Safeguarding Children in Stockport

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Purpose of the Review

Process & Purpose

Gracie's death was notified to the then Safeguarding Children Board and after a rapid review meeting it was determined that an independent author would be appointed to conduct a Serious Case Review into the circumstances of her death.

The Purpose of the review was to identify any local learning regarding our current practice and areas that could be developed to prevent future deaths.

A multi-agency chronology was developed to analyse the information and key events.

Alongside this, a practitioners' event was held to explore key lines of enquiry to identify learning.

Gracie's mother was invited to participate via discussions with the author but was not able to engage with the process and so was not able to share any insight or views.

The review explored practice from the beginning of the pregnancy through to her death at three months of age.

Purpose of the Review

Safeguarding Children in Stockport

Key Lines of Enquiry

The review sought to explore key lines of enquiry identified from the combined chronology:

- How did agencies respond to safeguarding referrals and concerns raised in respect of Mother and Gracie to ensure that their safeguarding needs were addressed?
- How did the TAC process ensure that agencies worked together to co-ordinate the needs of Mother and Gracie?
- Did the multi-agency working, intervention and information sharing on this case ensure that Mother had access to appropriate services?
- What enquiries did agencies undertake to identify any other person who was living or involved with, and/or providing positive support and protective factors to Mother and Gracie, including whether these persons presented any risks?
- What action did agencies undertake to ensure that Mother and Gracie remained 'visible' for their needs and areas of concern to be addressed?
- How did agencies establish that Mother and the UBB (Unborn baby – Gracie) were no longer at risk from substance misuse?
- To what extent did agencies understand the impact of Mother and Gracie's living circumstances?
- How did supervision and management oversight on this case influence decisions that were made?
- Were there any wider safeguarding needs identified during agency contacts with Mother and Gracie?

Pen Picture

- Gracie died in February 2019 – she was three months old.
- She lived and was cared for by her mother during her short life and was a much-loved baby.
- Her older sister had been removed from her mother's care some years earlier and she remained living with her father.
- Pre-birth assessment and team around the child plan with an allocated social worker.
- Her death was responded to as a sudden unexpected death in infancy (SUDI).
- Mother had consumed alcohol and drugs on the evening of her death and stayed up till the early hrs with a friend.
- Mother fell asleep on the sofa with Gracie by her side – the post-mortem was inconclusive
- A rapid review concluded that a serious case review should take place and a report was produced.

[1]To find out more about responses to Sudden unexpected infant deaths please see - https://greatermanchesterscb.proceduresonline.com/pdfs/pr_gm_sudc.pdf

Key Issues

- Gracie's mother grew up in a household where there was domestic abuse
- She had a significant history of alcohol misuse but withdrew from services and then self-reported abstinence for several years following previous care proceedings for Gracie's sister
- Mother had low mood and emotional well-being difficulties
- Mother was bereaved of parents and was socially isolated
- Mother had debt and housing difficulties
- Mother maintained contact with her older daughter who regularly stayed overnight with her
- There was a lack of contact and repeated missed appointments during the pre-birth period with the social worker, midwife and other health professionals

Key Agencies Involved

- Children's social care
- Midwifery, NHS FT
- Health Visiting, NHS FT
- Specialist perinatal community team, Wythenshawe, Greater Manchester Mental Health NHS Foundation Trust
- Pennine Care Foundation trust, mental health services
- GMP
- GP, CCG

May 2018 – Pregnancy Commences

- 9+3 weeks pregnancy identified
- 10 weeks Mum admitted to hospital dehydration hyperemesis
- 10+3 weeks discussion Midwife referral to Marie Stopes Counselling possibly for termination discussion
- 12 weeks booking in appointment – referred to mental health midwife

June 2018

- 14+4 weeks referred Children's Social Care due to non-engagement community midwife
- 15 weeks booked in with community midwife
- 16+1 weeks GP appointment disclosed daily cannabis use, occasional cocaine use – signposted to START & TPA
- 16+1 weeks GP safeguarding referral to MASSH

July 2018

- 16+5 weeks allocated to a social worker for assessment
- 19+4 weeks Social Worker T/C arranged an appointment – Mother DNA
- 20+6 weeks Mother moves to inherited home

August 2018

- Anonymous concerns expressed regarding state of home, cannabis and cocaine use & general appearance
- First face to face contact with Social Worker since June
- 23+5 weeks Mother admitted to maternity ward – first disclosure of father's details & drug debt issues not shared to social care
- 24+1 weeks referred to RAID Team & assessed
- 24+5 weeks 2nd referral to RAID Team with request for Healthy Minds
- Discharged from ward social worker not informed

Sept 2018

- 26+4 weeks social work assessment concluded after 1 face to face contact
- 27+4 weeks perinatal mental health midwife home visit – mother expresses concerns about risk from father – no details recorded
- 27+5 weeks social worker home visit – mother upset reports lack of help from midwife

Oct 2018

- 30+1 weeks RAID referral reviewed contact attempted
- 30+4 weeks home assessment perinatal mental health team – no risks identified case closed not shared with partner agencies.
- 31 weeks Legal Gateway panel – threshold for pre-proceedings not met, gaps in assessment to be addressed
- 31+1 weeks Healthy Minds informed & offered initial appointment – no contact achieved
- End of Oct referred to Stockport Self-Help

Nov 2018

- referred to New Beginnings by social worker – declined as due date being too close for group work
- Social worker supervision determined contact to be made to offer practical support in relation to home conditions
- 35+4 weeks labour commenced

Please note that (9+3 weeks) references reflect the stages of Gracie's pregnancy
Please see the appendices for details of all services referred to in the chronology

Post birth – Nov 2018

- Gracie is born at 35 +5 weeks gestation
- Mid-Nov SW visited ward no record in midwifery records
- Mother tells ward manager SW has said she can be discharged. Out of Hours contacted no record advising against discharge so discharged home no planning meeting

Post Discharge - Nov 2018

- Midwifery visit daily in the days following discharge.
- IAPT assessment – signposted to Women's Centre
- 3rd week Health Visitor notified of Gracie's birth & conduct home visit
- Allocated SW changed

Dec 2018

- 1st week IAPT assessment shared to SW who agrees to support access
- Mid Dec discharged community midwifery services & from healthy Minds after no successful contact or engagement
- 3rd week discharged from Stockport PWS
- Health Visitor referred to TPA for financial support

Jan 2019

- Week 1 TPA T/C Mother asks for contact at later date
- 1st 2 weeks Health Visitor home visits unsuccessful, including unsuccessful joint visit with HV and SW
- 1st TAC meeting – Mother, SW and HV, issues with Finances and awaiting TPA contact.
- 3rd week TPA call to discuss finances, offered key worker and referral to debt advice services to support with isolation
- 4th week – Gracie has not attended 8 week check-up – food bank and heating vouchers issued
- 5th week - Mother taken to Foodbank by SW meets Gracie's paternal grandparents who were not aware of the baby, 2x T/C Police re historic thefts. Identified as DVA risk assessed standard and referred to STRIVE
- Strive attempt to contact Mother x3 - not notified to SW

Feb 2019

- TAC status reviewed SW looking for lead professional with a view to stepping down case & considering start well coordinator
- 1st week attended 8 week check-up but TPA appointment cancelled for support with isolation
- 2nd week HV no access home visit Mum noted staying with family and rearranged home visit to 3rd week
- 3rd week Gracie found deceased

Please see the appendices for details of all services referenced in the chronology

Gracie

Serious Case Review

July 2020

Safeguarding Children in Stockport

Shared learning for the safeguarding partnership

- Impact of safe sleep advice and challenges for some parents to act on the advice & guidance given – consideration of the impact of out of routine and the risks around safe sleep
- Multi-agency communication, co-ordination, collaboration around plans for children
- Escalation of concerns by partners when processes not followed
- Supervision
- Self-referral
- Understanding concerns – learning and resources
- Sharing of information and risk assessments from perinatal services
- Understanding of the roles of workers and services at a local level

Learning to be Shared

There were no actions or inactions identified as a critical factor in Gracie's death.

There was evidence of a good relationship with Gracie's mother by the social worker and health visitor who worked together after her birth to address needs.

Gracie's life experiences have highlighted the importance of:

1. analysing and understanding historical vulnerabilities, in conjunction with current presenting factors in order to identify and assess risk, and for those risks to be addressed through a co-ordinated multi agency response.
2. a co-ordinated approach to service referrals prioritised based on the needs of Mother and Gracie.
3. Recognising when Mother's vulnerabilities would have made it difficult for her to have made self-referrals without the support and guidance of professionals.

Assurances need to be sought in relation to the following practice areas:

1. Supervision – all agencies should have meaningful supervision practice in place that creates space for oversight and reflective practice
2. Escalation – cases should be escalated to the appropriate level as needed
3. Self-referral – where individuals are unable to undertake this alternative pathways should be sought
4. Understanding concerns - Practitioners need to have a range of options that can help them build on relationships and engagement with families whilst maintaining professional curiosity regarding any limited information sharing around past and present lifestyle choices.

Recommendation's from the Independent Author

1. That Stockport Safeguarding Children Partnership prepares a schedule of recommendations from the last 3 child serious reviews it commissioned. The recommendation schedule should include the case reference, the individual recommendations and the current position relating to their implementation and where available, evidence that the recommendation has improved practice.
2. That Stockport Safeguarding Children Partnership constituent agencies inform in writing that they have a reflective based supervision processes in place that is supported by sufficient time for it to be meaningful.
3. That Stockport Safeguarding Children Partnership seeks assurances from partner agencies that practitioners have access to and are aware of the Resolving Professional Disagreements/Escalation policy and the circumstances of when this should be implemented.
4. That Stockport Safeguard Children Partnership disseminates the learning from this review to practitioners and for consideration when working with individuals of making a direct referral, rather than the reliance on self-referral in the most vulnerable individuals or where safeguarding concerns exist.
5. That Stockport Safeguarding Children Partnership seeks assurances from services that direct referral pathways are in place for individuals who do not have the ability to self-refer into services.
6. That Stockport Safeguarding Partnership ensures practitioners have access to resources to assist them in their engagement with families who have complex and vulnerable needs.
7. That perinatal services provide evidence to Stockport Safeguarding Children Partnership that it is sharing information from assessments and outcomes.

Overview of Key Actions

Action 1 Review of Embedded Learning

To ensure that we are effectively embedding learning from reviews into practice we will continue to review the implementation and impact of recommendations from Case reviews in the past 2 years to identify any areas for further development.

Action 2 Audit of reflective supervision

To ensure that we are utilising reflective supervision collectively as expected we will be monitoring the local model, it's use and aspects that require further development.

Action 3 Escalation

We will continue to promote and raise awareness of responsibilities and pathways for professional concerns in practice to be raised and addressed.

Action 4 & 5 Sharing Learning

We will develop a 7 Minute Briefing to share key messages for practice from this case particularly in relation to the pitfalls of directed self-referral

Action 6 Developing an Aide Memoire

To support frontline practice we will develop an aide memoire to support professionals to consider the available tools when working with complex and vulnerable needs and support this within our multi-agency training offer.

Action 7 Information Sharing

We will seek assurance that information from perinatal services is being shared appropriately to facilitate a shared full understanding of presenting risks.

Appendices – Agencies referred to in the Chronology

Agency	Involvement	Description	Links
The Prevention Alliance - (TPA)	Referred for debt support	provides support for anyone who is vulnerable due to their health, wellbeing or situation, with the aim of preventing things from getting worse and enabling them to work towards independence.	https://stockporttpa.co.uk/
Stockport Triage Assessment and Referral Team (START)	Referred for support around drug misuse	offer advice and referrals for a range of lifestyle areas including - stop smoking, eat a healthy diet, get more active, be a healthy weight, reduce the amount of alcohol you drink, stop taking drugs and feel more confident about making changes.	https://www.stockport.gov.uk/groups/stockport-triage-assessment-and-referral-team
The Multi-Agency Safeguarding and Support Hub (MASSH)	Referred due to safeguarding concerns	single point of contact for all professionals to report concerns, request advice and share information about a child and or family.	https://www.stockport.gov.uk/contacting-the-massh
Marie Stopes Counselling	Referred to support around anxiety about pregnancy	provide counselling services for anyone who would like to talk through their abortion or vasectomy options before booking their consultation appointment.	https://www.mariestopes.org.uk/other-services/counselling/
Healthy Minds	Referred due to expressing struggling to cope	provide a range of treatment and support options for people struggling to cope with low mood, stress, anxiety, depression, or any of the common mental health problems	https://www.penninecare.nhs.uk/healthyminds
Rapid Assessment Interface and Discharge (RAID)	Referred due to presentation on ward	support people who attend A&E, or who are on a ward, at Stepping Hill Hospital who have a range of mental health issues	https://www.penninecare.nhs.uk/services/stockport-liaison-mental-health-1
MOSAIC	Referred for support with substance misuse – alcohol	Substance misuse services	https://www.healthystockport.co.uk/getting-support/mosaic
Stockport MIND	Referred for help with self identified depression and anxiety	independent adult mental health charity	https://www.stockportmind.org.uk/
IAPT – Improving Access to Psychological therapies & Stockport Self-Help	Referred for support to cope	offers one-to-one support and structured courses for anyone experiencing common mental health problems such as anxiety and depression. It is available to anyone who is registered with a GP in Stockport and is aged 11 years and above.	https://www.selfhelpservices.org.uk/service/stockport-psychological-wellbeing-service/
New Beginnings	Referred to access support for behaviour change	work with families who are known to Children's Social Care for concerns relating to neglect; emotional, physical or sexual abuse.	https://www.stockport.gov.uk/groups/new-beginnings-greater-manchester
STRIVE	Referred by GMP after reporting of a crime	local volunteers attend homes where the police have attended but no crime has been logged. The volunteers then support individuals, couples and families, signposting them to further support.	https://talklistenchange.org.uk/component/content/article/42-bridging-to-change/65-other-services?Itemid=101