MK TOGETHER
Safeguarding Partnership

Strictly confidential

Child Safeguarding Practice Review Report in respect of 'Star'

November 2025

Approved by MKTSP Review Group: December 2025

Independent Reviewer: Jim Stewart

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1. Introduction

1.1 An 8-month-old baby, Star, was found unresponsive by her Mother one morning in February 2024. Mother called an ambulance but paramedics were unable to resuscitate Star. There were indications that Mother had been co-sleeping with her baby. Mother had an older child, Moon, who was 5 years old and living with her father at the time of the serious incident.

1.2 The family were well known to Health Services, Children's Services and the Police. Mother and Moon's Father had an acrimonious relationship and private law proceedings had been ongoing around Father's contact with Moon from 2019. There were referrals to Children's Services made by both parents who each reported allegations against the other.

1.3 Star was made the subject of a child in need plan at birth in 2023. Mother reported that she had experienced domestic abuse in her relationships with both children's fathers. Both children had been made the subject of child protection plans under the category of Neglect in September 2023 and Children's Services were also considering whether an application to court was necessary to ensure the children's welfare.

1.4 Milton Keynes Together shares its condolences with Star's family. In July 2020 the National Child Safeguarding Practice Review Panel published 'A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.'[1] There are between 300 to 400 cases of SUDI per year in England and Wales. As the report notes, an infant death is 'one of the most devastating tragedies that could happen to any family.'

2. Terms of Reference and Methodology including Key Lines of Enquiry

2.1 The statutory partners considered this serious incident at a Rapid Review Panel meeting on 27 February 2024 and decided that a child safeguarding practice review should take place. This decision was endorsed by the independent scrutineer.

2.2 The following Key Lines of Enquiry were identified:

- Advice given and assessment around safe sleeping and SIDS risk factors including co-sleeping
- Information sharing, assessment and multi-agency working, including where neglect is an issue
- Timeliness of decision making

[1] A sudden and unexpected death of a baby is usually referred as 'sudden unexpected death in infancy' (SUDI). The death of a baby (up to 12 months old) which is unexpected is also sometimes referred to as 'sudden infant death'. Some sudden and unexpected deaths can be explained by the post-mortem examination, however deaths that remain unexplained are usually registered as 'sudden infant death syndrome' (SIDS).

- Mother's presentation and ability to care for her child/ren and how that was impacted by drug/alcohol use, physical health condition including prescribed medication, and possible mental ill-health issues and how these issues were responded to and managed
- Effectiveness of professional interventions and the impact on mother's capacity to care, including consideration of pre-birth assessment and discharge planning, child in need planning and child protection planning and the operation of legal gateway meetings/the public law outline process
- Quality of recording and professionals' understanding of the family's situation, relationships and context
- The Voice/Lived Experience of the Child/ren
- Working with fathers

2.3 The following agencies contributed to this review:

- Milton Keynes Children's Services
- Milton Keynes Adult Services and Housing
- MK ACT (Charity providing Domestic Abuse Intervention Services) supporting children and families where domestic abuse is an issue
- GP Practice
- Central and North West London (CNWL) NHS Foundation Trust (Health Visiting Service and Perinatal Mental Health Team)
- Milton Keynes University Hospital NHS Foundation Trust
- Private Health Providers (Pain Management Clinic and Specialist Medical Cannabis Service)
- Primary School (Educational Trust)
- Thames Valley Police
- Probation Service
- MK ARC (Addiction Recovery Community) (a free and confidential service for support and drug testing provided in partnership by CNWL and We Are With You).

The Ambulance Service's only involvement with the family was on the day of Star's death.

Unfortunately, the Nursery which Moon attended has closed and therefore could not be asked to participate in this review.

2.4 The independent reviewer has been supported by the MKTSP Review Group and two practitioner learning events took place in 2024 to inform this report. The independent reviewer would like to thank all those who took part in the meetings and learning events and to acknowledge the support received from the MK Together Team in undertaking this review.

3. Family Details and Background

3.1 Star and Moon are pseudonyms chosen for this review by their Mother who says they reflect the importance of her children to her and the importance of Star to her half sibling Moon.

3.2 Star was born in May 2023. Her ethnicity was White and Black Caribbean although it was not initially recorded in Children's Services' records.

3.3 Star weighed 2.3kg (0.1 percentile on the growth chart) at birth and was kept in hospital for four days due to her low birth weight and concerns about the potential impact of mother's medication. She was intermittently jittery which may have been due to withdrawal symptoms. She initially fed poorly and weighed 2.26kg on discharge. She was maintaining the 0.1 percentile when a Health Visitor made a new birth visit.

3.4 During home visits, professionals were concerned about a lack of stimulation of Star in her mother's care. Star was often seen in a bouncing cradle, asleep or watching TV during home visits. Star's weight had increased over three centile lines[2] by the time she was two months old which was a large increase. Mother sometimes needed some prompting to address her baby's needs/basic parenting. Health Visitors had conversations with Mother as she had been putting rusk in bottles and was advised to give formula milk only.

3.5 The Police investigation into Star's death closed in September 2024 because no clear cause of death could be established. At the time of writing this report the coronial process was ongoing.

3.6 Star's older half-sibling Moon had a different father. Moon was born in 2019; her ethnicity is recorded as White British/Asian. She was born just before the Covid pandemic. Moon did not attend nursery very much in 2022 and the nursery Moon briefly attended in 2023 described her as a polite child to her new school that year. Social workers assessed Moon to be bright but had concerns about the care responsibilities she had been given for her baby sister by her Mother. The two children slept in the same room and Moon described undertaking some care for Star. In September 2023, Moon moved to live with her Father after concerns arose about Mother having blackouts and in October 2023 Court made Moon the subject of an interim Child Arrangement Order[3] to live in the care of her father. Moon's Father had significant support from his own mother in caring for Moon.

3.7 Mother informed professionals that she had experienced difficult family relationships as a child and was estranged from some family members. She lived in her own mother's home during the review period and was a carer for her mother for a period of time. Mother experienced significant bereavements; her father died in 2020 and her mother was seriously ill in 2022/23 and died in January 2024. Mother reported to the Police that she had been the victim of sexual assaults in 2022. She

[2] Centile lines in centile charts show the average weight and height gain for babies of different ages.
[3] A 'child arrangements order' decides where a child should live, when a child should spend time with each parent and when and what other types of contact should take place (for example, phone calls).

had taken an overdose in 2022 early in her pregnancy with Star. Mother is White British.

3.8 Mother and Moon's father both alleged that the other misused drugs and questioned each other's care of Moon. Mother reported domestic abuse in relationships with both her children's fathers.

3.9 Mother had developed a debilitating physical health condition for which she was prescribed a range of medication. By December 2023 Mother had a walking frame which she said helped her but she did not use it in the house.

3.10 Some professionals expressed concerns that Mother displayed some unusual behaviour which led them to question her mental health. Mother experienced racing thoughts and at times needed to explain things in detail and proved difficult to interrupt. The assessment of the Perinatal Mental Health Team who tried to work with Mother was that she did not have a mental illness.

3.11 Mother did not always share information about the fathers of her children with professionals.

Moon's Father

3.12 Police recorded domestic abuse incidents involving Mother and Moon's Father over a number of years. There were private law proceedings and Moon's Father had support from his family in his attempts to have regular contact with his daughter. The Police also reported that sexual abuse allegations had been made against Moon's Father in 2023; the complainants were unrelated to this review.

Star's Father

3.13 Mother began a relationship with Star's Father in 2022. Although she stated in 2023 that their relationship was over and that he would have some limited contact with the new baby, it appears that he had significant involvement in Star's life at Mother's home throughout the review period.

3.14 Star's Father told the Police that he was trying to mend his relationship with Mother when Police attended in November 2022 after her reports of a burglary and domestic abuse incidents.

Maternal Grandmother

3.15 There are no reports of any agency other than Adult Services speaking to Maternal Grandmother although she had been accused by Mother of aggressive behaviour towards her and Moon and she had also been present when Star's Father entered the house in November 2022. By October 2023 Maternal Grandmother moved to a care home where she died in January 2024.

Genogram

3.16 A family genogram (a graphic representation of a family tree that displays detailed data on relationships among individuals) was not shared by any agency as part of information gathering for this review; one was compiled by the MK Together team at the request of the independent reviewer.

4. Family Involvement in the Review

4.1 Family involvement was initially delayed due to a Police investigation into the circumstances of Star's death. The reviewer spoke to Mother as part of this review in April 2025. She stated that she followed safe sleeping advice and has been devastated by the death of her baby which she is still trying to understand and thinks may be the result of a genetic condition in her family.

4.2 The MK Together team contacted Star's Father and invited him to contribute to this review but received no reply. The MK Together team also notified Moon's Father of the review.

5. The Milton Keynes Context

5.1 Milton Keynes has previously promoted a strong family support model of service delivery: 'The Milton Keynes approach aims to work with families in a way which enables us to stop, listen and reflect on what has been said and consider the impact on the child's welfare. The family support approach promotes family centred solutions, ensuring a more proactive, child centred role for our workers with a clear focus on the safety of the child. This means that, wherever possible, child protection concerns are safely and effectively managed without entering formal child protection processes.' This is the background to the events and practice considered in this Review.

5.2 The number of children subject to Child Protection Plans in Milton Keynes in the financial year 2023/24 rose by 41%. Contacts/referrals citing neglect as a risk indicator increased by 26%.

5.3 Milton Keynes Children's Services reviewed their approach to working with children and families with partners in the light of the new Working Together to Safeguard Children 2023 guidance. An increased number of Independent Learning Reviews in Social Care helped to identify practice gaps and areas for improvement. In response, Milton Keynes revised their practice model. The Milton Keynes Local Safeguarding Protocol replaced the previous Levels of Need document in 2024. The protocol emphasises a Child First approach and as part of this professionals should 'Always be clear on what needs to change to improve outcomes for the child(ren) and when this needs to happen and ensure this is always in the child's not the parents' timescales.'

5.4 Ofsted published a report in December 2024 of an inspection of Milton Keynes Children's Services which noted progress made since 2021 and found that 'children and families in Milton Keynes now receive a consistently good service.' The report noted the need for improvement in the 'consistency in the quality of assessments for children in need of help and protection and in contingency planning across teams.' Inspectors reported that 'too many plans lack contingency arrangements if change is not achieved or sustained.' Senior Managers recognised 'that they have more to do, as some of the changes are recent and need to be embedded.'

6. Key Events

6.1 In April 2022, the carers of Maternal Grandmother raised concerns that Moon was answering the door sometimes and that Mother would be on the floor asleep or intoxicated. Mother denied the concerns and raised her own concerns about the carers who were then changed. There was a Child and Family Assessment that led to Moon's case being closed but due to an absence of recording, this review is not clear what reassurances were given to services around the potential risks to Moon given the concerns raised.

6.2 Mother was taken to hospital in July 2022 after she reported a sexual assault to the Police. A Child and Family /Early Help Assessment in respect of Moon was concluded in August 2022 and the outcome was No Further Action. Moon was three years old at this time.

6.3 There were six referrals in respect of Moon in 2022 and two in respect of Moon and Star in 2023.

6.4 Two referrals (Referrals 1 and 2) were made, one in June 2022 and the second in September 2022, raising concerns about the care Moon received in the care of her father. The first was anonymous and stated that Moon hit her mother and was dirty with matted hair when she returned from time with her father. The second referral was made by Mother who expressed concerns about a lack of routine for Moon in father's care, leading to late nights, exposure to unsafe situations and also Moon referring to severed heads, knives, and saying that her Mother was fat.

6.5 There was a further referral to MASH later in September 2022 (Referral 3) when a member of the extended paternal family alleged that Moon had spoken about Mother pulling buttons from her dress and smashing a DVD. The referrer reportedly shared a photograph of Moon's fingernails having been cut to the quick by her Mother approximately two months previously, with some blood on Moon's fingertips. Moon's Father was spoken to and he described difficulties in communication with Mother and concerns that Moon struggles to sleep when she is in his care and she is not in nursery. The outcome was a referral to the local Child and Family Practice (CFP) team to explore the impact of parental conflict on Moon in addition to the routines and boundaries across both households.

6.6 In October 2022, a member of the Mental Health Liaison Team made a referral to Children's Services after Mother took an overdose and attended hospital (Referral 4). Mother informed professionals that she was nine weeks pregnant and the

Hospital Midwifery team made a referral in November 2022 (Referral 5) about the same issue. MASH managers asked the CFP worker to follow up the issues this raised about mother's health and the impact upon her parenting and to report back any concerns.

6.7 Mother had reportedly stated that she took an overdose following Maternal Grandmother telling care staff that Mother was abusing her. Mother denied these allegations and made counter allegations. Mother informed staff that she was pregnant and had previously been the victim of a rape following an evening out.

6.8 In November 2022, Thames Valley Police made a referral (Referral 6) following two domestic incidents at the home address, when Mother reported that her ex-partner (and father of her expected baby) caused her alarm and distress. A Police report was submitted which highlighted concerns about cluttered and messy living conditions including a cat and kittens with an unclean litter tray. The CFP worker was again asked to follow up the incidents by managers in the MASH.

6.9 In January 2023 further referrals (Referrals 7 and 8) were made by a specialist perinatal nurse, and subsequently a GP, after Mother raised further concerns with professionals about Moon's Father's care of Moon including new concerns that the child may have been sexually abused by him. A strategy meeting was held and a joint investigation took place but there was no clear evidence to substantiate Mother's concerns. A social worker remained involved from this point.

6.10 A safety plan was put in place. A Child in Need meeting took place in March 2023. Star was born in May 2023 and was monitored in hospital for four days before discharge which was usual practice in respect of a baby with a low birth weight.

6.11 Moon began school in September 2023 and one afternoon near the end of that month, Mother did not collect Moon from school and school staff contacted social workers. Star's Father found Mother at home asleep with Star in her care. This was significant new information about children who were already allocated to a social worker. Moon's Father collected her from school and took her to stay with him/his mother. Children's Services convened a strategy meeting on 3 October and plans were made to hold an Initial Child Protection Conference and to begin to implement the Public Law Outline.[4]

6.12 The temporary Child Arrangement Order made in October 2023 stipulated that Moon remain living with her father and contact between Mother and Moon was agreed for every Wednesday after school and every other weekend. Star remained in her Mother's care and as part of the safety plan, Star's Father was to oversee Mother's care of Star.

6.13 From October 2023, Star and her half-sister Moon were the subject of Child Protection plans under the category of neglect. The local authority's attempts to implement the Public Law Outline were delayed partly due to a lack of cooperation

[4] The Public Law Outline (PLO) is a legal framework that provides guidance for the family court on how to manage cases involving care proceedings. It is used by local authorities to address concerns about a child's welfare and allows parents a last chance to make positive changes before care proceedings are initiated.

by Mother and Moon's Father. A Legal Gateway Meeting took place on 12 December 2023.

6.14 Maternal Grandmother died in January 2024. A review child protection conference that month decided that the children should remain subject to child protection plans.

6.15 In February, Mother found Star unresponsive in bed and despite the efforts of paramedics, Star was pronounced dead at hospital. Agencies are not clear whether Star's Father was present in the home at this time but he attended the hospital. Co-sleeping was suspected although Mother continues to insist that this did not take place.

7. Analysis of Agencies' Involvement with the Family

Advice given to parents and assessment around safe sleeping (and SIDS risk factors including co-sleeping) and safe care of babies and the impact of this advice

7.1 In 2019 a Health Visitor provided Mother with advice regarding caring for a new born infant (Moon) and safe sleeping advice in line with the Lullaby Trust[5] guidance (DOH/Lullaby Trust 1991). Mother and Moon were offered an enhanced health visiting offer (Universal Partnership Plus) due to the vulnerabilities identified.

7.2 A Safeguarding Midwife contacted Children's Social Care in February 2023. Mother was judged to be a high risk pregnancy due to a previous blood clot and her general health. Workers were very concerned about the number of appointments that had been missed, particularly with the consultant. A pre-birth assessment would have been valuable in planning for the birth of Star. As the pre-birth section of the Milton Keynes Safeguarding Children's procedure notes *'Young babies are particularly vulnerable to abuse, and early assessment, intervention and support work carried out during the antenatal period can help minimise any potential risk of harm.'* Milton Keynes do not operate a specific Multi-Agency Pregnancy Liaison and Assessment Group (MAPLAG) model but multi-agency meetings can be held prior to birth where prospective parents have substance misuse and/or mental health issues.

7.3 When Star was born in 2023, an enhanced health visiting offer was again appropriately put in place in the light of the family history. Health Visitors had undertaken antenatal home visits. The family received New Birth visits and a 6-8 week home visit during which accident prevention and sleeping patterns were also discussed.

7.4 The Health Visiting Service accessed a local charity Baby Basics during both pregnancies to provide practical items for the family including a Moses basket and bedding to support compliance with the safe sleeping advice given.

[5] The Lullaby Trust is a UK charity that aims to keep babies safe and support grieving families.

7.5 The potential risk to Star as a vulnerable baby was magnified by the earlier reports that Mother was allegedly found asleep or intoxicated when caring for Moon and this risk factor should have been more urgently considered in April 2022 when professionals were assessing the baby and Mother and planning for Star's safety.

7.6 In June 2023, a Health Visitor completed a full feeding assessment in respect of Star and provided advice on immunisations, accident prevention, safer sleeping guidance and the 'Red Book'[6]. The family home remained cluttered but the Health Visitor noted that mother appeared confident and was meeting baby's needs.

7.7 During a home visit in July, a duty social worker observed the home to be cluttered and evidence suggesting that Star was being prop fed. Both children were at home whilst Mother was in the garden, smoking and wearing ear pods.

7.8 Mother had been found asleep with Star in her care after not collecting Moon from school in September. Concerns increased that Mother did not adhere to safe sleeping advice. Star slept in her sister's bedroom. At the initial child protection conference in October 2023, Mother told professionals that she had a camera in the children's bedroom which she and Star's Father had access to. Star's Father had said that he would check in on the camera throughout the day to make sure that Star was being cared for. However, at the conference Mother stated that she had blocked Star's Father from accessing this camera.

7.9 During a social work visit in October 2023 a Moses basket was observed inside Star's cot and inside the Moses basket was a nursing pillow. The social worker advised that this was not safe but Mother stated that the previous health visitor and a doctor told her this was a safe method for Star to sleep. On the same visit, Mother pulled Star by her arms to lift her out of a bouncer chair and when the Social Worker asked her to be careful, Mother replied that she was 'not a normal baby' and then held Star (aged 5 months) in a standing position.

7.10 By the end of October 2023, the social worker had highlighted further concerns that Star was being prop-fed and that Mother was adding rusk to her milk feed. Mother did not acknowledge professionals' advice and guidance about unsafe parenting and had been aggressive and abusive to social workers.

7.11 In November 2023 two visiting social workers observed that the Moses basket/cot still had a pillow in it.

7.12 Mother was observed to lift Star by her hands during the initial child protection conference. She had also told health visitors that she was adding baby rice to bottles and was given further advice that this was a choking hazard. Social workers also saw Star sleeping sitting up and Mother insisted that the previous health visitor and a doctor had told her this was a safe method for Star to sleep. There was discussion at both the Initial Conference in October 2023 and the Review Child Protection Conference in January 2024 about unsafe sleeping practices and also night-time prop feeding.

[6] A personal child health record.

7.13 In mid-December 2023 the Health Visitor gave advice promoting safety now that Star was becoming mobile and the need to clear clutter and debris from the floor.

7.15 Social workers who made home visits regularly addressed their suspicions that Star was not sleeping in her moses basket and was possibly sleeping in the same bed as Mother. Mother denied any co-sleeping. It is not clear how much workers challenged Mother's denials of this in the later visits. During a visit near the end of January 2024, Mother described the risks of co-sleeping in discussion with the social worker; she said that Star slept in her Moses backet and was transported to the cot and again was advised to put Star in her cot to sleep.

7.16 Joint visits between Children's Social Care and the Health Visitor would have been beneficial to jointly deliver the same messages and to prevent any misinformation being relayed to workers trying to provide advice in the best interests of Star. In mid-December 2023, a Health Visitor attended a planned joint home visit but the social worker did not arrive. Another planned joint visit at the end of January 2024 was not effective due to the health visitor not attending the home.

7.17 Records and reports do not indicate that any safety work was undertaken with either of the children's fathers.

The Children's Voice/ Lived Experience

7.18 Star was often described as appearing vacant and unresponsive to communication from adults when seen during home visits by social workers and health visitors. Star did not react in any way when Mother became aggressive to a social worker during a visit in January 2024 and asked the worker to leave.

7.19 Records indicate that Star spent a significant amount of time in a bouncer chair in the front room facing the television (whether it was on or off). When spoken to about this, Mother said that there was a need for Star to sleep upright due to mucus and that this was a health visitor's advice.

7.20 There is no reference in records to the possible effects of second-hand inhalation for Star, being so young and vulnerable to the toxins of Mother's drug use. This could have been raised explicitly and addressed at an early stage.

7.21 Moon was spoken to by social workers during assessments and during the joint police and social work enquiries. She was described by professionals as a bright, intelligent child. When spoken to in January 2023 Moon told social workers that she enjoyed seeing her dad and that she was sad that she could not have overnight stays. There are only three home visits recorded between March and August 2023; this does not meet practice standards around frequency of social work home visits and seeing and speaking to children. Moon was seen by duty social workers on 9 March and 12 July and was spoken to briefly with limited recording. She was seen by the allocated social worker on 12 April but no written record of the visit was made. The core group meeting minutes presented as a report to the review child protection

review in January 2024 do not include the dates of any social work visits when the children were seen.

7.22 In September 2023 Moon told the social worker that she woke up in the night to check on Star, as they shared the same bedroom. The social worker was concerned that Moon may be seeing to her little sister when their Mother was asleep.

Professionals' understanding of Mother's physical health and treatment provision

7.23 Mother's debilitating physical health condition was diagnosed in early 2020 and caused her to regularly be in pain; Mother says that the pain came on after Moon's birth.

7.24 In June 2023, Mother referred herself to a private health clinic which operates nationally and specialises in prescribing medicinal cannabis to help pain management. She reported to them that she had been told by a different pain clinic that there were no further treatment options and was therefore seeking medicinal cannabis. She was triaged, had an online consultation and her referral was discussed by a multi-disciplinary team at the clinic before a prescription was offered.

7.25 In August 2023 Mother had a telephone call with a GP regarding her medication and her pain. The GP practice made an urgent referral to a private pain clinic that day and later made a referral to rheumatology. Mother told Perinatal Mental Health Team (PNMHT) workers in September 2023 that she had had four referrals to a pain clinic and was waiting for steroid treatment. The reviewer has not been able to establish whether this is accurate or not but there are no references in review reports to any NHS records supporting this account. Mother complained about inadequate pain management.

7.26 Mother had a telephone consultation with a Pain Advanced Physiotherapy Practitioner from the private pain clinic in November 2023 after she forgot to attend an appointment. She was placed on a waiting list for referral to their pain management programme.

7.27 There was some limited communication between the family's GP practice and these private health providers but there is no record that any relevant information exchanged was shared with the social worker or other professionals working under child in need planning or from October 2023 in a child protection core group. It is important that social workers engage with both private and NHS health providers particularly given the expansion of private providers. The Care Quality Commission guidance for providers, in additional prompts for online healthcare providers of primary care, includes a question 'How does the provider manage any risks around safeguarding vulnerable children and adults at risk of abuse and neglect?' (in section 1 How do systems, processes and practices keep people safe and safeguarded from abuse?) Social workers should contact private clinics as part of their assessments where appropriate.

Professionals' understanding of Mother's mental health

7.28 When the GP practice shared information in 2023 with the private health provider which Mother approached for medicinal cannabis, the information outlined previous difficulties including self-harm, depression and anxiety. An incident of self-harm when Mother was approximately 21 years old is significant but this was not mentioned in assessments or the agency reports for this Review.

7.29 In 2019 a Health Visitor undertook regular maternal mood examinations of Mother using a standard mood assessment tool (PHQ9). By early 2020, a Health Visitor had identified maternal low mood and parental conflict.

7.30 Although there had been reference to mother experiencing historical depression and anxiety, she denied experiencing these feelings in discussions with workers during the time the Perinatal Mental Health Team (PNMHT) worked with her. The workers offered Mother access to psychology services and other therapies. Mother declined appointments with the Perinatal Occupational Therapist and Nursery Nurse who would have discussed the different groups available at that time. Mother did not want to attend groups. She did not respond to an invitation to attend a Circle of Security Group (an intervention to increase attachment security among socially disadvantaged children between the ages of one and five).

7.31 The Central and North West London NHS Foundation Trust (CNWL) describes a spectrum of Perinatal Mental Health Illness:

- **Mild** which includes Depression, Anxiety and Baby Blues
- **Moderate** which includes Birth Anxiety, Depression, Anxiety, PTSD, Tokophobia, Obsessive Compulsive Disorder and Personality Difficulties, and
- **Severe** which includes Bipolar Affective Disorder, Schizophrenia, Schizoaffective Disorder, Severe depression and/or psychotic symptoms and Postpartum Psychosis.

7.32 The Perinatal Mental Health Team workers focused on the fact that Mother did not display any symptoms which would support a diagnosis of mental illness. Other professionals were concerned about Mother's presentation and her behaviour in front of the children and other professionals. For example, the GP practice shared concerns with the PNMH Team in September 2023 that Mother told them in a telephone call that she did not have Star. A Health Visitor visit confirmed that she did and this was a few days before Mother did not collect Moon from school. In October 2023, Mother presented as erratic to social workers and jumped between different topics of conversation.

7.33 It would have been helpful if there had been joint discussion and exploration by all agencies about whether Mother had potential personality, cognitive or behavioural issues, especially given the concerns raised by a number of professionals and assessments that suggested that Mother was not putting her children's needs first and may have been using both prescribed and illicit substances.

7.34 A psychiatrist attached to the PNMH Team raised the possibility that Mother may have ADHD in October 2023 and asked the GP in November to expedite an ADHD assessment of Mother.

7.35 On 18 January 2024 PNMHT workers had observed, for the first time, 'some twitches in (Mother)' when she moved her head right towards her neck a few times. Mother said this happened sometimes, and that the GP was investigating this. This was only days before the first child protection review and there is no mention of this being discussed. Also in January 2024 (after the Perinatal Mental Health Team involvement had ended), the social worker noted that Mother said a word over and over again, made large movements of her arm, and spoke with a clicking sound in her voice. This had not been observed before and the social worker planned to explore this further on subsequent visits. There is no record of the PNMHT worker, the GP or the social worker sharing information about, or discussing, these observations which would have been useful.

Professionals' understanding of Mother's use of prescribed medication and its impact on her parenting

7.36 Social workers and other professionals working with the family did not have a clear understanding of Mother's prescribed medication at any point during the review period. Mother was selective and contradictory in the information she shared with different agencies. She had six different drugs prescribed – two anti-depressants, another drug which treats neuropathic pain, another anti-inflammatory drug and also anti-acid medication. In addition, in August 2023, Mother was also prescribed another medication used to relieve muscle spasms, cramping or tightness.

7.37 A number of these drugs can cause sleepiness and drowsiness and should not be used with alcohol. There were additional concerns that Mother used illegal substances and on occasion may have used her mother's medication (for example, when she took an overdose in 2022).

7.38 A Pharmacist at the GP practice and another attached to the Perinatal Mental Health Team did review Mother's medication on occasion but there is no evidence that information about its potential impact on mood and alertness or on Mother's ability to be available to parent safely was shared with the social worker or discussed within a core group meeting. A patient summary dated November 2023 was shared with the social worker and listed medication and the quantity issued and referred to cannabis '(form not specified)'. A case note in January 2024 details a GP letter which mentions Mother's use of cannabis oil but it is not specific about the substance prescribed. There was a lack of clarity about prescription, the type of cannabis substance prescribed (oil, leaf, bud etc) and/or the method of use.

7.39 In October 2023, a Health Visitor informed the Social Worker that Mother said she bought marijuana oil from a private clinic to help with her pain, and it cost approximately £400 a month.

7.40 It is clear from the records of the two child protection conferences, the child protection plans, and other agency records that professionals accepted Mother's account of continuing to take medicinal cannabis from the private health clinic throughout the review period. However, the clinic has informed this review that cannabis oil and dried cannabis flower were prescribed in July 2023 and then in August but Mother only received the flower prescription and did not have the oil prescription dispensed on this last occasion. The flower prescribed would have lasted one month and the clinic have had no further contact from her despite appointments being offered. Mother has informed the reviewer that she bought cannabidiol (CBD) oil from a local market.

Storage of Medication

7.41 It is important that professionals clarify with a parent the arrangements for the safe storage of prescribed medication and/or illicit substances. It is noted in the record of a social work home visit on 15 November 2023 that Mother's bedroom was seen and a tray of cigarettes on her bed. Mother advised the Social Worker that these would not have been out if Moon had been staying with her. She also showed them her medication bag and said that she would put the cigarettes into this and out of reach.

The Assessment of Substance use and Alcohol use

7.42 Mother had not disclosed any substance misuse when Moon was a baby. There had been a history of referrals from Moon's Father and his family alleging that Mother frequently used cannabis and other substances and that this impacted on her ability to safely parent. However, the risk around substance misuse was not explored during the social work child and family assessment completed in August 2022. Allegations were made by both parents about the other during private law proceedings. In November 2022, Mother told the Police that neither she nor Star's Father had any problems with drugs, alcohol or their mental health.

7.43 When Children's Services discussed allegations of substance misuse following a referral in January 2023, the social worker advised Mother to attend Addiction Recovery Community (ARC) Milton Keynes. Mother said that she would attend but did not. There were subsequent actions for the social worker to check if Mother had an open referral with the substance misuse service but there was a missed opportunity to make a direct referral for Mother then or at any point thereafter to impress upon her the importance of this taking place.

7.44 Mother repeatedly stated that she vaped and smoked cannabis outside but workers reported that it could be smelled during visits and believed that Mother did this within the property. Mother continued to say that the cannabis she used was prescribed medicinal cannabis. Workers continued to be concerned that Star was often vacant and unresponsive.

7.45 The action for Mother to work with MK ARC was again raised at the legal gateway meeting in October 2023 and there was also an action for her to undergo drug testing but neither was achieved before Star died.

7.46 Professionals' focus was on Mother's substance misuse but it would have been appropriate to also explore her alcohol use. Mother had asked her own mother's carers if they had taken a bottle of vodka on one occasion before the review period. Mother has told the reviewer that she drank occasionally with Maternal Grandmother who drank spirits. Mother drank a bottle of wine with medication when she took an overdose in 2022 and social workers found three bottles of alcohol in the bin outside the home in October 2023 although the record does not indicate what these were or the outcome of any discussion with Mother.

The Response to Referrals including Early Help Involvement in 2022

7.47 A Child and Family Assessment was completed following the first referral for Moon in June 2022 and no further action was taken. The response to the next referral in September 2022 is not clear. The second referral in September led to a referral to the Child and Family Practice Team. It is not clear if the concerns about cutting Moon's fingernails to the quick and damaging a dress and DVD were discussed with Mother. There was a discussion with Moon's Father's relation who described difficulties in communication with Mother and concern that Moon struggled to sleep when she was in her father's care and that she was not in nursery. The plan was to explore the impact of parental conflict on Moon in addition to the routines and boundaries across both households.

7.48 The decision to ask the CFP worker to consider the two referrals made in November 2022 following mother's overdose was expedient but it would have been appropriate to have allocated a locality social worker. As requested by her senior, the CFP worker confirmed with Mother that Moon had been cared for by her maternal uncle and uncle's partner at the time of the overdose. Mother informed the worker that she was emotionally abused by her mother as a child, that she had been the victim of a rape in June 2022, that the Hospital had made a referral to MK Carers (a charity offering support to unpaid carers) and that she was on a waiting list for psychotherapy.

7.49 The response could have been more robust after such a significant incident and given the family history and circumstances. This was an opportunity to draw up a chronology and genogram and to explore building a family network to promote Moon's safety. The CFP worker could have considered the allegations and counter allegations of abuse reportedly made by Maternal Grandmother and Mother against each other. It was also an opportunity to explore further Mother's report of rape and the history of allegations about substance misuse and to also consider preparations for the expected baby.

7.50 The CFP worker had also been asked by their manager to confirm the current safety plan and support network but as these have not been clearly set out in the chronology or shared with the review, it is concluded that this did not take place. A

safety plan dated 3 February 2023 is recorded and an updated Safety plan dated 17 February 2024.

7.51 The CFP worker and their manager discussed closing Moon's record in January 2023. There had been no liaison between the CFP worker and other family members, nor any discussion with Housing, Perinatal Mental Health or MK ACT about their work with Mother during this period of involvement. Also, the family network had not been fully explored.

7.52 The initial response to Mother's concerns in January 2023 that Moon's Father may have sexually abused Moon was appropriate and escalated to social worker involvement. A strategy meeting, joint section 47 enquiries and a medical assessment took place. There was no physical evidence that abuse had taken place which is not uncommon. The Police report for this review noted that officers should have taken witness statements from Mother and any others about why they were concerned given the nature of the allegations.

7.53 There was an action raised by the Multi–Agency Safeguarding Hub social worker for preventative work to take place with Moon but the referral to a specialist resource for this was rejected for some reason. Moon was not attending nursery where some further work around preventative work could have been undertaken and also monitoring of the situation.

7.54 A Health visitor was not invited to the strategy meeting held in October 2023. The Headteacher raised concerns at the meeting about Mother's ability to care for Star if Mother suffered from blackouts. The Police report for this review judged that the information provided to Thames Valley Police in the strategy meeting amounted to neglect and in line with the Home Office Counting Rules (HOCR), two reports of neglect (one for each child) should have been created on NICHE (a police records management system). A police investigation into neglect could then have been instigated by Thames Valley Police.

Assessment and multi-agency working - including where neglect is an issue

7.55 There was no agreement between professionals about what good enough home conditions for the family looked like and how this should have been addressed within what timescale:

- The CFP worker told the Reviewer that it was possible to get around the house when they were involved in 2022.
- Police reported concerns in November 2022 about the home conditions being smelly, messy and cluttered with a vast amount of cat faeces present inside. The Police review report states that an opportunity was missed then to share body worn camera images to demonstrate home conditions.
- Health Visitors also raised concerns in January 2023 and June 2023.
- In September 2023 a referral by the previous social worker to the FAST team to support with poor home conditions was closed as home conditions had reportedly improved.

- A social worker advised Mother against letting Star have tummy time at home as the carpet was not clean.
- Mother stated that the clutter in the house was from equipment that was needed for Maternal Grandmother and there were questions about whether Maternal Grandmother hoarded.
- In November 2023 the Health Visitor noted that the house remained cluttered and rubbish was dumped in the garden. She suggested to Mother working on small tasks in the house to keep it tidy.
- That month Housing helped to dispose of items in the garden which Mother could not transport to a recycling centre.
- Also in November, social workers described the kitchen as "poor" during a visit. There were lots of rubbish bags all on the kitchen floor; worktops were dirty and messy.

7.56 The home remained cluttered and unclean throughout agencies' involvement and there were no notable improvements in home conditions for the children despite the case escalating to Child Protection and the Public Law Outline.

7.57 Workers did not use a neglect assessment tool which could have been helpful in planning work with Mother. There were signs and reports that the children were being neglected and that their needs were not being put first throughout the review period:

- The impact of Mother's chronic pain condition and her medication on her parenting was not sufficiently explored.
- In November 2022, the Police noted that Mother was asleep on the two occasions when Star's Father had entered the family home, first in the afternoon around 3 or 4 pm and then early evening around 8pm. The CFP worker did not clarify or did not record if Moon was present or how she was being supervised on either of these occasions if her Mother was sleeping.
- Mother asked a social worker to visit in the afternoon which was better for her due to her medication although she had a young baby and another child who would have benefitted from regular nursery attendance.
- The lack of toys for Star and the frequent reports of her being in a baby bouncer sometimes facing television during visits raise concerns about her stimulation.
- Mother talked about attending a baby group with her friend but the name of the resource and the frequency of attendance were not recorded.
- In January 2023 Moon's Father wanted to take her to a playgroup at church but Mother was opposed to this.
- In September 2023, Moon was not collected from school and her Father and School reported that she was wearing no socks and that her feet were rubbing against her shoes.
- Professionals were unclear whether Moon was registered with, or had seen, a dentist.
- Mother missed many health appointments for herself and Star, including appointments for immunisations.

7.58 The Police agency report for this review judged that, if the Police had reviewed the minutes of the Review Child Protection Conference held in January 2024, a criminal investigation into the neglect of the children would have been justified and should have been instigated at this point. However, the minutes were not reviewed by the Police at the time due to an administrative error, the neglect offence was not identified and there was no consideration of commencing an investigation.

7.59 Social workers completed a Child and Family Assessment in respect of Moon in 2022 and another in respect of both children in October 2023 before the initial child protection conference. The first assessment report lacked focus and included 30 statements in the harm section; some were duplications and others were complicating factors rather than risks. The later assessment would have been more robust if the following had taken place:

- All information pulled through from previous assessments had been reviewed and updated or deleted as necessary
- Completion of a genogram and the 'Key Family Members and Support Network's Experience' section of the assessment form
- More up to date, and consistent, personalised recording for each child
- Inclusion of both children's fathers in the assessments or clear recording of attempts to involve them
- More clarity about harm, complicating factors and strengths/safety
- More direct work with Moon (the August assessment states that she had been seen by a social worker once in January 2023, twice in February 2023 and on three occasions between 21 August 2023 and 24 October 2023 (the date of the initial conference) and more recorded observations of Star
- Clear and separate danger statements and safety goals for both children
- Recording in the 'What needs to happen' section
- Inclusion of scoring by parents and key members of the support network
- Acknowledgement of the need for immediate safety planning and actions given the very low scoring of professionals (a judgement on a scale of 0 to 10 is a feature of the Signs of Safety Model used at conferences).

7.60 The 'timelines' section of the assessment forms used is very confusing because it was not updated and does not include specific dates. Workers at the Practitioner Learning event shared that this section is not in the latest version of forms now being used.

7.61 There was a tendency for professionals to accept Mother's self-reporting of information and events, for example, as described earlier about medication. Workers did not routinely triangulate information (collect and compare information from different sources to test its validity).

7.62 The Initial Conference record states that 'Mummy has a good support network around her from her family and friends.' There had been limited work to explore the family network and no genogram or ecomap had been completed. A friend of Mother attended the initial conference as a supporter but there is no reference to any

assessment of their involvement and whether they or family members could contribute to family support or child protection planning.

Safety Planning

7.63 In February 2023 Mother agreed that she would work with MK ARC drug and alcohol services and would take Moon to pre-school, and that she would work with her midwife and health visitor.

7.64 At the beginning of March 2023, a safety plan was put in place by a social worker in the FST.

7.65 In the Reviewer's experience, early safety planning by social workers sets out an immediate action or actions to address an identified risk (as distinct from later child protection planning which may have actions with varied timescales). The concern that Mother may fall asleep when intoxicated or due to medication when caring for a child was identified early in 2022. It would therefore have been appropriate to request that there should always be another suitable adult present who was able to care for the child whilst this issue was explored and work with MK ARC took place. These issues were not adequately addressed throughout the review period.

Child Protection Planning

7.66 The forms used for the initial and child protection review conference did not promote clear *SMART*(specific, measurable, achievable, realistic and timebound) planning. There was a delay in the plan at the initial conference being recorded on Children's Services' system (although other professionals report having received a copy of the plan after the meeting) and the plan at the second conference was not fully completed.

7.67 The records of the conferences pulled through some old information which continued some of the lack of clarity noted earlier regarding assessment records.

7.68 A Safeguarding Lead, not the allocated Health Visitor, attended the Initial Child Protection Conference in October 2023 because the Health Visitor had left the Trust.

7.69 Probation Officers in respect of both fathers were invited to the initial conference but did not attend or provide a report.

7.70 When a new social worker was allocated in November 2023 and a new Team Manager took on supervision and oversight of the case, there was more robust planning, better highlighting of risk and a pattern of more frequent visiting, including unannounced and weekend visiting. They immediately recognised that there were some grey areas around knowledge of the family that needed to be addressed.

Core Group meetings

7.71 The Core Group is the forum to co-ordinate multi-agency collaborative work, to share information about resources and services available, and to develop, implement and review the child protection plan. The Lead Professional (usually the social worker) is tasked with recording decisions and actions agreed at core group meetings as well as the written views of those who were unable to attend, and to follow up those actions to ensure they take place. The initial child protection conference identifies the membership of the core group and establishes timescales for meetings. The first core group meeting should meet within ten working days of the initial conference. The date set for the first core group for Star and Moon was 6 November 2023 which would have met the practice standard. However, the Health Visitor recorded that this core group meeting was cancelled. It was not rescheduled.

7.72 Local child protection procedures set out how frequently the core group should meet after the first meeting. Milton Keynes's local procedures state that 'the core group should meet within six weeks of (its) first meeting and at a minimum frequency of once every two months following the first review conference.' Some safeguarding partnerships direct that core group meetings should take place at least every four to six weeks.

7.73 On 30 October 2023, the Perinatal Mental Health Team workers had advised Mother to write down her concerns about her contact with Moon for discussion at the next core group meeting. The Child Protection Plan was updated on 8 November 2023, but it is not clear that this took place at a core group meeting. On 5 December, PNMHT workers told Mother that they would attend the next core group meeting prior to her discharge.

7.74 A core group eventually took place on 19 December, eight weeks after the initial child protection conference.

7.75 The Milton Keynes procedures state that 'More regular meetings may be required according to the needs and age of the child.' Given the level of concern for both these children, more regular meetings from the outset would have been appropriate.

7.76 The first child protection review held on 21 January 2024 set a core group meeting date for 29 January. It went ahead. A Health Visitor received a call and a Teams meeting link to join the online core group after it had started. They could not do so and sent an e-mail to the social worker stating that they had not seen Star since the review conference.

7.77 A core group is expected to progress the child protection plan. The limited number of core group meetings for Moon and Star may well have contributed to the delays in progressing multi-agency child protection planning. The local safeguarding procedures state that 'Where any member of the core group is aware of difficulties implementing the protection plan, the lead social worker must be informed immediately and a core group meeting/discussion co-ordinated to agree a reconsidered child protection plan.' This did not happen.

Contingency Planning

7.78 A contingency plan, as part of a child in need or child protection plan, will identify what action Children's Services will take in specific circumstances, if a plan is not followed by parents and/or sufficient progress is not made to reduce risk or achieve safety for a child.

7.79 In March 2023, Mother told a child in need meeting that she had not referred herself to MK ARC and did not feel that it was necessary. The Social Worker advised that this work was required and any evidence of substance misuse would lead to a Child Protection Plan being implemented. Mother was also missing medical appointments, including ante natal appointments. Clear and applied contingency planning could have led to more effective intervention for the children.

Legal Planning

7.80 Private proceedings were still ongoing in respect of Moon in 2022 because Mother and Moon's Father could not reach agreement about contact arrangements and raised concerns about each other's care of Moon. In April 2023, the Council received a Request from the Family Court to file a letter of involvement for the private proceedings. A social worker submitted a Section 7 report in September 2023 recommending shared care of Moon.

7.81 In September 2023 the allocated Social Worker and their Team Manager discussed in supervision whether a Section 37 report would have been more appropriate than a Section 7 report.[7]

7.82 There is no record of any consultation between the Children and Family Court Advisory and Support Service (Cafcass) and Children's Services or information sharing as part of assessments or following the request for a social work report for the private law proceedings. The policy agreed between the Association of the Directors of Children's Services and Cafcass in November 2022 on whether Cafcass or a local authority should prepare a section 7 report advises that 'Whether Cafcass or a local authority are directed to prepare the report, each agency is able, pursuant to Rule 12.75 of the Family Procedures Rule 2010, to provide the other agency with all the information they hold to ensure that the court has a complete picture'. It is not clear why this did not take place in respect of Moon.

[7] A Section 7 Report is a court-ordered report prepared under Section 7 of the Children Act 1989 when parents cannot agree on arrangements for children's care, usually if there are aspects of the children's welfare that require further investigation. Where a court considers that it may be appropriate to make a supervision or care order, it may direct a local authority under Section 37 to conduct investigations into the circumstances and welfare of a child.

7.83 In October 2023, after the incident in September, Court made a temporary Child Arrangement Order stipulating that Moon remain living with her father.

7.84 The social work team sought legal advice on 3 October and were advised that the PLO should be started. This was agreed by a Service Manager on 6th October 2023. The Public Law Outline Panel in Children's Services had agreed that the PLO process should be implemented for both children due to the history of neglect and concerns raised about the parenting of Moon, the parents' animosity, and inability to co-parent effectively. The plan was for the social worker to update parenting assessments, hair strand testing of Mother and her partner to take place, Mother to seek support regarding her mental health from the perinatal team and get an appointment with her GP to review her medication if she was having blackouts, social worker to make a referral for a Family Group Conference (FGC), a referral to the Specialist Assessment and Intervention Team (SAIT) to consider further support for mother, and the FAST team to make weekend welfare.

7.85 The new social worker allocated in November 2023 did not agree with the previous assessment and recommendations made to court in the Section 7 report and felt that she could not submit an update as requested. The Court had moved the submission of an updated section 7 report to January 2024. Legal Services requested all the papers alongside an extension for the social worker to carry out her enquiries in full.

7.86 The first Legal Gateway meeting with parents was scheduled for 25 October and then 3 November but it did not take place. Legal tracking meetings were held on 8 and 23 November 2023. The later meeting noted that two gateway meetings had been cancelled by parents (the first because parents had not sought or secured legal representation/ the solicitors did not have the relevant paperwork and the second because of a mix up of date). A plan was made for an urgent meeting to be arranged.

7.87 The First Gateway meeting did not actually take place until 12 December with the newly allocated social worker. None of the plan was implemented. The two children remained subject to PLO until Star's death in February 2024.

7.88 The Social worker has confirmed to the Reviewer that a Legal Planning meeting took place on 7 December. Legal Services had advised Children's Services to issue proceedings but this advice changed on 12 December after the social worker provided further information; the new advice was that the PLO should continue and more information was required. The social worker recalls that she was told she did not have enough evidence to meet the threshold at this time. Legal Services advise Children's Services but it is Children's Services' management who make decisions about implementing care proceedings.

7.89 A PLO tracking meeting on 8 January 2024 heard that Mother had asked the Social Worker to leave during the first visit arranged to undertake a parenting assessment. It was decided that the agreed plan should continue but if there was no engagement within two weeks, further legal advice was to be sought to consider issuing proceedings. At the PLO tracker meeting on 8 January, concerns were raised that PLO was not progressing and that there was no confirmation that Mother was agreeing to the actions.

7.90 A Legal Planning Meeting on 1 February 2024 decided that because there had been a lack of progress or engagement by parents and a lack of response to the safety plan, proceedings would be considered subject to a request being made to have access to the private proceedings' paperwork re Moon. Access to this paperwork would have been useful in September 2023 when the social worker completed a section 7 report.

7.91 There was significant delay in progressing a plan under PLO and in initiating legal proceedings. One purpose of the pre-proceedings process is to confirm at the outset non-negotiable 'bottom lines' that outline what must or must not happen to achieve change and safety for a child. Plans agreed at PLO meetings were not recorded in the children's case records. This should have happened and Children's Services confirmed that it is now expected practice.

Working with Fathers

7.92 Children's Services had limited involvement with either of the children's fathers and the Health Visiting Team had no contact with them. Mother reported domestic abuse and disputes. Records indicate that Mother often did not share information about the men with professionals but she has told the Reviewer that she did share concerns which were not acted upon by professionals. There should have been more professional curiosity regarding both fathers' roles and their contact with Star and Moon.

Moon's Father

7.93 Moon's Father had raised concerns about Mother's care of her in 2022 but did not cooperate with the Child and Family Assessment which took place and declined attending parenting courses which were offered to him.

7.94 Two allegations of sexual abuse (unrelated to parties in this review) should have been discussed in detail with Moon's Father and analysed in assessment before the decision was made that he could take on care of Moon in September 2023.

7.95 Regarding the decision to place Moon with her Father, professionals have described to the reviewer a lack of clarity around the care arrangements at that time. It appears that Paternal Grandmother provided a significant amount of care including taking Moon to school and arranging medical appointments. Moon may have stayed at Paternal grandmother's home during the week. Moon's Father worked but his job and working hours have not been set out in reports and therefore this information may not be on file.

Star's Father

7.96 Some information regarding Star's Father was identified at a strategy meeting in February 2023. Mother informed the Health Visitor that he was no longer involved in

her life but would have some contact with Star. The Social worker did not consult the Probation Service as part of the section 47 enquiries at that time.

7.97 There was very limited social work contact with Star's Father due, in part, to his lack of cooperation. There were risks highlighted about him and some ambiguity about Children's Services' expectations in relation to him. Further attempts should have been made to assess Star's Father and possible risks to his daughter, given his involvement in ongoing plans for Star. Despite Mother stating he was not on the birth certificate, she always declared that he was Star's father.

7.98 Police information for this review indicated that Star's Father had asthma and this reinforces the importance of thorough assessments of fathers' circumstances including their medical history.

7.99 In July 2023, the Probation Service completed a Pre-Sentence Report (PSR) after Star's Father had been charged in relation to a serious physical assault of an ex-partner in late November 2022. As part of their assessment, the Probation Officer contacted the social worker responsible for the children of the ex-partner, however they were unable to speak with the social worker for Star and Moon before completing their report.

7.100 Probation assessed Star's Father as posing a high risk of causing serious harm to known adults and to the children of any partners. He already had a caution in respect of causing physical harm to two children in 2013. He had been reported to the Police for domestic abuse by Mother in November 2022 and she had also accused him of sexual assault. Star's Father told a Probation Officer that he saw his daughter daily. His sentencing was adjourned in August 2023 and did not take place until after the period of this review.

7.101 There was good communication and information sharing between the Police and the Probation Service.

7.102 There was no social worker allocated to Star's Father's ex-partner's children in 2023 but the social worker for Star and Moon could have reviewed the service records to review previous involvement and assessments.

7.103 Despite the concerns outlined above, Children's Services made Star's Father central to the safety plan to safeguard Star against Mother's 'blackouts' in September 2023 but they did not speak directly with him. Mother told a Health Visitor during a telephone call that month that Star's Father was looking after Star.

7.104 A social worker planned to invite Star's Father to the initial child protection conference in October 2023, but Mother raised concerns about his attendance in light of his abuse conviction and allegations made against him by his ex-wife. Mother also expressed a fear that he may have been the person who abused Moon.

7.105 Mother told workers that Star's Father was asleep in the property during two visits in early October 2023 and at the end of the month, the Social Worker spoke in supervision about him no longer engaging with Children's Services. When a social worker visited in February 2024, Star's Father was present at the property and was caring for Star whilst Mother was outside. By this time, Mother had been asked by

the social worker to supervise all contact between Star and Father. Social workers found him holding Star at the family home during an unannounced visit in February 2024. He left shortly after the social workers' arrival.

7.106 Star's Father worked but his job and working hours have not been set out in review reports and therefore this information may not be on file. He had a previous conviction of child abuse and there were ongoing allegations of domestic abuse Mother told the Reviewer that she had shared concerns about him with professionals. It was not appropriate or realistic to have included Star's Father in the safety plan for Star in September 2023.

The impact of caseloads, changes of personnel and staff shortages

7.107 In August 2023, Moon was allocated to Social Worker 2 as a result of the high caseload of the previous social worker. In November 2023, a new Children's Services' Team Manager noted that Social Worker 2 had left the Local Authority without bringing the electronic file up to date or writing up meeting notes as planned, and also that expected visits had not taken place.

7.108 Frequent change of Health Visitors in 2023 and early 2024 contributed at times to a lack of family contact and the triangulation of all relevant information. At the time of her death, Star did not have a named Health Visitor and a Health Visitor last saw Star on 18 December 2023 despite a core group and child protection review taking place in January 2024. The CNWL individual agency report noted that the Health Visiting service was experiencing an unprecedented level of vacancy and sickness absence at the time of Star's death. This impacted on information sharing and multi-agency working.

7.109 Due to staff changes and sickness, Mother had three different Perinatal Mental Health workers. Two workers did work together and carried out joint visits. Changes in professionals across both health and social care led to some delays in information sharing and also to planned family support and later core group meetings being cancelled.

7.110 Good recording is always important but particularly so when there are significant changes in personnel.

The use of duty social workers to make home visits to ensure that they remain in timescale

7.111 Whilst the children were subject to child protection plans, eight home visits were undertaken between October 2023 and February 2024 by various Duty Social Workers rather than the allocated social worker. Such practice ensures that visits are made within timescales but does not promote consistency or a good working relationship between the allocated social worker and family members. A Team Manager at the Practitioner Learning Event shared that efforts have been made since September 2023 to stop the frequent practice of duty social work visits.

Recording

7.112 Gaps in social work case recording have made it difficult for new workers to fully understand previous events and actions taken and this has been an obstacle at times for this Review.

7.113 On 28 September 2023, Children's Services' Emergency Duty Team had informed the Police that there had been a significant lack of recording in the child/ren' s files for at least six months.

7.114 The Initial Child Protection conference record included out of date information about Moon's legal status and contained March 2023 updates to the child and family assessment. The section 'What has got us to this point' only contains chronology information up to November 2022. There is a lack of clarity about information held in the Harm, Complicating Factors and Strengths section.

7.115 On 8 October 2023, a Team Manager raised concerns that the ICPC minutes were still not on the LCS information system because relevant tasks had not been completed by Social Worker. The Team Manager requested that minutes of Core Group Meetings be recorded in Word and uploaded whilst the file was updated.

7.116 An audit in Children's Services had identified shortcomings in recording and practice in 2023 but there is no evidence that remedial action took place. Children's Services have assured the Review Group that processes are in place to ensure that remedial action identified in audits is completed and that this was an aberration.

7.117 CNWL report that Health agencies communicated via email to share care plans regarding Mother. It was noted that GP and 0-19 Universal Health Service's information was recorded in Star's health notes but information for the Perinatal Mental Health Service was not.

7.118 The Core Group meeting in December 2023 changed the danger statement[8] for the children, but the danger statement in the minutes for the January child protection review remained the one from the initial conference.

Supervision and Escalation of Professional Concerns or Disagreements

7.119 Health Visitors involved with the children had regular one to one supervision sessions with a focus on caseloads and they attended Safeguarding supervision groups. However, no Heath Visitor or PNMH Team worker requested individual safeguarding supervision which could have been used to explore the issues for these children and the drift and delay in the multi-agency response.

7.120 The social worker appropriately challenged PNMHT workers about their plan to end their involvement.

[8] A Danger Statement clearly identifies what Children's Services are worried will happen to a child in the care of the parents/carers if nothing changes. It is dynamic and is amended to reflect changes in a child's situation.

7.121 This review also highlights the importance of SMART plans being agreed or reviewed in supervision and of clearly reviewing progress and amending plans as necessary.

7.122 Reflective supervision for the social worker was recorded in November and December 2023 demonstrating a 'fresh look' at the case. In the December supervision, the Social Worker and Team Manager acknowledged that there had been drift and there was an urgency to progress the PLO – particularly to get the required assessments completed, including drug testing for Mother and a greater focus on this element of risk.

7.123 No professionals used the escalation procedure to raise concerns about drift and delay in the work with the two children.

The importance of multi-agency working and communication, especially when parents do not cooperate with agencies and/or do not provide consistent information or accounts of events.

7.124 Mother could be difficult to contact and engage in work. She provided contradictory information to professionals at times and reported contradictory advice when challenged. Mother regularly criticised other professionals when talking to the PNMHT workers.

7.125 The Health Visiting Service made unsuccessful attempts to contact Mother in August and September 2022. There was no communication between social workers and health visitors in the second half of 2022. Health Visitors did not receive a copy of a multi-agency referral form from adult mental health services in October 2022 after Mother took an overdose.

7.126 On 1 December 2022, Mother said that she was working with MK Carers but this was not verified. Mother said that the perinatal team were referring her to Improving Access to Psychological Therapies (IAPT) (now known as NHS Talking Therapies for anxiety and depression) due to mental health difficulties but it is not recorded that this was followed up.

7.127 There was significant involvement with the PNMH service but no communication between Health Visitors and the Perinatal Mental Health team in 2023 to plan care or discuss ongoing safeguarding concerns.

7.128 In January 2024, the GP noted that Mother had told the Perinatal Mental Health Team that the GP had referred her for an ADHD assessment but she had told the GP that the Perinatal Mental Health Team had done this.

Working with Domestic Abuse

7.129 Mother had been open to the MK ACT Domestic Abuse Crisis Service between January and September 2020 and she contacted the Crisis Service and their Peer Support Worker sporadically from June 2021 to December 2023. On 17 January

2023, Mother told the CFP worker that she had an allocated MK ACT worker. It would have been useful if a representative from MK ACT had been invited to the Initial Child Protection Conference in October 2023 and involved in subsequent child protection planning.

7.130 Mother told the Reviewer that she did not feel that her voice carried as much weight as that of Moon's father with professionals. A non-molestation order[9] had been made in respect of Moon's Father but this was overtaken by events in September 2023 when he became Moon's primary carer.

7.131 There should have been discussions in advance of Star's birth about the most appropriate contact arrangements for Star's Father. She stated that their relationship was over and therefore contact did not need to involve Mother or take place at the family home.

7.132 From November 2023, the Social Worker advised Mother not to let Star's Father have unsupervised contact with Star. The risk to children and mothers can be increased if restrictions are placed upon contact and therefore the reviewer's view is that this requirement should initially have been shared with Star's Father by a social worker or Team Manager (although it is recognised that achieving contact with him was difficult).

7.133 Mother was not referred to MARAC despite the reports of domestic abuse.

8. Service Developments in Milton Keynes during the review period and since February 2024

8.1 The Milton Keynes 0-19 Children's Universal Health Services reviewed record keeping templates so that where substance misuse is recorded, there is an additional free text box to promote a risk assessment of impact on parenting capacity. Information regarding prescribed medication is already available within the shared S1 record.

8.2 The 0-19 Services have also changed management practice and arrangements so that agency Health Visitors now have a caseload to improve consistency and a named Health Visitor.

8.3 Following the recent completion of an unrelated Child Safeguarding Practice Review, Thames Valley Police is developing a recommendation for the MASH to review their processes for sharing audio and visual material captured by police officers with partner agencies to improve sharing of visual material. At completion of this Review Thames Valley Police confirmed this recommendation has been adopted and changes have been put in place.

[9] A non-molestation order is a form of injunction issued by the family court to protect an individual and any relevant child from abuse or harassment by a named person or to prevent the respondent living in the applicant's home.

8.4 Following an inspection by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) published in November 2023 which found that TVP was not effectively investigating cases of child neglect, a working group consisting of a Detective Chief Inspector, Detective Inspectors and Sergeants and key staff within the MASH was set up to identify areas for improvement. Decisions on neglect made by the MASH and police were not always being re-visited. New operational guidance on neglect has been developed and implemented. This includes a 'workflow' document consisting of aide memoires and signposting for reference. Investigation processes have been reviewed to address instances of the criminal offence of wilful neglect effectively and training for officers has taken place.

8.5 In their October 2024 inspection, Ofsted noted that Children's Services had recognised through routine audits that 'there is still some inconsistency in the quality of assessments, and (managers) are rightly taking action to address this.' Inspectors also found that significant improvements had been made regarding the pre-proceedings stage of the Public Law Outline (PLO). 'Letters before proceedings are written with a clear focus on the concerns about children's experiences. Monthly reports for court and pre-proceedings activity prepared by the principal lawyer provide a comprehensive overview of performance against court-related practice.' MK Children's Services had published updated guidance for social workers about implementing the Public Law Outline process in November 2023.

8.6 Ofsted also noted that there was 'a comprehensive and effective workforce recruitment and retention strategy' to address the challenges in recruiting qualified and experienced social workers and to avoid multiple changes in staff.

8.7 Children's Services have shared with this review a comprehensive quality assurance framework which was introduced in September 2024. It includes a monthly audit and moderation process and monthly performance and data meetings. It could usefully indicate how and when remedial action will take place when practice is judged to be inadequate. 'The development of practice will be through individual plans for Social Workers, teams, and Team Managers to support learning and embed change'.

8.8 A comprehensive strategy meeting template has been introduced and utilised since July 2024.

8.9 The forms used for assessments and for recording child protection conferences and child in need and child protection plans have been updated so that they are easier to follow and there is a clear plan recorded in one place.

8.10 Child Protection Conferences now take place in a dedicated space and meetings in person are the preferred method of holding meetings.

8.11 Children's Services have reviewed core group timescales and these now take place at least every four weeks after the first core group meeting.

8.12 Milton Keynes Children's Service launched their new Local Safeguarding Protocol (referred to in paragraph 5.3) in May 2024.

8.13 Discussions are ongoing regarding the implementation of a neglect screening tool to achieve best practice in identifying the effects of neglect on children and young people as well as parental capacity, with the aim of promoting positive care and intervention plans'.

8.14 In response to early findings from a local Domestic Homicide Review, extra safeguarding supervision has been instituted for staff in adult mental health services to reinforce the importance of considering children's welfare within the family context.

8.15 Multi-agency training sessions around substance use, including the use of medicinal cannabis, have been delivered by Milton Keynes City Council and sessions were well attended.

9. Positive Professional Practice

9.1 There were several instances where positive practice was highlighted by agencies in their reports and discussions.

9.2 Health Visitors and Social Workers have clearly recorded the advice they had given to Mother in respect of safe feeding and safe sleeping. Health Visitors follow the Lullaby Trust guidance for Safe Sleeping. Health Visitors used a local charity to provide basic equipment for Mother to promote safe sleeping.

9.3 In responding to the call about domestic abuse in November 2022, Police Officers recorded that they had seen Moon and considered speaking with her, but she was too young (three years old). They also recorded the unborn child within the involvements screen on NICHE.

9.4 Staff in the GP practice were pro-active in maintaining contact with Mother who was inconsistent in keeping appointments. For example, a doctor called Mother in October 2023 following the report that she had had an unresponsive episode/blackout.

9.5 The new Social Worker and Team Manager in 2024 recognised the shortcomings of previous social work involvement and were working to improve intervention. Unfortunately, there was further delay in making progress through the PLO process and changes were not achieved before Star's death.

10. Conclusions and Summary of Learning

10.1 The 2020 National CSPR Panel report notes that almost all SUDI incidents involve parents in co-sleeping in unsafe sleep environments with children, often when the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse. Agencies were trying to address these issues with Mother in 2022 and early 2023 through Early Help and Child in Need intervention and then through Child Protection planning and pre-proceedings work (implementation of the Public Law Outline) from September 2023

until Star's death. Mother has consistently stated that she did not co-sleep with Star at any time but professionals' concerns remained and agencies consider this to be a factor in Star's death.

10.2 Midwifery and Health Visiting Services correctly identified Star as a baby who would require additional visiting and monitoring. A 2023 report from the National Child Mortality Database (NCMD) on Sudden and Unexpected Deaths in Childhood highlighted that co-sleeping with a baby who was born prematurely or weighed under 2.5kg or 5½ lbs when they were born was a heightened risk factor.

10.3 This review has highlighted the importance of relationship based, trauma informed practice and the need for persistent attempts to work alongside parents who can be challenging to engage due to their life experiences. Mother had experienced many challenges in her life and faced many changes in staff working with her during this review period. This illustrates the importance of work taking place in all agencies to establish a stable workforce.

10.4 Children should be seen regularly by social workers and other professionals and their presentation and voices noted as part of both child in need and child protection planning. There was limited contact by social workers with the children in 2023 and the use of duty social workers to achieve visits in timescale limited the opportunity to build a positive working relationship. The most recent social worker has worked hard to develop a good working relationship with Mother since 2024, and this practice is to be commended.

10.5 It is important to clearly identify potential support offered, or risks presented, by fathers and male partners involved in children's lives. Neither of the children's fathers cooperated with social workers although Moon's Father did raise a number of concerns about Mother's care. This review demonstrates again the importance of professionals being tenacious in seeking to involve fathers in assessments and planning.

10.6 This review also highlights the importance of multi-agency working and professionals exercising professional curiosity and respectful uncertainty in undertaking assessments and trying to progress plans to keep children safe. Joint visits are a useful way to promote multi-agency working and to deliver consistent advice.

10.7 Information shared by parents should be cross-checked ('triangulated') across services working with a family, to build up an accurate picture of the child and family's life.

10.8 There was an opportunity for a pre-birth assessment in respect of Star and more robust discharge planning in early 2023 but this did not happen. This could have included discussion about the most appropriate arrangements for contact for Star's Father.

10.9 Mother stated that her relationship with Star's Father was over but the high level of contact at the family home and the observations of professionals indicate that she was unable or unwilling to achieve this. Social workers working with families where

there are issues of domestic abuse should work closely with specialist services and make repeated attempts to engage parents in work around domestic abuse and safety planning. There has been considerable work in recent years to ensure that those involved in private law proceedings around contact where there have been issues around domestic abuse are fully aware of the dynamics of domestic abuse and the potential risks to women and children.

10.10 There was considerable delay in progressing child protection planning and legal planning for Star and Moon. There was a lack of clarity around risk assessment and planning for Moon in the early stages of Early Help and Child in Need involvement. Some risks for both children were more clearly identified after September 2023 and then in November when the new social worker and manager became involved. However, agencies still could not engage Mother in work to achieve positive changes and the slow progress of the PLO process added to delay in progressing to more assertive action through the courts. All professionals should challenge, and escalate their concerns, when an assessment or plan is not completed, key meetings do not take place or agreed information sharing is not achieved.

10.11 The assessments and planning for Star and Moon were not robust. This included contingency planning, safety planning and legal planning. This review has highlighted the importance of carefully considering parents' histories and circumstances in detail and the potential impact on their parenting in assessments.

10.12 There were limitations and gaps in social work recording which did not assist new social workers reviewing previous records and undertaking updated assessments. Gaps in recording have limited the information available to this review on certain issues and therefore hindered a full understanding of events and intervention. The forms used did not support good recording and clear analysis and planning but Children's Services have taken steps to address this.

10.13 The involvement of both NHS and private health providers was a complicating factor in work with Mother. There are a growing number of private clinics nationally which prescribe medicinal cannabis and it is therefore important that social workers and GP practices establish good working relationships and communication with these health providers and include them in planning and request information/reports when required.

10.14 It is important that professionals consider the impact of prescribed medications as well as substance use on parenting capacity in assessments.

10.15 When Children's Services are asked to provided section 7 reports in ongoing/longstanding private law proceedings, there should be early consultation with Cafcass to ensure that all relevant information is shared as soon as possible. The implementation of the Public Law Outline and applications for care proceedings should take place in a timely way.

10.15 The completion of full genograms and regularly updated chronologies are important tools to help professionals gain a full understanding of a family's history and circumstances. The fact that workers did not complete these tools with this

family limited their understanding of the family history and the family network and opportunities to consider any support within the wider family.

11. Recommendations

1. MK Together Safeguarding Partnership (MKTSP) to share the findings of this review widely within the children's workforce and reference it in relevant learning events.

2. Children's Social Care to work with health partners to develop agreed best practice to ensure that pharmacy medication reviews for parents whose children are subject to plans (CP or CiN) are discussed with Children's Services to inform assessments and planning. MKTSP to be assured when this work has been completed.

3. MK Together to seek the assistance of the National Panel to help identify a source of expert knowledge and advice on the use of medicinal cannabis by parents so that staff are supported in considering the potential implications for parenting and the safety of children.

4. Children's Services to provide assurance to MKTSP via relevant Working Group, about the effectiveness of the quality assurance systems now in place in ensuring the quality of case recording on children's files, the timeliness of visits, good quality assessments, children's plans, genograms and chronologies and the effectiveness of internal checks on files, particularly when social workers leave or change.

5. Children's Services and CAFCASS to review their information sharing processes to ensure full and timely consideration and joint understanding of risks to children linked to private law proceedings.

6. MK Together Safeguarding Partnership to formally review the National Panel's Out of Routine 2020 report and its proposal for 'a prevent and protect practice model for reducing the risk of SUDI'. Also, to consider how to further promote safe sleeping practice in Milton Keynes (including participation in the annual national Safe Sleeping week) and to highlight that professionals need to consider and involve fathers when promoting safe-sleeping practice.

7. Children's Services and MK Together Safeguarding Partnership to highlight to professionals the need for communication with private health providers as well as NHS organisations as part of assessments and planning. Professionals should not solely rely on information shared by family members and should exercise professional curiosity.

8. MK Together Safeguarding Partnership to discuss with the National Panel and the Care Quality Commission, the format of CQC inspection reports so that

the safeguarding of children as well as the safeguarding of adult patients is reported in inspections of private health providers.

9. MK Together Safeguarding Partnership to review their procedures around the assessment of neglect and to agree and implement an assessment tool to assist professionals and family members to work together around this issue.

10. Agencies will refine their single agency recommendations where necessary to ensure that they are SMART and indicate to the Partnership the timescale for their implementation.

Jim Stewart
Independent Reviewer

19/11/2025

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