Serious Case Review

Overview Report: Sarah

Author: Stephen Ashley

Date: 11th February 2022

Note: All names and identifying details have been anonymised to protect the identity of the child and their family

Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

Contents

1. Introduction....3
2. The Story of Sarah....4
3. Key Themes....11
4. Summary....13
5. Recommendations....15

1. Introduction

1.1 This serious case review concerns a child known, for the purpose of this review, as Sarah. In the summer of 2017 when Sarah was eight days old she was at the family home with her parents and older sister. At about 10 pm Sarah's father says that Sarah woke up crying very loudly. Sarah's father rocked the Moses basket she was sleeping in, but Sarah remained distressed. Sarah's mother was upstairs when Sarah had woken up. When Sarah's mother went downstairs, her father passed Sarah to her mother who noticed that Sarah was floppy and lifeless. Sarah's father telephoned the local hospital and paramedics arrived at the scene. Sarah was taken to hospital. Despite full resuscitation Sarah was declared deceased at 0006hrs the next morning. Following a post-mortem, it was established that Sarah had a number of injuries including a fractured leg, the conclusion of the pathologist was that Sarah had died from a head trauma caused by shaking.

A police investigation resulted in criminal charges being brought against both parents. In January 2022 they were both convicted of causing or allowing Baby Sarah's death, two counts of causing or allowing serious physical harm to a child and child cruelty. Sarah's mother was sentenced to 8 years imprisonment and her father to 10 years imprisonment.

Lancashire Safeguarding Children Board (LSCB) agreed this case met the criteria laid down in Working Together 2015 for a serious case review to be conducted.

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of Sarah, whether information was fully shared by the professionals involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people

1.2 The author of this report was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and has chaired several local safeguarding children's boards.

At the time the review was initiated and written, the author was independent of Lancashire Safeguarding Children Board in accordance with *Working Together 2015* chapter 4 (10*)*. However, under the new safeguarding arrangements he has since been appointed as the independent scrutineer for the children's safeguarding assurance partnership in Lancashire.

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Lancashire Safeguarding Children Board (LSCB) business unit supported the panel.

1.3 The methodology agreed by the Lancashire Safeguarding Children Board (LSCB) review panel is based on a model consistent with the requirements of *Working Together 2015*. It ensures that:

- A proportionate approach is taken to the SCR
- it is independently led
- professionals who were directly involved with the case are fully engaged with the review process
- families are invited to contribute

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement, and the work being undertaken to address those issues, was included. All the agencies that were asked for a report provided the information requested. In cases where further clarification was required agencies responded in an open and honest way.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology. In addition, interviews with front line staff and managers took place.

This review was conducted in parallel with a lengthy police investigation. As a result, learning from the review has been acted upon prior to the final completion of the review. Given the protracted nature of this case, the reviewer was asked to produce a shortened version of his review to ensure an accurate record of the agreed learning would be available and to ensure those learning points had been actioned

2. The Story of Sarah

2.1 This section sets out the facts in this case. It begins with a description of Sarah's parents and the environment she was born in to.

2.2 Sarah's father lived in the Greater Manchester area. In 2014 Sarah's father had reported to his general practitioner (GP) that he was in low mood and had used cannabis since he was 11 years old. Sarah's father was referred into a drugs team for further help. In 2016 Sarah's father again reported to his GP that he was depressed and using cannabis and was prescribed anti-depressants. The GP treated him for anxiety and depression and noted that he was also consuming excessive levels of alcohol. Sarah's father was offered, and signposted to, appropriate support. Throughout the timeframe of this review Sarah's father sporadically reported low mood and cannabis use.

Sarah's mother had lived in Hampshire for most of her life. Sarah's mother suffered from cerebral palsy that affected her right side. Sarah's mother was also an epileptic. Sarah's mother disclosed that in her teens she had suffered from depression and had self-harmed. There was also some evidence that Sarah's mother suffered a mild learning disability and was autistic.

In March 2016 Sarah's maternal grandmother (referred to as GM1) had reported to Hampshire Children's Social Care that her daughter was leaving university to return home as she had become pregnant and that she would need a social worker. A social worker was allocated to her. It is understood that Sarah's mother had met Sarah's father on the internet, and he was the prospective father.

In May 2016 Sarah's mother moved to the Greater Manchester area to be with Sarah's father and registered with the local acute hospital. At this point she was 26 weeks pregnant. No mental health, drug or alcohol issues were recorded. In August 2016 Sarah's sister was born in a Manchester Hospital. Sarah's mother and sister were discharged from hospital and received universal services[1]. There is no record of a plan for supporting Sarah's mother and her new baby, which given the physical issues she faced might have been expected.

Learning Point – The Manchester Hospital maternity services should ensure written records reflect the needs of mother and baby. Support plans should be clearly documented to ensure links with Early Help teams.

The health visitor conducted regular visits with the family and did not report any particular concerns. Efforts were made to involve the parents in family support, and they were directed towards the Homestart programme, but they failed to engage.

In October 2016 GM1 contacted Greater Manchester Police. She reported that Sarah's father was controlling her daughter and was *"kicking her out"*, but would not let her take their 6 week old baby with her. Police attended the home of Sarah's parents. The couple agreed they had been arguing and they both wished to end their relationship. There were no allegations made by either party and they agreed that they would resolve their issues the next morning. Police officers completed risk assessments but were satisfied there was no risk to Sarah's mother or sister.

The following morning GM1 contacted Children's Social Care (CSC). GM1 made the same allegations that she had to the police regarding Sarah's father and his control over her daughter. The matter was dealt with by the Emergency Duty Team (EDT). The appropriate checks were made with the police and health services. There was also a referral made to Adult Social Services due to the issues faced by Sarah's mother.

An Early Help Family Support plan was completed. This plan was comprehensive and contained considerable support for the family. Several home visits were jointly conducted by health visitors and social workers and in each case, comment is made on the positive way Sarah's mother and father interacted with Sarah's sister. Information was also appropriately shared with the GP. Outreach workers were allocated, and an Early Help plan was developed. It was established that Sarah's parents had decided to continue their relationship. At this point the family had an outreach worker and were engaged with two children's centres. They were also re-referred to the Homestart programme.

Whilst there is some confusion, Sarah's mother and possibly Sarah's father returned to Hampshire to stay with GM1 for an unknown period. The outreach worker continued to engage with the family.

[1] **Universal services -** Universal Services from the health visitor provides the Healthy Child Programme to ensure a healthy start for children and family (e.g. prompts for immunisations, conducting health and development reviews). The health visitor supports parents and facilitates access to a range of community services/resources and refers to the GP where appropriate.

When the family failed to engage, the outreach worker followed up missed appointments. Through until the end of 2016 there was good quality and coordinated support provided to the family.

Good practice – Good coordination between agencies resulted in effective support for this family. The outreach worker coordinated the multi-agency response and there was strong evidence of good information sharing.

At the beginning of January 2017 Sarah's mother informed a health visitor that she was pregnant. At the trial of Sarah's parents, it became clear that the paternal grandparents of Baby Sarah took considerable care of Sarah's older sister and spent considerable periods living with them because Sarah's mother was clear with them that she could not cope. It was also established that the parents' relationship was a violent one with violent episodes initiated by both parents.

2.4 The facts of this case

2.4.1 Phase one – Pre-birth engagement with Sarah

Initially an outreach worker tried to maintain contact with the family. A Team Around the Family (TAF) meeting was arranged by professionals. However, Sarah's parents stopped engaging with professionals and began missing appointments. By mid-February 2017 Sarah's parents stated they no longer required additional support and as a result the additional support provided by the children's centre was closed. Whilst the GP was informed of this decision it would have been appropriate to discuss the issue with other professionals before closing the case.

Learning point – When significant support is in place for a family it is good practice to hold a professionals' meeting before that support network is closed.

At the end of February GM1 alleged to midwives that Sarah's father was controlling Sarah's mother and isolating her. A referral was made to the Multi-agency Safeguarding Hub (MASH).[2]

An unannounced visit was undertaken by a social worker to the family home. Sarah's sister was seen and there were no concerns raised about the family or their care of Sarah's sister. A Child and Family Assessment (CAF) was commenced. That assessment was completed in April and there was a recommendation that the case was closed. The social worker stated: *"It is the opinion of the social worker that the referral information has been unsubstantiated and no indications of control have been noted. [xx] is particularly isolated due to the impact of her reduced mobility has when living in a first floor flat and due to this the family would benefit from a house move, which would enable [xx]'s access to the property to improve. [xx] and [xx] have an allocated health visitor and midwife who are aware of [xx]'s low mood and will continue to monitor [xx]'s mood."*

By the time this assessment was completed Sarah's parents had moved from Greater Manchester to Lancashire and her case had been transferred. The correct process was followed in completing

[2] **Multi-agency Safeguarding Hub (MASH) -** The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all professionals and members of the public to report safeguarding concerns.

a detailed CAF. The social worker had received appropriate supervision and support and there was clear evidence of liaison with midwifery and health visiting professionals.

The case was transferred to a Lancashire midwifery service. Whilst the transfer was correctly conducted some important paperwork was not completed. This included the social needs assessment and the psychological profile of Sarah's mother. The midwife asked Sarah's mother to book antenatal appointments, but it would have been more appropriate for the midwife to have done this. In fact, Sarah's mother was thirty-eight weeks pregnant before she attended the community antenatal clinic.

<u>Learning point</u> – Lancashire maternity services must ensure that there is a full transfer of information in cases where a pregnant mother moves from one area to another. It is critical that where appointments are missed there is an effective 'follow up' mechanism.

At the beginning of April GM1 contacted the midwifery service to again raise concerns about Sarah's father and the fact that he controlled Sarah's mother. The hospital safeguarding team were informed and a request for information made with a Lancashire Children's Social Care team. The safeguarding team established that there were no ongoing concerns but noted the previous complaints. At this point the CAF completed in the Greater Manchester area had been received and that provided the information to support the view that no further action was required at this point. By the beginning of May the case had been closed to the Greater Manchester children's social care team and transferred to Lancashire.

At this time an 'orange alert' form was raised by midwives. This form highlights that the case needs added attention and is used and monitored by the safeguarding team.

On receipt of the medical records by the health visiting team the standard operating procedures require that the health visitor makes contact with the previous health visitor. This does not appear to have taken place. It also requires that a home visit takes place within 10 days, which did not occur.

<u>Learning Point</u> – Health visitors should follow standard operating procedures when a patient is transferred from one area to another.

During May, Sarah's mother failed to attend any of the appointments that she had been given. Whilst plausible reasons were given by Sarah's mother there is concern around the way in which these 'failed to attend' (FTA) incidents were recorded. In essence when an FTA incident occurred there was no system to ensure follow up. This has now been rectified and a more robust process is in place.

At the beginning of June, Sarah's mother failed to attend another appointment and the only 'follow up' was by way of telephone. Guidance is clear that a home visit should have taken place.

<u>Learning point</u> – When a pregnant patient fails to attend appointments it is critical that these failures are correctly recorded and that a 'follow up' is carried out according to procedures. In this case some of the policies and procedures in place were not sufficiently robust and should be strengthened.

By the middle of June, Sarah's mother should have been seen for a twenty eight week check, a growth scan at thirty two weeks and a thirty four week check. In fact, Sarah's mother had not been seen since she had been twenty two weeks pregnant.

At this point midwives and health visitors were engaged in exchanging information, but there still appears to be little physical contact with Sarah's mother or sister.

In mid-July Sarah's mother was seen at an ante-natal clinic. There was a record made that Sarah's mother was having mobility issues. It was agreed that Sarah's mother would give birth by way of a pre-planned caesarean section. At this time Sarah's mother had not had any ante-natal care for fourteen weeks. Whilst it was noted that she had mobility issues there appears to have been no consideration as to whether she would be able to care for her baby. At this time professionals dealing with Sarah's mother knew of her physical and mental issues. They were aware of complaints around domestic abuse and that Sarah's father also had mental health issues and abused cannabis. No consideration appears to have been given to a further referral to CSC. If a referral had taken place, and pre-birth protocols regarding child protection followed, a strategy meeting would have been called and a more formal process of providing support and protection provided.

<u>Learning point</u> – By mid-July health visitors and midwives were aware of the physical and metal issues faced by Sarah's mother. They were also aware of the issues previously reported in the relationship between Sarah's parents. A referral to CSC should have been considered at this point.

Sarah's parents attended hospital at the beginning of August reporting reduced foetal movement and a few days later Sarah was born by caesarean section.

2.4.2 Phase two – Post birth engagement with Sarah

The day after Sarah's birth GM1 again spoke to midwives. GM1 gave specific details of abuse suffered by Sarah's mother from Sarah's father. This included threatening texts and descriptions by Sarah's mother that he had threatened to kill her. GM1 had telephone evidence of the abuse (a screenshot of her phone). GM1 was told to contact the police. The hospital safeguarding team discussed the matter with GM1. The team also sent a risk assessment document to the midwife for completion. They advised GM1 to inform CSC and the police. They also considered making a 'Clare's Law'[3] application.

[3] **Clare's Law -** The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

The midwife asked Sarah's mother about domestic abuse, but she stated her autism often made her angry and she would then cause arguments. Sarah's father and GM1 also had a discussion at this time to resolve issues. No referral was made to either adult's social care or CSC at this point.

There was evidence that Sarah's mother was having mobility issues while in hospital. The midwife raised a number of concerns including the fact that Sarah's mother suffered from epilepsy, cerebral palsy and autism. In addition, it was noted that Sarah was the second child and the older sibling was not yet one year old, which brought additional pressures given Sarah's mother has little family support in the area (GM1 lives in Hampshire). Concerns about potential domestic abuse were also raised. It became clear during the parents' criminal trial that Sarah's sister was being cared for by paternal grandparents.

Two days after the birth of Sarah her father asked for mother and baby to be allowed home and stated he did not want any carers. The safeguarding team made a Child in Need referral to CSC and asked Sarah's mother about domestic abuse, but she declined to talk about it. A referral was also made to the specialist nurse for learning disabilities. It was unknown by professionals at this time that Sarah's parents had asked paternal grandparents to take Baby Sarah from them and care for her in Manchester; they refused to do this as would be expected but continued to care for Sarah's sister.

<u>Learning Point</u> – Two days after the birth of Sarah there was no referral to either CSC or ASC. No risk assessment had been completed regarding the potential domestic abuse of Sarah's mother by her partner or the risks to Sarah. There appeared to be no discharge planning at this point. The case at this point lacked 'grip' by professionals who could and should have had a robust plan in place to provide protection and support.

Later the same day Sarah's mother agreed to the referral to adult's social care, regarding a carer, and the midwifery team also considered a discussion with the hospital adult safeguarding team. The following day a referral was made to CSC. The referral is detailed. A social worker was allocated and attempted to make contact with the hospital. Despite several attempts this was unsuccessful and eventually the social worker made contact with the health visitor. The health visitor stated that she had never met the family and although she had attempted to visit on a number of occasions the family were *"never in"*. The social worker reports the following in her response to the referral: "*[health visitor] stated that there are no safeguarding concerns raised other than the third party report from maternal grandmother that there was DV in the relationship. I advised that mother's health needs needed to be assessed by Adult Social Care as there was nothing to suggest mother was meeting needs and nothing to suggest that father, could not meet his children's needs.*
I advised [health visitor] that at this time this did not meet threshold for CSC intervention."

<u>Learning point</u> – This shows poor communication between health and the social worker. The social worker made contact but only spoke to a health professional who had had no contact with the family. The social worker correctly identified that Sarah's mother needed to be assessed by ASC, but because she was unable to speak to the most relevant health professionals. The case should not have been closed without further work. Professionals in health and social care need to better understand structures and processes to improve information sharing and joint working.

Sarah's mother was discharged from hospital. There appears to have been no discharge plan. It is not apparent that professionals understood what support Sarah's mother was going to receive or whether she was capable of looking after her children. None of the issues raised whilst Sarah's mother had been in hospital had been resolved. In fact Sarah's father had demanded the release of Baby Sarah and her mother and was so insistent that security officers were called to the ward to calm him down.

Learning point – Information sharing was poor at this stage, no plan was in place to support Sarah's mother and her children and it was unclear whether domestic abuse issues were resolved. A complete discharge plan should have been in place, and it should have been clear who was taking responsibility to support Sarah's mother and protect her and her children. CSC and ASC should have been engaged at this stage.

Over the following three days visits were made to the family home. There was no reply on any occasion. Community midwives left cards and attempted phone calls without response. Four days after Sarah's mother and Sarah were discharged from hospital a midwife gained access to the home. This was the first visit by a medical practitioner to the family home. The midwife did not document the visit that day but was contacted by the hospital safeguarding team the following day. The midwife reported that a referral had been made to ASC but CSC had stated the case was closed to them.

However, the social worker contacted the police and asked them to conduct a Cause for Concern' visit. This was very good practice by the community midwives and social worker who did everything they could to gain access to the home. A visit was conducted by the police who were informed by Sarah's mother that there were no issues. Sarah's sister was not present at home and was being cared for by grandparents. No further action was taken by the police. The visit took place in the early evening. At 11.00pm that day an ambulance was called to the address as Sarah was unresponsive. Sarah was taken to hospital where she sadly died.

Following the death of Sarah, a joint home visit was conducted. The professionals who attended noted that the home was in poor condition stating it was; "***dirty, cluttered, untidy and chaotic***" and there were possible unsafe sleeping issues in that all of the family appeared to be sleeping in a double bed.

As a result of the injuries identified to Sarah, both Sarah's parents were arrested and a police investigation commenced.

Learning point - Sarah's mother and Sarah were discharged from hospital with no plan by professionals as to how the baby and Sarah's mother were to be supported and protected. Despite the high risk nature of the case no risk assessment was conducted. There were clear risks that Sarah may be at risk of suffering significant harm, but no strategy meeting took place and CSC were not engaged with the family. There were clear issues around information sharing. No agency took the lead and no escalation took place when concerns by some professionals were ignored. Systems designed to protect children and vulnerable adults were not used by professionals.

3. Key Themes

3.1 The application of pre-birth protocols

In this case a significant level of support had been provided to Sarah's parents. This included a significant Early Help package. Professionals had identified that the mental and physical issues facing Sarah's mother and the mental health issues facing her father would cause potential difficulties in the care of Sarah. This care package remained in place until Sarah's parents disengaged.

When the family moved to Lancashire their records were transferred but there was some confusion regarding where the family were living. On initial booking a number of standard assessments were not completed and GM1 made allegations regarding domestic abuse. This prompted the use of an 'Orange Alert' form to raise the profile of the case and ensure that information was properly shared.

As Sarah's mother progressed through the pregnancy she missed appointments on a regular basis, and these were not followed up. By July 2017 there had been no home visits and limited understanding by professionals of Sarah's mother and the level of competence she had to care for two babies.

By June 2017 professionals should have understood the risks to this family. Whilst reports about the first pregnancy and birth in Greater Manchester had been largely positive, professionals had assessed the risks and needs of the family and as a result put in place a comprehensive Early Help programme.

On arrival in Lancashire a social needs assessment and a psychological assessment should have been conducted. These documents would have alerted professionals to the apparent needs of this family. Some professionals did understand that there were risks associated with the family and raised an 'Orange Alert'. It is unclear what effect this had.

In May 2017 when Sarah's mother was five months pregnant the following facts were known: Sarah's mother had cerebral palsy, epilepsy, mild learning difficulties and was autistic. Sarah's mother had previously suffered from mental health issues. Sarah's father had been a cannabis user and had alcohol issues and been treated on numerous occasions for depression and mental health issues. GM1 had made allegations on several occasions that Sarah's mother was subjected to domestic abuse. During her first pregnancy, and following the birth of her first baby, the family had required significant Early Help support. In addition, it was unclear what the position was regarding housing and the permanency of their future arrangements.

There were factors that mitigated the apparent risks. Most notably that professionals in Greater Manchester were positive about the relationship between Sarah's mother and her baby. There had been no reports suggesting that Sarah was at risk of physical abuse and formal child protection procedures had never been considered.

Lancashire Safeguarding Children Board agreed a new pre-birth protocol in March 2017[4]. This built on a previous protocol published in October 2012. This document clearly and simply lays out for professionals the path to be followed where there are concerns about a family prior to the birth of a child.

The concerns and circumstances for Sarah and family met the criteria of several examples within the Pre-Birth Protocol where a pre-birth assessment should have been considered. The protocol lists 34 risk factors that might initiate a multi-agency response and 13 of those factors applied in this case. The document also lists protective factors that would mitigate the risk. There are 25 mitigating factors listed of which only 2 would have applied in this case.

No consideration was given to the use of pre-birth processes, despite all the known issues.

If a pre-birth assessment process had been commenced a meeting of all professionals involved would have been convened enabling the sharing of information and risks. Unfortunately, the pre-birth assessment process for Sarah was not instigated and consequently the multi-disciplinary assessment and planning did not take place.

3.2 Support for mothers with disabilities

Sarah's mother suffered from cerebral palsy, epilepsy and had a mild learning disability and autism. There appears to have been no consideration given to her special needs during her pregnancy. Following the birth of Sarah, a specialist nurse dealing with learning disabilities was available and there was consideration given to contacting that nurse. A referral was made to Children's Social Care and Adult's Social Care but the only health professional that was spoken to was a health visitor who had not had contact with the family and had not visited the family home. In fact, the referral was made by nurses at the hospital who had identified that Sarah's mother had mobility issues. The health visitor was advised that there was nothing more CSC could do and that these two professionals concluded that Sarah's parents were able to meet the needs of Sarah.

Sarah's mother received disability allowance and Sarah's father was receiving a carer's allowance. It was known that the family's housing situation was unstable, and they might be moving, but it is not clear whether there was any consideration as to the suitability of their accommodation.

A social needs assessment was not completed. That document lists pathways that health professionals should follow and if it had been completed would have led to referrals for additional support.

Sarah's mother had clear and identified disabilities and these were not properly assessed, and the correct levels of support were not offered to the family.

[4] **The protocol was updated again in November 2021 -** http://panlancashirescb.proceduresonline.com/pdfs/multi-agency_prebirth_protocol.pdf?zoom_highlight=pre+birth#search="pre%20birth

3.3 Hospital discharge procedures

Sarah's mother and Sarah were discharged from hospital with no plan by professionals as to how the baby and Sarah's mother were to be supported and protected. Despite the high risk nature of the case no risk assessment was conducted. There were clear risks to Sarah but no strategy meeting took place and CSC were not engaged with the family. There were clear issues around information sharing. No agency took the lead, and no escalation took place when concerns by some professionals were ignored. Systems designed to protect children and vulnerable adults were not used by professionals.

3.4 Information sharing

There are numerous examples throughout this case of failures in information sharing. Whilst the transfer arrangements between Greater Manchester and Lancashire worked well there is little evidence that agencies worked together. As a result, hospitals, health visitors, midwives, children's social care and adult's social care acted in isolation and failed to 'join the dots'. No agency took a lead to produce a picture of the family and how it was coping. Despite the warning signs and several alerts by GM1, no single agency identified the full risk posed by the parents of Sarah to her and her sister.

This case was complicated by the fact that care of the family was spread over three very different areas, but by the time Sarah was born there had been sufficient engagement to build a picture of the family. Professionals had sufficient information to determine whether the parents could cope with a second child joining the family unit, and what support they would need to do this effectively.

4. Summary

This case involved a family who had numerous issues that meant they required considerable support from a range of agencies. The parents of Sarah were assessed on several occasions and support was put in place. In fact, there was considerable help made available to the couple and their first child, although their use of this support was sporadic.

GM1 made at least four direct complaints to the police and children's social care about Sarah's father and allegations of domestic abuse. On one occasion her concerns were supported by evidence. On each occasion professionals responded and visited the family. On no occasion could they substantiate allegations made by GM1 and Sarah's mother refuted the allegations and made no complaints herself. GM1 did not make any allegations regarding any risks to the children and confined her complaints to the controlling behaviours and threats made by Sarah's father. Professionals responded to each concern raised by GM1. Whilst professionals did not appear to have sufficient evidence to act on these complaints at the time they were made they should have, taken together, been sufficient to raise the profile of this case in the eyes of safeguarding professionals. In fact, only once did these complaints result in action (the raising of an 'orange alert') by professionals.

This review has demonstrated that professionals need to radically improve their information sharing. This review has also demonstrated that professionals acted in isolation or without vital pieces of information. In particular, the various alerts raised about the family tended to be dealt with in isolation and as a result professionals failed to coordinate their response and provide all the support that was required.

Pre-birth protocols need to be strictly adhered to and more work needs to be undertaken to ensure professionals understand the needs of a new mother suffering with disabilities. In this case Sarah and her mother left hospital without an effective and holistic plan in place, and the professionals failed to ensure that the correct level of support was in place prior to Sarah's discharge from hospital to enable her to look after her children given her disabilities.

This case has highlighted several areas for improvement. They are;

- Information sharing
- Use of escalation procedures
- Understanding transfer arrangements for pregnant mothers from one district to another
- The use and understanding of pre-birth protocols
- The use of discharge plans for new mothers
- Understanding leadership and case management by front line professionals
- Understanding the needs of new mothers who have disabilities
- Professional understanding of referral processes
- Professional understanding of the use of child protection processes
- Professionals' ability to 'join the dots' by working closely with other safeguarding professionals and agencies

Professionals did not have any clear evidence that Sarah and her sister were at risk of physical abuse by their parents. Interaction between Sarah's older sister and parents had always been viewed as positive by professionals. Parents had successfully hidden from professionals their inability to care for Sarah's sister and that paternal grandparents had filled the gaps in parenting. GM1 made several complaints about the controlling nature of Sarah's father but did not suggest he was violent towards Sarah's mother or sister.

If safeguarding procedures had been followed, and professionals had shared information, there could have been a better programme of support in place for the family. Child protection procedures may have been put in place.

Professionals could not have foreseen that Sarah was at risk of her parents allowing or causing her death. The responsibility for the death of Sarah lies with her parents.

5. Recommendations

Given the protracted nature of this case agencies have already undertaken work to resolve issues raised in this review. There is only one recommendation.

Recommendation 1:

The Children's Safeguarding Assurance Partnership should ensure that the learning points raised in this review are subject to a SMART action plan.