Serious Case Review

Child G

REVIEW REPORT

Lead Reviewer: Nicki Pettitt

Agreed by the KSCB: 28th September 2018

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the KSCB prior to publication.

The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

CONTENTS

1 Summary of the learning from this review

1.1 This Serious Case Review (SCR) is in respect of a child to be known as Child G[1]. She was two months old when she died while in the care of her parents in 2017. Her father admitted manslaughter. He was convicted and received a custodial sentence in June 2018. Child G died from injuries consistent with being shaken.

1.2 Learning has been identified for the agencies involved and for the Kent Safeguarding Children Board (KSCB). Improvement action and a number of recommendations have been made in section 9 of this report. Learning was found in the following areas, the detail of which is included in the analysis section of this report:

- The need to assess and provide support and services to both parents, regardless of gender.
- When a parent is vulnerable, professionals may struggle to identify that they are not meaningfully engaging with services.
- The importance of supervision and clear processes for professionals to follow if they are not receiving supervision as required.
- The need for on-going communication and information sharing around, and following, transitions between services.
- The need for a timely response to any decline in a family's situation, particularly bearing in mind the vulnerability of very young babies.

2 Introduction to the Case

2.1 Child G lived with her mother and her father. She was their first child, and her parents were aged 18 and 19 when Child G was born. They had support from extended family members and lived in social housing provided by their local council following a period in temporary accommodation while Mother was pregnant.

[1] In order to provide protection of the families identify, a pseudonym is being used.

2.2 Child G's father has admitted that he was responsible for her death. In the early stage of the investigation into what happened, Mother stated that Father had slapped the back of Child G's head whilst feeding her around 2 weeks prior to her death. He also admitted this. Mother also said that he had, on one occasion, neglected to feed Child G, and that on another occasion he had co-slept with her.

2.3 Mother had been receiving support from CAMHS[2] until she was 18, and then from services for adults with mental health issues, which is on-going. Prior to Mother's pregnancy, Early Help attempted to engage with her, and Housing and the Specialist Children's Services (SCS)[3] Adolescent Support Team (AST) undertook a Housing Protocol Assessment.

2.4 The family received support throughout the pregnancy and Child G's life from a family nurse working with the Family Nurse Partnership[4] (FNP), as well as universal service provision from other professionals, such as midwives and GPs.

2.5 Child G was not the subject of any plan[5].

3 Process

3.1 The KSCB agreed that this Serious Case Review (SCR) would be undertaken using the Significant Incident Learning Process (SILP) methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. Practitioners, managers, and agency safeguarding leads then come together for a learning event[6]. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the event. The same group then meets to study and debate the first draft of the SCR report. Later drafts are also commented on by all of those involved, and they make an invaluable contribution to the learning and conclusions of the review[7].

3.2 It was agreed that the scope of the review would be from 1 June 2015 to 9 January 2016. This allows consideration of services received by Mother when she was homeless, Mother's pregnancy, and the birth and life of Child G until her death. Relevant information prior to these dates was also considered as required, particularly any significant and relevant agency involvement with Child G's parents.

3.3 Early family engagement is required as part of the SILP model of review. Kent Police were unwilling for the lead reviewer to meet with the family prior to the conclusion of the criminal investigation. This was accepted by the KSCB and lead reviewer. The lead reviewer and a

[2] Child and Adolescent Mental Health Service

[3] Providing social care services to children and families in Kent.

[4] The Family Nurse Partnership (FNP) works with parents aged 19 and under in the area, partnering them with a specially trained family nurse who visits them regularly, from early pregnancy until their child is two. By focusing on their strengths, FNP enables young parents to: Develop good relationships with and understand the needs of their child; Make choices that will give their child the best possible start in life; Believe in themselves and their ability to succeed; Mirror the positive relationship they have with their family nurse with others. (Taken from the FNP website.) The FNP is a licensed programme supported by a national unit, commissioned by the Department of Health and Public Health England.

[5] No early help, child in need, or child protection plan, was in place in this case at the time of child G's birth or death.

[6] The Chair of the KSCB agreed the SCR, the lead reviewer was appointed, the terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in October and November 2017. The lead reviewer is Nicki Pettitt, an independent social work manager and safeguarding consultant. She is an experienced chair and author of SCRs and a SILP associate reviewer. She is independent of KSCB and its partner agencies.

[7] Working Together 2015 states SCRs should be conducted in a way that; recognises the complex circumstances in which professionals work together; seeks to understand precisely who did what; considers the underlying reasons that led to actions; seeks to understand practice from those 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. This review has achieved these objectives.

representative of the KSCB requested a meeting with Father. He declined. Mother met them prior to publication[8]. Her views are included in the report.

3.4 Kent Police asked that one professional who had significant involvement, and who was a potential witness, did not attend the events. The lead reviewer met with her separately to ensure her contribution to the review.

3.5 Statutory Guidance expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information and case detail will not be disclosed in this report. It is written in the anticipation that it will be published, and contains the information that is relevant to the learning established during this review.[9]

4 Family Structure

4.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Child G
Mother of Child G	Mother
Father of Child G	Father
Mother's mother	Maternal Grandmother

5 The background prior to the scoped period

5.1 Mother had significant mental health issues as a teenager, which included a 12 month stay in a mental health unit, partially under S3 of the Mental Health Act[10], when she was 14-15 years old. CAMHS were involved with Mother from age 14 to age 18. She was then transferred to adult mental health services. CAMHS told this review that Mother's mental health issues included low mood and anxiety, PTSD[11], and 'features of emotional dysregulation which was thought to be an emerging personality disorder'. Mother had a history of self-harming and suicide attempts. She was prescribed medication[12] and also known to smoke cannabis before she was pregnant.

5.2 Mother lived with her parents and sibling until a few months prior to her pregnancy. Other than contact with her CAMHS worker and the time she spent in hospital, there was little involvement with services prior to the scope of the review.

5.3 Father grew up living with his mother. It is reported he may have been an informal carer for her due to her physical health needs. Father admitted to smoking cannabis but was not known to drug agencies. Neither Father nor Mother was in education or employment during the scope of the review.

[8] Kent Police requested that no contact was made with the parents prior to the conclusion of the criminal investigation.

[9] KSCB recognised the potential to learn lessons from this review regarding the way that agencies work together in Kent to safeguard children. The review has therefore:

- Identified improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice.
- Clearly identified what lessons have been learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result.[9]

[10] Where the person is detained for treatment following the diagnosis of a mental health illness and where treatment is necessary for the patients health, safety or for the protection of other people.

[11] Post traumatic stress disorder

[12] Fluoxetine (anti-depressant) and Lamotrigine (mood stabiliser).

6 Key Episodes

6.1 The time under review has been divided into three 'key episodes'. These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and their families. They are key from a practice perspective rather than to the history of the child. They do not form a complete history of the case but summarise the relevant activities that occurred and include the information that is thought to be most helpful in informing the review.

Key Episodes	
1	Contact with agencies between June 15 and March 16
2	Pregnancy
3	From the birth until the death of Child G

Key Episode 1: Contact with agencies between June 2015 and March 2016

6.2 Mother and her sibling became known to SCS in June 2015 when they contacted SCS and said they had been 'thrown out' of home. When contacted, their mother (Maternal Grandmother) requested they come into care as she had no control over their behaviour. An assessment and support were offered, including the involvement of Safer Stronger Families[13]. Maternal Grandmother declined the support and the children remained at home[14]. The children were not spoken to directly.

6.3 At this time Mother's mental health was stable. There was an overdose that was thought to have been due to Mother not managing her medication well, and Maternal Grandmother not supporting her daughter with this. Mother presented as unhappy at home and in March 2016, said she was homeless. CAMHS referred her to Early Help who assisted with an application for housing. Housing then referred Mother to the Adolescent Support Team (AST). The AST did not know Early Help had been involved and that they could have contributed to their assessment. The support from the AST was in relation to homelessness but included a plan to engage Mother in education or training and to develop life skills, such as budgeting, as it had been from Early Help[15].

6.4 Mother's cooperation was very limited, other than in regard to the provision of housing. Her parents engaged with the housing assessment, advocated on Mother's behalf, and offered to ensure Mother attended appointments. Early Help closed the case prior to the pregnancy as Mother had not engaged.

6.5 Mother spent some time living with Father at his mother's home and in bed and breakfast accommodation. The family negotiated that Father stay with Mother in the bed and breakfast due to her vulnerability and need for support. It was agreed they would be re-housed together, and a tenancy was sought.

6.6 CAMHS remained involved with Mother at this time. They also referred her to Addaction, a drug support agency, to address her cannabis use. Addaction spoke to Mother and she stated she was only using cannabis occasionally, but was interested in stopping. Appointments were made, but Mother did not attend. Mother is said to have stopped when she found out she was pregnant.

[13] A crisis intervention service to enable young people to remain living with their family and avoid becoming looked after.

[14] SCS have noted in their agency report that they have identified learning in regard to the importance of speaking directly to children when issues such as these emerge.

[15] Early Help was the lead agency for NEET (Not in Education Employment or training). SCS AST undertakes joint housing assessments of children under 18.

Key Episode 2: Pregnancy

6.7 Concerns were noted for the unborn baby soon after professionals who knew the parents became aware of the pregnancy. The CAMHS worker had concerns that Mother would not cope with a baby unless she took her medication and continued to engage with mental health support. The social worker and social work assistant (SWA) from the AST who were working with Mother were concerned that she had stopped taking her medication due to the pregnancy and spoke to both parents about the impact of their insecure housing situation, smoking tobacco and cannabis, and their need to accept support. The social worker recorded that consideration should be given to referring the unborn child to the SCS Central Duty Team[16].

6.8 When Mother reached her 18th birthday she was 10 weeks pregnant, and no referral in respect of the unborn child was made by the social worker who closed the case. The record of the closure stated that the pregnancy was not yet 'viable' and that when a midwife was allocated, they could refer if there were any concerns. They also recorded that CAMHS were 'considering a mother and infant mental health (MIMHS) referral'. This referral was made, but CAMHS were told they were unable to make refer[17].

6.9 Plans were in place to transfer Mother from CAMHS to adult services in respect of her on-going mental health needs. It is noted that Mother only met the adult criteria because she had previously been sectioned under S3 of the Mental Health Act 2007 and because of her pregnancy. The transfer happened before the birth of Child G, but Mother did not attend any appointments. The mental health worker spoke to midwives, and later to the family nurse, and felt their involvement provided the appropriate support. They recognised that Mother would not meet the criteria for the MIMHS at the time.

6.10 The family were notified to the FNP shortly after a midwife met them, as they met the criteria for the service[18]. After initially engaging with the FNP nurse, the parents decided they did not want the additional support[19]. This was accepted, but the FNP family nurse contacted the family when Mother was around 7 months pregnant to see if they would reconsider, and they agreed to re-engage with the FNP. They continued their involvement, following the established plan, through the birth of Child G until her death. There had been 5 weeks of the programme missed so there were gaps in regard to some of the topics covered in the programme. The FNP and parents agreed together what to focus on from this period and they covered feeding, bathing, soothing a crying baby and 'shaken baby'.

6.11 Mother stated that she was no longer smoking or using cannabis during her pregnancy. Maternal Grandmother disputed this and contacted the midwife to say that Mother continued to smoke tobacco. Father told the Family Nurse that he had stopped using cannabis when Mother became pregnant.

Key Episode 3: From the birth until the death of Child G

6.12 Child G was born slightly early and spent 11 days in the Special Care Baby unit (SCBU) due to poor feeding following her birth. There were no concerns from SCBU staff, however they

[16] Kent County Council front door for SCS, where new referrals are made for children where there may be safeguarding issues or need for support.

[17] At the time, MIMHS referrals could only be made by those working in adult mental health services. This is no longer the case.

[18] The FNP National Unit is commissioned by the Department of Health and Public Health England, who hold the license in England and have the lead role for its strategic policy direction. It is accountable to the University of Colorado for the quality of programme delivery and to ensure that it is implemented in the way it was designed. The Family Nurse Partnership National Unit through its contract with Public Health England grants sub-license's to provider organisations or commissioners. Kent Community Health NHS Trust commissioned this programme. The 'Licence' requirements to deliver the FNP programme stipulates that the 'core model elements' must be met to ensure the programme is replicated in the UK, consequently not to dilute or change the programme.

[19] FNP is a voluntary service.

were not aware of the extent of Mother's mental health history. The adult mental health worker had telephoned the delivery ward and explained that she was involved, but this information was not then shared with the SCBU. They were aware that the FNP were involved and the family nurse visited Mother and Child G on the unit, which was good practice. Mother's family visited and were involved in helping Mother and Father make the difficult journey to the hospital.

6.13 Community midwives planned to keep the case open for 28 days following discharge. They were aware the FNP were involved and they coordinated visits with them to provide optimum support. No concerns emerged.

6.14 Mother had not engaged with adult mental health services in the previous months, but after the birth of Child G she accepted support. Around a month after the baby was born, Mother's mental health worker visited (although Mother had earlier tried to cancel the appointment) and Mother had stated she felt unsupported by Father and that she felt isolated as her anxiety meant she struggled to leave the house. She was exhibiting some OCD[20] symptoms. A referral was made to an occupational therapist (OT) to assist with this issue. The OT tried a number of times to speak to and then meet with Mother, but this was a challenge.

6.15 On 15 December 2016, the OT tried to visit Mother and did not get access[21], but then spoke with her. Mother stated that she could not see her that day as Child G was ill. She was advised by the OT to attend the GP, which Mother stated she intended to do. Mother said the baby was looking pale, sounded raspy and was not taking much milk. She added that she wasn't getting much sleep and that Father was not much help and spent a lot of his time playing on his games console. Mother had shared similar issues with the family nurse, stating to her that she could not trust Father to do anything with the baby, and disclosing that he had fallen asleep while feeding Child G and had taken her into bed with him on one occasion.

6.16 Child G experienced poor weight gain during the Christmas period and was reported by her parents to be vomiting, unsettled and with reduced feeding. They contacted the 'out of hours' GP service and Child G was seen, with the GP reporting no concerns.

6.17 Child G was seen by the family nurse on 3 January 2017 with her Father. Father reported that Child G had been feeding well. When weighed, she had gained weight, was observed to smile at Father and to copy his mouth actions.

6.18 When the family nurse visited on Friday 6 January 2017, both parents were present. She noticed and recorded a mood change in the household, with neither parent smiling at the baby or each other. When asked about this both parents reported that Child G only smiled every other day. Father said he smiled at Child G every day and Mother said she 'sometimes' smiled at Child G. The baby was asleep and was woken to be weighed during the visit. She was unsettled, so the family nurse could not establish if there was any change in the baby's demeanour, although she saw the baby naked when weighing her and had no concerns. Following the visit the family nurse requested supervision on the case for the following week. This was because the relationship between the parents appeared strained, and Father had previously stated that he couldn't settle Child G like Mother could, that he often felt rejected by the baby, and that he was unconfident of his bond with Child G.

6.19 On the evening of the following day, Mother called an ambulance, saying that Child G had gone limp while in Father's care. Non-accidental injury was part of a differential diagnosis

[20] Obsessive compulsive disorder.

[21] The accommodation was in a block with a communal access by security buzzers. This made it difficult to get to the flat door.

for the child's condition. Mother shared with the police that about 2 weeks before, Father had hit Child G on the head whilst feeding her. She stated she had challenged him at the time and his response was that he was winding the baby. Mother reported that Father was in an agitated mood at the time, but that she had checked the baby who seemed fine.

7 Analysis by Theme

7.1 From the information gained from the agency reports and from the discussions with the professionals involved and with Mother, several key themes have emerged. The following are judged to be most significant and enable us to identify learning for the KSCB and its partner agencies:

Emerging themes
Father
Meaningful engagement
Supervision
Transitions and communication
Thresholds
The vulnerability of babies

Father

7.2 A large number of SCRs undertaken nationally have found that partner agencies need to be more proactive in involving fathers (and/or mother's partners) in assessments and plans. There are a wide range of services in place to support teenage mothers, but services tend to ignore or marginalise young fathers.[22] There were no specific concerns identified about Father when professionals became aware of the pregnancy, other than he was a young and first-time parent who was open about his use of cannabis. His relationship with Mother appeared to be caring and supportive while she was pregnant. However, after the birth of Child G, Mother stated that Father was not being as helpful. Father told the family nurse that he felt rejected by the baby and he appeared to have lost confidence in his ability to build a relationship with the baby. He was also reported, by Mother, to be spending a lot of time playing on a games console.

7.3 Research[23] by the Family Rights Group shows that professionals often struggle to engage with fathers, that they have limited expectations of them, and when looking at plans to support or protect children, it is often assumed by professionals, and the parents themselves, that 'parent' really means 'mother'. The research argues that professionals tend to see men in a family as either 'a risk or a resource' rather than an as equal parent who needs to be assessed, supported and challenged equally along with the mother. In this case, the family nurse involved Father in much of the work being undertaken, as he was always present during visits. The FNP service is expected to work with both parents, although the mother is the client, and the recording of the work undertaken in this case reflects this focus on Mother. While Father was engaged in much of the work, his mental health or general health and wellbeing were not explored in detail, and his own experiences of being parented and family history were not recorded in the way that Mother's were. Father had his own health issue at the time of Child G's birth and there is no evidence that the impact of this was discussed with him, although the family nurse is clear she did spend time asking him about

[22] Fatherhood Institute Research Summary: Young Fathers. 22 July 2013

[23] Family Rights Group, Fatherhood Institute, Daryl Dugdale (Bristol university), Professor Brigid Featherstone (Open University) 2012

his health concerns, but that it would not have been appropriate to record his health issues in Mother's notes.

7.4 In regard to cannabis use, while completing the Family Health Needs Assessment, the family nurse identified that both Mother and Father had smoked cannabis. The family nurse told the review that both reported that they had stopped when Mother found out she was pregnant, although this is not clear in the records. The FNP find that cannabis use is fairly prevalent, especially in partners of their service users. A large number give up during the pregnancy, but often take it up again once the baby is born. The family nurse believed that the couple had also given up smoking and she never smelt either cannabis or tobacco in the home.

7.5 A report by Barnes et al, published in 2008, evaluated the first year of the pilot sites for the FNP in England. It stated that 'although young first-time mothers were the main target for the programme, an important feature of the FNP is to involve the 'whole family'. In practice this meant that family nurses would seek to work with fathers and partners as part of the programme delivery'. It found that where fathers were involved, it encouraged better engagement from mothers with the family nurse programme. In this case Mother was often anxious and appeared to prefer to see professionals with Father's support. Father was thought to be a positive help to Mother during her pregnancy and was very good with Child G, showing a clear bond and practical and emotional engagement. However, he could be easily put off when he felt that Child G would rather go to her mother. This shows his insecurity and immaturity and there would have been a need for him to receive help in managing this had it continued.

7.6 It appears that Father's constant presence meant that Mother was rarely seen alone. While there was no consideration given at the time to domestic abuse by control or coercion, this was a possibility. Mother was vulnerable, she had disclosed sexual violence from an ex-boyfriend, and she suffered with mental health issues. The CAMHS worker had spoken to Mother prior to her pregnancy about her relationship with Father and raised the potential of him being controlling, but Mother stated this was not the case. She was dependant on him due to her high levels of anxiety, and he was thought to be instrumental in ensuring she took her medication. Father claimed carers allowance[24] for the care he provided to her.

7.7 With hindsight, it could look as though Father may have been taking over, however Mother did feel able to voice her concerns about him not helping much and about the amount of time he was spending time on his games console. The family nurse also often saw Mother being assertive. The family nurse was clear with both parents about the different ways that relationships can be abusive, and Mother said she had no concerns. Mother told the lead reviewer that she had not recognised Father was controlling at the time, but now recognises he was. The FNP model includes relationship work and trust exercises and these were completed with both parents together. No formal opportunity was provided to Mother to speak to the nurse alone. On one occasion, Mother had texted the family nurse reporting that she and the Father had had an argument. The family nurse visited them and discussed the situation, (although not the text message), including a conversation about the change in relationship dynamics following the birth of a baby. Mother and Father stated that tiredness and stress had exacerbated the situation. The family nurse did not believe this was evidence of domestic abuse in the couple's relationship and their reaction to the session was positive and not of concern.

[24] A government benefit that is paid to those who care for someone for over 35 hours a week, and they recieve a benefit such as disabilioty living allowance.

7.8 It is good practice for professionals to meet with both parents individually if working with the family. Arguably in this case it was particularly important due to Mother's vulnerabilities. It is also the case that young fathers may be less likely to have experience of or feel confident in caring for or being with young children in our society, so their needs with regards to parenting education and support needs individual consideration[25]. Providing support to fathers so that they can be a positive feature in their children's lives and can support their partners as a co-parent, leads to positive outcomes. The second year evaluation of the FNP recorded that 64% of the young women asked stated that the intervention had helped their relationship with their partner. The longer term benefits to children are also stated. (Barnes, 2009). Despite this need, it is not expected that family nurses meet individually with fathers. In this case however, the work undertaken with Father was extensive and the family nurse had good knowledge of him, his hopes, concerns and expectations. This was not always evidenced in detail in recordings, but the family nurse states that it was always considered by her in her work with the family.

7.9 Father was not always as confident in his relationship with his daughter as he wished to be. This was something that the family nurse wanted to work on with him in the coming months. There is increasing evidence of father's suffering with post-natal depression[26] and this may have been an issue in this case. The risk factors were evident and professionals need to be aware of this as a possibility, and consider it when difficulties emerge after the birth of a child, including relationship issues and lack of confidence in the role, as was evident in this case.

7.10 It has been confirmed that both of the parents were given information on the dangers of shaking a baby by the SCBU and on a number of occasions (pre and post birth) by the family nurse.

Learning:

- All professionals working with young parents should consider creating an opportunity to meet with both parents on a one to one basis.
- A mother-focused plan for support does not necessarily allow a full understanding of the risks and protective factors within a family. The outcomes for children, if both parents are positively involved in their lives, shows the benefit of focusing on engaging with and supporting both parents.
- A parent may not recognise that a relationship is controlling at the time they are involved.
- Fathers can suffer with post-natal depression.

Meaningful engagement

7.11 The Triennial Analysis of SCRs 2011-2014 shows that poor or inconsistent parental cooperation is commonly seen in SCRs. It is not necessarily easy to identify problematic engagement as it is not always obvious. The parents in this case were said to look and present as younger than they are, and to professionals they largely came across as polite and compliant. Both parents appeared to sometimes find it hard to communicate with professionals and would not engage in long conversations, but they were not dismissive or argumentative. This

[25] Lero, D.S. (2008) Policies Affecting Young Fathers. In the FIRA Inventory of Policies and Policy Areas Influencing Father Involvement. Canada: Father Involvement Research Alliance. Article available at: http://www.fira.ca/article.php?id=91

[26] Research available from the National Childbirth Trust found that more than 1 in 3 new fathers (38%) are concerned about their mental health. In general, studies have shown that one in 10 fathers have PND and fathers also appear to be more likely to suffer from depression three to six months after their baby is born.

behaviour was not identified as avoiding engagement, but more as a reflection of their personalities.

7.12 As Mother's vulnerabilities, and at least some of her history, were well known, some professionals found it hard to challenge her. When she got upset, which she often did, they did not like to push her too much. Those working with the family identified them as a family in need of help and support, not a family where the child needed to be protected. It was considered by most of those involved that if Mother continued to receive help with her own mental health, and if the FNP provided a programme to assist her with parenting her baby, there was no obvious risk.

7.13 There was an opportunity when Mother's case was closed to the SCS AST early in the pregnancy for Mother to have remained open to Early Help in her own right, as a step down from a child in need plan when she reached 18 years of age. This often happens now, but Early Help was very much in its infancy at the time, and this does not appear to have been considered at the time in Mother's case. Mother would have needed to agree to the on-going support, and as her engagement with Early Help and the AST was predominantly to achieve housing, she may not have seen the need for any on-going work.

7.14 Mother did not disclose the extent of her mental health history to the midwife, who was unaware of the year spent in a mental health unit. When the midwife asked Mother for the history, Maternal Grandmother and Father were present and did not provide the full information either. The midwife assumed that the information provided was the whole picture and was not suspicious about the information shared. She did not contact the GP for information.

7.15 Other than a short period when Mother was pregnant, and she refused the FNP, the parents, and Child G following her birth, were seen regularly at home by the family nurse. Appointments were generally kept and there were no issues with accessing the baby. The parents were thought to be open and honest with the family nurse about their concerns including with each other. They came across as willing to learn and open to advice and support. The family nurse had no concerns about compliance with the programme.

7.16 How meaningful this engagement was is an issue considered by this SCR. Mother missed a number of appointments with the Early Help Worker, she was able to avoid the adult mental health worker and the OT, she didn't always attend her appointments with the midwife, and did not attend appointments at Addaction. Father did not want a referral to services to consider his cannabis use.

7.17 Mother spoke to the adult mental health worker a number of times on the telephone, after missing appointments. She said she had forgotten to attend. Just prior to the birth of Child G, she stated she no longer felt she needed the service, but it was agreed the case would remain open until after the baby was born. The adult mental health nurse continued to call Mother regularly to monitor her moods and managed to visit unannounced on one occasion when Child G was around five weeks old, after Mother had unsuccessfully tried to cancel the appointment.

7.18 There was a good degree of engagement with the AST, until the final missed appointment. There is clear evidence in the case records and from SCS staff that the parents were very candid and open in discussing Mother's mental health, self-harming, cannabis use (reported to be to supplement medication), as well as plans for their future together. Whether this was due to their wish to be re-housed or recognition that they required support as they were moving into a place of their own, it cannot be said.

7.19 The KSCB SCR on another child, known as Child C, found issues with the engagement of the family with professionals and recommended that the KSCB training programme on 'Dealing with Hostile and Resistant Families' should be updated 'to include enhancing awareness of disguised compliance and professional curiosity and working with complex families'. The learning from this review will be a helpful case example for this training.

Learning:

- Parents can avoid engaging with services without showing the classic signs of disguised compliance or avoidance. Information about avoidant behaviour should be shared with other professionals involved.
- Professionals need to respond to a parent with vulnerabilities in a positive and understanding way. When considering their potential to parent a child, there should also be robust and honest challenge about the areas and behaviours which would negatively impact on the child.

Supervision

7.20 It has been identified that there were gaps in supervision for both the family nurse and the SCS AST during the time they were working with the family. In the case of the AST this was due to team manager sickness, although the SWA did receive support and advice from the social worker involved in the case. There are no supervision records about the case from the time it was open to the team, and neither practitioner recalled discussing the case with a manager prior to the point of closure. It is acknowledged that the team's decision to close the case and not to refer the unborn baby for an assessment, expecting that this would be done by either adult mental health or the as yet not allocated midwife if required, may have been challenged had they received supervision on the case during the time the case was open to the team.

7.21 At the time of involvement, the team were moving to use the Case Progression [27] and the Signs of Safety[28] models of practice, which may have added an additional level of short-term instability for the team. Neither of these processes was used in respect of work with Mother, or to consider the best course of action regarding the unborn child.

7.22 Significant learning has been identified in the agency report considering the FNP, regarding supervision in this case. The practice of the FNP supervisor[29] involved did not meet the standards required by the organisation. The systemic issues which have been identified have been shared with the commissioners of the service and shared with the FNP National Unit in order to enable them to learn from this case. There are very clear expectations in the FNP programme regarding supervision. Supervision between the family nurse and her supervisor should have been weekly[30]. Monthly psychologist supervision and 'tripartite' (Safeguarding member, FNP Supervisor and family nurse) supervision is then every three months. The psychologist supervision and the 'tripartite' supervision did occur; however, this case was not discussed.

7.23 The family nurse did not have access to her FNP supervisor on a weekly basis. It is reported that she had only received 5 out of 24 sessions with her supervisor in the 6 months from April

[27] Case progression is a system being adopted by the Council across Children's Services, designed to track the progress of each case intervention through a system of manager oversight and group Signs of Safety supervision discussion, to ensure creative, effective interventions and prevent drift.

[28] The Signs of Safety is an innovative strengths-based, safety-organised approach to child protection casework.

[29] The FNP supervisor in question was new to the post, and left after 6 months, acknowledging she was not suited to the job.

[30] Family Nurse Supervisors as part of the FNP licence should provide weekly one to one supervision for each family nurse, conduct at least four team meeting per month, facilitate the learning of each Family Nurse, and make a minimum of one home visit every 4 months with each Family Nurse for field supervision purposes.

2016. A lack of supervision records and the departure of the supervisor from the organisation have not enabled this review to clarify why this was. This was not escalated to the KCHFT[31] safeguarding team at the time. The family nurse was new to the organisation and did not feel confident to assert herself. She was not entirely sure what she should expect from the supervisor, although she knew that she should be getting more supervision than she was. The family nurse reported being in a difficult position and felt uncertain regarding what to do. She reported to the Lead Reviewer that she did receive help and support from her colleagues at this time and they provided her with the information on the FNP processes that she did not get from her supervisor and line manager. The responsibility for challenging and managing the supervisor was with the Head of the FNP and HV team, however there is no evidence that support was formally sought from them. There is no documentation to show that the breach of the contract was reported to the FNP National Unit, and internal mechanisms such as the DATIX system[32] was not used to flag the breach of contract.

7.24 The family nurse did discuss the family in her supervision with her FNP supervisor in August 2016, however the action plan completed by the supervisor is minimal and does not identify needs and risks, as would be expected. The local Named Nurse for Safeguarding within KCHFT offers monthly clinical supervision for the FNP supervisor, however the FNP Supervisor did not book the sessions. This did not follow the FNP guidance[33]. A new FNP supervisor came into post during the timeframe of this review, but as a newly promoted family nurse, she was also managing her own caseload while providing supervision to the family nurse and her colleagues.

7.25 The CAMHS team received good and regular supervision and KMPT staff received clinical/ professional supervision at least every 6 weeks.

Learning:

- Supervision is essential to support and challenge professionals. Where it has been identified that regular supervision is required as part of an intervention with a family, processes must be in place to ensure professionals are able to safely and easily raise the lack of supervision with senior managers and/or commissioners.

Transitions and communication

7.26 The family faced a number of changes during the time being considered by this review. They were:

- Mother turned 18 and became an adult.
- Mother and Father started living together alone in their own home and moved out of their family homes. This followed a period of bed and breakfast accommodation.
- The pregnancy then the birth of Child G.
- Mother stopped taking her medication when pregnant, although it had been safe to continue. Mother gave differing accounts of when and if she stopped taking it.
- Change of service delivery for Mother from CAMHS to adult mental health, and the loss of a professional she knew well.
- A number of different professionals inevitably became involved due to the pregnancy, such as midwives and hospital staff.

[31] Kent Community Health Foundation Trust.

[32] NHS risk management reporting tool.

[33] The FNP guidance stipulates that the Named Nurse for Safeguarding should provide clinical supervision for FNP supervisor's clinical work on at least a monthly basis and should be available for advice. The organisation does have a daily consultation / duty line that the FNP can use. The FNP supervisor did not attend this supervision or rebook as stipulated in the guidance. The data regarding supervision or lack of supervision is not clear or consistently documented.

7.27 For Mother, who struggled with anxiety, and Father, who supported her, this must have been a difficult time. Mother told the lead reviewer that she can now see that she should have requested ongoing regular support from adult mental health services, as she had previously received from CAMHS.

7.28 For professionals, it is essential to ensure communication is good when services and circumstances change, particularly if the family move areas or a parent moves from children's to adult services, as in this case. There was good practice identified and also areas where there could have been improved communication and joint working to ensure understanding between agencies.

7.29 The following is of note with regards to information sharing and communication.

- Information sharing and communication was good between the Early Help Worker (EHW) and CAMHS to engage mum, but the EHW was not aware of the previous SCS involvement and was not contacted by AST when they were undertaking their assessment. CAMHS were aware of the involvement of both Early Help and AST.
- It was identified by the midwife that Mother would benefit from FNP involvement due to her age and vulnerability and Mother was notified to the service.
- The midwife sent a Concern and Vulnerability notification to the GP, but there was no liaison. The notification does request recipients to review their records on the family and contact the author if any additional relevant information is held to ensure an accurate holistic assessment can be made. The midwife was not aware of the time Mother spent in a mental health unit, as this was not disclosed by the family or shared by other professionals. The GP has all of a patient's health history, so making this link is helpful.
- The midwife and CAMHS sent referrals to MIMHS, but Mother did not meet the criteria, and MIMHS would not accept referrals from either agency at the time.
- The adult mental health worker shared information about Mother's mental health when Mother went into hospital to give birth, this information was not then shared with the SCBU who had responsibility for the child.
- The family nurse went to the hospital to visit Child G and the parents before they were discharged[34].
- There was good communication between the family nurse and the hospital professionals.
- The information received from the GP for this review shows very little GP involvement, although they were aware that a young person with a significant mental health history was pregnant at age 17. GPs are a crucial part of the safeguarding system. Sharing information with them, and seeking the information they hold, should be a standard action in any assessment, and consent should be requested to enable this.
- As stated in the agency report concerning the FNP, due to the level of vulnerability and Mother's significant history, a joint home visit with the family nurse and CAMHS and then the adult mental health nurse would have been beneficial and may have enhanced the support Mother was receiving. There is evidence of telephone discussions between the family nurse and the adult mental health worker, but none between CAMHS and the family nurse.
- The organisation with responsibility for CAMHS services in the area changed during the timeframe of the review and some records are missing.
- The adult mental health worker rang the family nurse to share information gained in her visit to the family when Child G was around five weeks old.

[34] There was no expectation of a discharge planning meeting as the baby was not open to SCS.

- There was some confusion about Mother's compliance with her medication during her pregnancy, which could have been more effectively communicated between professionals.
- The family nurse was aware that Mother had a social worker/SWA until she was 18, although the case was closed by the time she became involved. It would have been good practice to speak to the social worker. It appears an assumption was made that the involvement had been purely due to the housing need, however, this should have been checked out.
- Those involved in the AST made an assumption that the unborn baby would be referred to SCS by those with an on-going involvement but did not have a conversation to ensure this assumption was accurate, or to ensure all relevant information was known and transferred to those continuing to work with the family, before closure.
- The CAMHS worker and adult mental health worker communicated in advance of the transfer of the case and met jointly with Mother. There was a delay in the transfer of the case which reflected known staff shortages within adult mental health services35.
- A letter and full case summary were sent by CAMHS to Mother's GP to advise them that Mother's care had now transferred to the local adult mental health team.
- There was an assumption that the maternal grandparents were supportive, as they had provided practical assistance at the time that Mother and Father moved into their accommodation. Following the birth of Child G, their on-going support was not specifically confirmed with them, and not evidenced beyond the earlier assistance they gave Mother around her housing and early help needs.

7.30 Once the baby was born, the midwives provided support alongside the family nurse following the baby's discharge from an extended stay in hospital. The family nurse then became the main contact the family had with professionals regarding the baby. CAMHS involvement continued until June 2016, and then the adult mental health practitioner who was allocated attempted to engage with Mother. As there was more than one professional involved with the family, consideration of an early help plan, where those involved met together with the parents and shared information and worked to a plan to ensure they were supported, may have been of benefit.

7.31 A further vulnerability in the systems has been identified, which is that the various health services I.T systems do not 'speak to each other'. For example, the midwives cannot see GP records and the SCBU do not have access to midwife systems. When a baby is in the NICU, any pre-birth concern of vulnerability form previously submitted would be on the mother's record, not the baby's, which is not available to the NICU[36]. However, it is acknowledged that a verbal handover between the midwives and SCBU staff is important, followed by key information being recorded on the child's record.

7.32 A learning lessons review[37] was undertaken by the KSCB in 2017 where communication was highlighted. It made a recommendation stating that the GP and midwifery services review how effectively information is shared between professionals (particularly GP and midwifery) at the start of a pregnancy, including history and information about fathers. This recommendation is also relevant to this SCR, as is a recommendation made about assessment processes ensuring the effective consideration of fathers and partners within the household.

[35] Kent is a 'hard to recruit to' area, and there is a national recruitment shortfall in suitably qualified mental health professionals.

[36] Identified staff members from NICU & SCBU are currently being trained to access the C&V forms from maternal records.

[37] Where the criteria for an SCR were not met but it was identified that lessons could be learned about the way that agencies work together to safeguard a child.

Learning:

- When a family has experienced a number of changes and transitions of professionals involved with them, there needs to be clear and effective information sharing, and assumptions should not be made about what is known by those involved. It must be acknowledged that families may be more vulnerable at these times.
- Professionals need to show additional curiosity and information sharing when an individual or family has moved between services due to their age, changing circumstances, or a geographical move.

Thresholds

7.33 Consideration of this case has led to reflection on thresholds for a number of the services available in Kent, and the understanding professionals have about them. The need for thresholds for intervention is understandable, and they are required to ensure services are available to those who need them. In this case the need to enforce and to be flexible with thresholds was evident.

7.34 The following thresholds are relevant:

- Adult mental health services: Mother would not have met the threshold at the point of transfer from CAMHS if she had not been pregnant and if she had not previously been sectioned under s3 of the mental health act.
- Mother did not meet the threshold for support from MIMHS at the time. The threshold has now changed, and Mother would now be eligible. It is also now possible for midwives and CAMHS to refer to the service. It is noted that the social worker who closed the case without speaking to the Central Duty Team, assumed Mother would receive a service from MIMHS, which would have reassured her that a degree of scrutiny was in place and that a referral would be made by them if there were concerns.
- The Social Worker stated that she could not refer the case for a pre-birth assessment when Mother was 10 weeks pregnant as the baby was 'not yet viable'38.
- The professionals involved did not think that the unborn child would meet the threshold for a pre-birth assessment by SCS, although this was not discussed with them. This assumption may have been right, but there is the facility to discuss the case with a social worker, and for the pre-disposing risks to be considered.
- When Mother received services from SCS prior to her 18th birthday, the focus was on her homelessness and the practicalities of independence. While there was regular discussion between SCS and CAMHS regarding concerns about Mother's medication, the focus of assessment did not broaden to incorporate the impact of her pregnancy on Mother or consideration of the unborn child as potentially in need or at risk in her own right.
- There was no consideration of the need for Mother to remain open to Early Help post-18.
- The parents planned to engage with groups available at the Children's Centre after Christmas of 2016. The Family Nurse had recommended groups and encouraged them to attend.
- In light of Mother's mental health, there could have been a plan around the baby's birth including a meeting with those involved.

[38] KSCB Pre-birth Procedures, state that delay must be avoided when making referrals, and that any concerns should be addressed as early as possible to maximise time for assessment and support.

7.35 The SCS report for this review states: 'it is notable that although a highly significant and life-changing event had been shared by Mother (her pregnancy), bringing a new set of concerns and risks to consider, (both in respect of impact for Mother and potential risk for the unborn), the focus of continued assessment remained on Mother and support towards her independence'. At the time that Mother's case was being closed, a discussion regarding the unborn baby could have been had with SCS to consider if an assessment was required.

7.36 The parents received a lot of help and support. They were accommodated in an appropriate secure tenancy prior to the baby's birth, they received regular support, including with their parenting from the family nurse, and Mother was offered on-going support from services provided by adult mental health in order to deal with her own issues.

7.37 CAMHS had put in place a clear plan of support for Mother to support her mental health going forward into adult life, which also considered her as a parent to Child G. It included on-going psychological therapy and monitoring of mental health to be provided by the adult mental health worker. However, Mother did not engage initially with her mental health worker. Consideration of the impact on Child G of Mother's history of being unable to regulate her mental health and emotions and the impact this would have on her as a parent was required. The family nurse would be expected to have an awareness of these issues as over 60% of FNP clients appear with low mood, a history of depression, or are on medication. A joint approach with adult mental health and the family nurse would have been beneficial, and in light of Mother's significant history, there could have been a meeting with the parents and all the involved professionals prior to the baby's birth to ensure information sharing and a plan of support and monitoring around the birth.

7.38 The information shared that Father was struggling in his relationship with Child G was significant, especially alongside Mother's low mood. The noted increase in anxiety and low mood, and arguments between the couple that were shared by the adult mental health worker following their visit on 7 December 2016, discussed with the couple by the family nurse following Mother's text, and the changed atmosphere in the household when the family nurse visited on 6 January 2017, needed consideration.

7.39 The emerging relationship problems and Mother's low mood in the last weeks of Child G's life were an indication that parenting a young baby would become increasingly difficult for the parents. The need for support was recognised and the professionals involved worked hard to engage the couple and enable them to care safely for Child G. The risk of physical harm had not been considered, as neither parent had a history of violence. However, there are a number of examples of cases where children have been killed or physically harmed in circumstances where the parents are vulnerable, have relationship issues, and where a parent is withdrawing from the child care and voicing concerns about the baby not responding to them.

7.40 <u>Learning</u>

- In cases where first time parents require on-going support due to their predisposing vulnerabilities, the possibility that the baby could be at risk of physical harm (not just potential emotional harm or neglect) should be considered.

The vulnerability of babies

7.41 The thematic report on learning from SCRs from 2007 – 2011, Ages of Concern[39], focused on babies due to the high proportion of SCRs that were completed on children under one. The report identified recurring messages from the reviews that concerned babies and found that:

- there were shortcomings in the timeliness and quality of pre-birth assessments
- the risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
- there had been insufficient support for young parents
- the role of the fathers had been marginalised
- there was a need for improved assessment of, and support for, parenting capacity
- there were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months
- practitioners underestimated the fragility of the baby.

7.42 These issues are relevant to some extent in this case. There was nothing in Father's known history that would have identified that he would harm his baby in this way, however, Mother's significant mental health history could have necessitated an assessment pre-birth to ensure she was receiving the support she required to be a parent. This was acknowledged to some extent by those involved at the time that Mother became pregnant, but no agency took advice from SCS regarding the appropriateness of a pre-birth social work assessment or considered the need for a coordinated plan around the time of Child G's birth.

7.43 A Children and Families Assessment was completed by the AST when Mother was homeless, but it did not consider or analyse either the impact of her relationship with Father or her pending motherhood. Although Mother and Father's relationship appeared to be positive, and Mother's mental health remained largely stable, an assessment with the unborn child in mind, which considered if there were needs or risks, may have provided the required focus on the baby and ensured the required support was in place.

7.44 The FNP, by design, works with some of the most vulnerable families. Mother and Father met the criteria for their services and they were accepted for the additional support the project provides. The FNP undertake a large number of assessments and direct work. Their involvement in this family helped in a number of the vulnerable areas, particularly in supporting Mother with her own vulnerabilities and involving Father. As stated above, there were limitations partly due to the lack of supervision of the family nurse that is an essential part of the model. As band 7[40] senior nurses there is an expectation that family nurses have a high level of skill and analysis, and the ability to work independently much of the time. However, being new in post, the practitioner required supervision to challenge her views of the family and question whether she was expressing sufficient professional curiosity. Despite this, the family's receipt of services from the FNP ensured that the recurring issues identified in previous SCRs were not identified in this case, as the family did receive support, including the opportunity to reflect on the changes and challenges of being parents, practical help and advice, and ultimately work which would have improved their parenting capacity.

7.45 Some concerns had started to emerge in the final visits from the family nurse and in reports to the mental health worker. These included the possibility of difficulties in the parental

[39] Ofsted 2011

[40] The pay scale that reflects experience, qualifications and training.

relationship, Father's possible detachment and increased use of his games console, and Mother feeling down and frustrated. The opportunity to reflect on these issues (including in supervision), monitor the situation, and provide support were pre-empted by Child G's death.

Learning:

- Professionals working to support families with young babies need; support and supervision; to be professionally curious; and to regularly discuss the family with the other professionals involved. This would assist with timely responses to any decline in the family's situation, particularly bearing in mind the vulnerability of very young babies.

8 Conclusion

8.1 As stated in the 2016 Triennial Analysis of SCRs, for many of the children considered in an SCR, 'the harm they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.' This was the case with Child G. It is also acknowledged that following Child G's admission to hospital, Mother was open with professionals about Father's behaviour towards Child G and there have been absolutely no concerns identified about her physically harming her child.

8.2 There were a number of predisposing risks evident at the time of Child G's birth. They were:

- Mother and Father were young first time parents.
- Little was known about their own experience of being parented. Although, it was stated that Maternal Grandmother suffered with depression and that Paternal Grandmother had physical health issues.
- They had been in temporary accommodation during the pregnancy and prior to this, Maternal Grandmother had requested that Mother be taken into care.
- The parents had not been living together for long when the baby was born.
- The parent's engagement with professionals was intermittent, although they largely engaged with the FNP just before and after the birth of Child G.
- Both parents used cannabis in the past.
- Mother has a significant mental health history, continuing anxiety and inconsistently used her medication.
- The recent transition from CAMHS, who knew Mother well, to adult mental health professionals who Mother largely avoided.
- Father's own health concerns.
- Father's constant presence when professionals saw Mother and Child G, leading to the view with hindsight that he may have been controlling. The family nurse who knew them had regularly discussed healthy relationships with the parents, and this was not identified at the time, even by Mother herself.

8.3 The risks need to be looked at along with the vulnerabilities, which included:

- Child G was a young baby who was entirely dependent on the care provided by the adult/s responsible for her. It has been established in previous SCRs, that the frailty of babies is often under estimated by professionals and parents/carers[41].
- Child G was pre-verbal and could not tell professionals about her life-experiences or what had happened to her.
- At birth, Child G had some feeding issues that led to an 11 day stay in the special care baby unit.

[41] The Ofsted report: 'Ages of concern: learning lessons from serious case reviews' thematic analysis of 482 serious case reviews.

- Both parents also had their own vulnerabilities that are included on the list of predisposing risks to Child G.

8.4 Those involved with the family were aware of most of the vulnerabilities and risks in the case. They felt the family needed support to ensure they met Child G's needs. There was no consideration of whether the threshold for a safeguarding referral was met prior to the child's presentation on the 7 January 2017 and there was no social work assessment of the parent's capacity to care for Child G. The amount of support being received was thought to provide the family with the best chance of thriving. The focus was predominantly on the risk posed by Mother's mental health. Father did not receive any specific assessment or services, yet his conviction shows it was Father who physically harmed Child G.

8.5 The review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour" (Woods et al[42]). It has identified the learning that is relevant both to this case and to the wider system.

8.6 Significant individual agency learning has also been identified and KSCB has ensured that a robust consideration of the concerns identified has been undertaken by each agency involved in this matter.

8.7 It is important to also learn from the good practice identified during the course of this review. Good practice across a number of agencies has been acknowledged throughout the report, and includes the following:

- CAMHS showed a commitment to Mother and provided her with the services required to meet her needs. They also provided a consistent worker.
- The CAMHS worker took the initiative in discussing their relationship with both Mother and Father.
- Robust information sharing at transition from CAMHS to adult mental health and a plan for introductions and a gradual withdrawal of the CAMHS service.
- A formal discharge planning meeting was held with Mother, Father, Maternal Grandmother, the CAMHS worker and Consultant Psychiatrist in attendance.
- Adult mental health's decision to keep the case open despite there being no contact from Mother for 6 months.
- The housing team took all of Mother's vulnerabilities into consideration and swiftly resolved the housing issue.
- The Social Worker and SWA encouraged Mother to be open and candid in discussion about her vulnerabilities when she was homeless.
- There was good communication between CAMHS, housing and the AST.
- When Mother did not engage with Early Help, they contacted CAMHS to inform them.
- Early Help consulted with the GP prior to closing the case.
- The midwife was flexible and visited Mother at home.
- The family nurse provided intense support and knew the family well.
- The family nurse reported that she undertook extra work with the family after the gap in their engagement prior to the birth of Child G.
- There was communication between the mental health worker, the family nurse and the midwife regarding engagement issues and to discuss the case around the time of the baby's birth.
- All of the professionals cared for the family and wanted them to succeed.

[42] David D Woods et al. Behind Human Error. 2010.

- The investigation completed after the child's death was sensitive and followed procedures.

8.8 There has been a high degree of cooperation and engagement from agencies with the SCR process, which has been appreciated and has been essential to identify the learning.

9 Recommendations

9.1 It is recognised that actions have already been taken in relation to some of the individual agency identified learning, and that systems and processes have changed, all of which will be outlined in the KSCB's response to this SCR. The agency reports have made recommendations which have largely been completed by the conclusion of the SCR. Some of the learning identified within this overview report has been addressed by the single agency actions plans.

9.2 The purpose of providing additional recommendations is to ensure that the KSCB and its partner agencies are confident that any areas identified as being of particular concern, and not included in the single agency plan, or which require an interagency or Board action, are addressed.

Recommendation 1:

Partner agencies of the KSCB to provide assurance and evidence that processes are in place to ensure that that:

- supervision is of an appropriate standard
- supervision is being completed as expected
- staff are able to raise issues of non-compliance in expected supervision
- any gaps in supervision are addressed

Recommendation 2:

The KSCB to request assurance and evidence from its partner agencies that services for young parents include the expectation of appropriate engagement with father's or mother's partners.

Recommendation 3:

The partner agencies of the KSCB to provide assurance that when vulnerable young parents transition between services, there is a robust and joined up plan to ensure their children's needs and their own needs continue to be met.