeed and there had been significant positive progress at times in relation to their care for the twins. Agency records were mainly descriptive and there was little evidence of effective multi-agency reflection or consideration to understanding the lived experience of the twins. Work was responsive; there was a high level of anxiety amongst practitioners about the lived experience of the twins however this was not reflected within agency records.

Escalation of Professional Concerns

5.62 It was clear from discussion at the Learning Event that there were concerns at the time about multi-agency practice to safeguard the twins. Some professionals raised concern with colleagues in CSC about closure of the initial assessment and lack of consultation with partner agencies during the assessment process.

[28] Your Premature Baby and Child: Gastroesophageal Reflux in Premature Infants; Dianne I. Maroney accessed at http://www.prematurity.org/baby/reflux-maroney.html on the 28/01/2019

However, the escalation procedure was not followed and there was limited evidence that discussion of concerns impacted on practice.

5.63 Practitioners who attended the ICPC expressed concern that the assessment and information shared did not adequately take into account the vulnerability of the twins. Agency records indicate that all professionals who attended the ICPC agreed with the decision and there was no escalation within agencies which would be expected practice.

5.64 It was acknowledged that there is practice learning for all agencies involved with the family. Had concerns been escalated effectively it is possible that key decisions would have been challenged and intervention to safeguard the twins more robust. Escalation has emerged as a practice issue in previous BSCP SCRs and whilst there has been much training and awareness raising it remains a practice issue of concern.

Response to Non-Accidental Injuries in Babies

5.65 The correct procedure was not followed when the bruising was identified as the twins should have been taken straight to the nearest A&E department[29]. There was a delay in contacting the Social Worker for the twins and the foster carer was advised to attend a routine physiotherapy appointment with the twins and wait for a Child Protection Medical to be organised. The twins were subject to a car journey which could have exacerbated their condition and caused unnecessary pain. There was further delay as the Social Worker could not be contacted and professionals involved in the physiotherapy appointment were placed in a difficult position and there was lack of transparency with Father about why the twins were being kept at the hospital. Lack of communication from CSC caused unnecessary stress for all concerned as professionals were unable to be transparent with Father about why he and the twins were being kept at the hospital.

[29] 2.1 Arrangements for Medical Assessment of Children in Cases of Suspected Abuse and Neglect: Procedure | Buckinghamshire Safeguarding Children Board Procedures Manual

5.66 Discussions at the Learning Event and within the Review Steering Group suggest that practice regarding the arrangement of Child Protection Medicals in partnership with the Police is generally good. It is possible that that the identified practice shortcomings are specific to this case. However, given the potential serious impact on vulnerable babies if the correct procedure is not followed this will be included as a learning point.

6 Good Practice

- Practitioners responded to Mother at times of distress to assist her to care for the twins
- The Community Midwife made a referral to CSC regarding concerns about cannabis misuse
- The Housing Support Worker was commissioned to provide additional hours to support the parents when the twins were discharged from hospital
- Practitioners met to consider how best to support Mother to cooperate with other agencies

7 Context

7.1 Children's Social Care in Buckinghamshire County Council has experienced a period of significant change and challenge over the past seven years. Children's Services were judged 'inadequate' following two Ofsted inspections (2014 and 2018) and there was a change in leadership at a strategic and practice level.

7.2 The 2018 Ofsted report noted: *The high turnover of Social Workers, high caseloads in some teams and poor recording have all been significant contributory factors to the slow progress of children's plans, and have led to some children being left at risk and in unsuitable circumstances for too long. Frequent changes in Social Workers or visits conducted by rotating Duty Workers make it hard for children to develop trusting relationships or for Social Workers to properly understand children's experiences and circumstances.*

All these factors featured in this Review.

7.3 Findings from a recent monitoring visit in December 2019 noted that there have been limited improvements[30]. Some ongoing concerns continue, specifically regarding "*frequent change in Social Worker, variable quality of practice and assessments not regularly updated. Significant progress has been made however processes to improve challenge and oversight have only recently been put in place, and it is too soon to see their impact".*

7.4 Given the comprehensive changes that were required it will take time for improvements to be evident in all areas of practice. The challenges within CSC impacted on the work of all agencies as is evident within this Review.

8 Conclusion, Learning and Recommendations

8.1 Poor assessment and planning was evident throughout the timeline for this Review and Mother and Father did not receive adequate support. Risks and vulnerabilities were not identified, decision making was not robust and safeguarding of the twins was not effective. Intervention by the local authority increased in response to concerns and the twins became looked after children at sixteen weeks.

8.2 It is important that learning from this Review contributes to improvement plans to strengthen decision making procedures for unborn babies when parents have known vulnerabilities.

8.3 A Thematic Review of SCRs published by BSCP between 2009 and 2019 included eight reviews relating to non-accidental injuries in babies. Findings within this Review are similar to those identified in earlier Reviews. It is important that partners understand why similar practice issues have recurred within this Review and ensure that actions to address learning focus on improvements required to reduce future repetition of the same practice shortcomings.

8.4 Whilst implementation of a detailed improvement plan is underway there is agreement at all levels of the Safeguarding Partnership that further progress is

[30] https://files.ofsted.gov.uk/v1/file/50134640

required. This Review provides an opportunity for partners to ensure that the learning identified contributes to practice change in a way that is measurable, improves the assessment of risks and vulnerabilities for babies in Buckinghamshire and ensures that children benefit from Social Work intervention.

8.5 This Review has highlighted opportunities for practice improvement when the Mother is a looked after child. Whilst this Review has focussed on the twins it was inevitable, given the known vulnerabilities of Mother that there were at times competing priorities and on occasion the needs of the twins were not prioritised. The Review has highlighted learning for the local authority as a corporate parent regarding practice to support Mothers who are known to have significant vulnerabilities when they become parents.

8.6 It was evident during this Review that the challenges within CSC impacted on the practice of partner agencies. Frustration about the challenges of communication with Social Workers and limited information about plans to safeguard the twins were compounded by frequent turnover of staff. It is important to note however, that omission to complete a comprehensive multi-agency assessment was central to the learning from this Review. Whilst CSC have responsibility as the lead agency it is critical that multi-agency partners are proactive in assuming their responsibility to contribute and participate in assessments and decision-making processes.

This Review has benefited from the generous participation and reflection of practitioners and managers at the Learning and Recall Events. Whilst practitioners worked to support the children and family within their respective agencies there were systemic issues which had a significant impact on the practice of all.

Learning Point 1
When looked after children become pregnant it is important that the local authority, as corporate parents, undertake a comprehensive Unborn Baby Assessment in order to:

- Understand the needs and vulnerabilities of the unborn baby
- Provide effective multi-agency parenting support to enable parents to meet the needs of their baby
- Understand the impact of pregnancy on a looked after child and provide emotional and practical support

Recommendation 1
The Safeguarding Partnership seeks assurance that learning from this Review is addressed within the improved process and procedures regarding Unborn Baby Assessments

Recommendation 2
The Safeguarding Partnership considers improvements to the support for looked after children who become pregnant which include:

- **Timely communication with Mother (or Father) if there are concerns for the baby**
- **Identification of parental support needs (physical/emotional)**
- **Clear communication between Social Workers for the parent and Social Worker for the baby**
- **Opportunity for parents to contribute to care plans for the babies**

Learning Point 2
In the absence of a holistic multi-agency assessment important information may not be shared, historical concerns may be omitted, and the risks and vulnerabilities of vulnerable babies may be overlooked.

Recommendation 3
The Safeguarding Partnership seeks assurance that learning from this Review is addressed within the improved process and procedures for multi-agency assessments with specific regard to;

- **Involvement of Fathers,**
- **Use of historical information to inform analysis**
- **Contribution of partner agencies to assessments led by CSC**

AND

Assurance is sought about the impact of improved assessments on practice

Learning Point 3
When multiple Social Workers are involved with a family it is important that parents and professionals understand the different roles and responsibilities of each.

Recommendation 4

The Safeguarding Partnership seeks assurance that information about the role and responsibility of practitioners from different agencies are included within all multi-agency plans

Learning Point 4
When there are concerns about the possibility of coercion and control within parental relationships when one parent is a vulnerable young person it is important that there is clarity about the nature of the concerns and there is clear understanding between agencies about the support and intervention required for both the parent and child.

Recommendation 5

The Safeguarding Partnership seeks assurance from partners that multi-agency practice regarding coercion and control is informed by learning from this Review, specifically:

- **When a looked after child becomes pregnant there is a holistic assessment which includes a robust analysis of:**
- **Historical information regarding both parents**
- **The quality of the relationship between partners**
- **Early identification of actions required to safeguard baby/babies**

Learning Point 5
Without clear understanding and awareness of the escalation policy concerns raised by practitioners may not result in change and inappropriate safeguarding decisions may be unchallenged.

Recommendation 6

Buckinghamshire Safeguarding Partnership with partner agencies identify and address the barriers to the effective use of the escalation policy and procedure.

Learning Point 6
When non-mobile babies require a Child Protection Medical for suspected non-accidental injuries it is critical to follow the correct policy and procedure to reduce the risk of additional harm.

Recommendation 7

Safeguarding partners request assurance that there is understanding and confidence amongst practitioners from all relevant agencies to implement the Child Protection Medical procedure.

Learning Point 7

Multi-agency Discharge Planning Meetings should be held for all vulnerable babies prior to discharge from hospital in order to discuss any professional concerns and agree a robust multi-agency plan to safeguard vulnerable babies.

Recommendation 8

Buckinghamshire Safeguarding Partnership with partner agencies seek assurance that the system to implement a discharge planning meeting is robust and understood by practitioners

Recommendation 9

Practice learning from this Review is shared with agencies and practitioners across the Safeguarding Partnership

In addition, it is suggested that prior to identifying plans for practice improvement in response to learning from this Review consideration is given to the following:

- Buckinghamshire Safeguarding Children Partnership seeks to understand why practice learning identified in previous Reviews has been repeated within this SCR
- Actions in response to learning from this Review are informed by an understanding of why previous efforts to improve practice may not have been effective
- Buckinghamshire Safeguarding Children Partnership seeks assurance that implementation of the recommendations from this Review has an impact on practice to safeguard children and vulnerable babies