Milton Keynes Safeguarding Board
Thematic Learning Review

August 2017

1. Introduction

1.1 This report sets out the learning arising from a thematic learning review commissioned by Milton Keynes Safeguarding Children Board (MKSCB) in the autumn of 2016. The review was commissioned because of a number (3) of child deaths, all sudden unexpected deaths in infancy (formerly known as cot deaths) which occurred over several months and which had some common features, including the fact that the parents were all young parents.

1.2 All three deaths were unique personal tragedies for the families concerned. There is no question or evidence of fault or responsibility for the deaths, all of which were totally unexpected. However, given the apparent similarities between them, MKSCB decided it was important to see whether there was anything in relation to the services provided to those families which could be improved upon for similar families in the future. The Board also agreed to publish the learning in the interests of transparency and accountability. The review has maintained strict anonymity for the families involved who have the right to have their privacy protected.

1.3 The review was not an inquiry or formal multi-agency serious case review. There was no evidence that neglect or abuse contributed to the deaths or that agencies did not work well together. On the contrary, there was a lot of communication between the various NHS, Local Authority and voluntary sector services about how best to support the babies and their families. Undertaking the review was a shared Board decision rather than a compulsory requirement.

1.4 The review identified that there was much that was done well, with some significant examples of good practice. As always, when something is examined retrospectively there are also things that can be learned to help every service involved to improve their practice. Nothing from the review could have prevented what are essentially deaths with no identifiable cause but it may ensure babies born to similar families get an improved service in the future.

2. Summary and recommendations

2.1 The review identified that there were five themes arising from the review. These were:

- The way vulnerability and need are assessed by services involved with families who are doing their very best to bring up their children well
- The way agencies communicate and share information on a multi-agency basis
- How leadership and responsibility is exercised when there are multiple organisations involved with a family
- Working with young parents who have been in the care system at some point in their lives
- Housing for young people

2.2 The themes that were identified were thoroughly explored and the learning considered. The recommendations made by the Board's review panel on receipt of the learning from the review workshop are designed to apply the learning most effectively and create service changes for the better. The recommendations are that:

- A multi-agency task group needs to be established jointly with the health and wellbeing board (in line with the Annual Public Health Report) to improve outcomes for the children of young people through the development of early intervention services, with clear access routes to multi-agency support and provision
- Work needs to be done to redesign the current approach to early help assessments (the Common Assessment Framework – CAF) so that agencies feel confident and skilled enough to use the assessment tools provided to support their practice
- The local integrated framework for coordinating service provision for young parents needs to be redesigned with new shared common multi-agency tools for supporting them
- A new protocol for information sharing on a multi-agency basis needs to be designed by the Safeguarding Board, to ensure assessments, vulnerabilities and risk factors are shared in a timely and effective way
- Housing Services to agree that all vulnerable parents under 20 with children under 2 will be prioritised and provided with housing support in Milton Keynes rather than outside the city

2.3 Work has already begun to implement all the recommendations.

3. Scope and methodology

3.1 The scope of the review was to look at the assessment processes used by public sector agencies for young parents and their children, review the way services

identify, manage and respond to risk for young parents and review the way criteria for access to services and thresholds for intervention are understood and used. Two other areas to be reviewed were (1) the co-ordination of Early Help support and how it is used to support families, and (2) housing availability.

3.2 The cases had a number of commonalities between them. All the parents involved were under 20, all the deaths were attributed to Sudden Unexpected Death in Infancy (SUDI) and there were some medical complications in two of the three cases. None of the commonalities were causal factors in relation to the deaths of the children.

3.3 All the parents were smokers, and there were some issues in relation to the use of drugs and alcohol, and the existence of domestic violence. The parents all had had their own challenges as children. All the families had housing problems, with frequent moves for a variety of understandable reasons, and all were placed in accommodation out of the area. They all experienced some difficulties feeding their babies and co-sleeping was also present in all three. There were also issues in relation to mental health and involvement from young people's mental health services, and all had contact with the NHS, through various universal as well as more specialist services, with the police and with a range of services in the local authority.

3.4 None of the babies' families were identified as families which required statutory safeguarding services or which raised child protection concerns in relation to the babies.

3.5 Each mother had expressed concerns about their ability to cope as parents, their isolation and lack of local support networks due to them being provided with accommodation outside Milton Keynes, compounded by the need to organise support from Milton Keynes through organisations in other local authority areas.

3.6 In looking at the cases initially there were clearly some issues to explore in relation to timely information sharing, the timing and robustness of assessments, the nature of multi-agency planning and delays in assessing specific areas of concern.

3.7 The review took into account the extensive research and evidence available in relation to young parents, and their capacity to parent well. There is extensive evidence of the impact of and the use of drugs and alcohol during and after pregnancy. Many young parents manage extremely well, but young parents are also

more likely than the majority of parents to experience educational problems, poor health and diet, poor housing, or involvement in a range of issues such as crime, drugs, alcohol, mental health problems, abuse and domestic violence and relationship breakdown. The Annual Public Health Report presented to the Milton Keynes Health and Wellbeing Board on the 5th April 2017 sets out some of the key data in relation to these issues.

3.8 The process for undertaking the review consisted of:

- A review of case material submitted to the review group (There was no additional access to individual agency files)
- Interviews with key stakeholders in agencies (23)
- Discussion with a group of young parents
- Learning and planning from a reflective multi-agency workshop held on 23 November, 2016. Workshop groups considered a series of challenge questions, concerns and possible solutions around multi-agency assessments, prioritising housing, communication and working together to support improvements in services for young parents
- Incorporation of the learning from the interviews, discussions, case material and reflective workshop into a detailed presentation addressing a multi-agency approach to supporting young parents
- Identifying recommendations
- MKSCB then began to implement the learning
- The preparation of a report for publication

4. Learning from the review

4.1 Theme 1 – Assessments of need, risk and vulnerability

The review established that each agency had a range of assessment tools, some of which were evidence based authorised assessment and intervention tools. They also had specific services which were directed towards meeting the needs of vulnerable parents, including young parents. Some had specific multi-agency or multi-disciplinary services. The Family Nurse Partnership was required to follow strict national guidance, tools and materials. Child and Adolescent Mental Health Services treated teenage referrals as urgent same day cases, and undertook robust holistic two to four day assessments of the parent's needs (but not of their parenting capacity per se). Housing services assessments were assessments of housing need but not parenting capacity.

The MKSCB Levels of Need Framework was well-known and applied by all agencies and referenced as necessary. Whilst all agencies understood the principles of early help and support and recognised they were using tools to support early help they were less clear about the processes to follow to create coordinated "packages" of support, or who should take the lead in doing this. In addition they were all working to different assessment tools and criteria for access to services.

Overall, the view was that the current common assessment framework (CAF) tools do not facilitate a full multi-agency integrated assessment of a family's need for coordinated early help and support or support the actions required to provide the services needed to provide that support.

4.2 Theme 2 - Communication and sharing information

The overall consensus is that communication in Milton Keynes between agencies works well but there is room for improvement. Health agencies, the police, social care and housing meet bi-monthly at a strategic level to address issues in relation to communication, shared understanding, and service delivery arrangements, and there are good examples of effective practice across a range of cases.

There are a range of ways in which communication can be improved including the use of professional conversations (face to face), multi-agency meetings, the use of secure e-mails, co-location of services and multi-agency teams, and access to advice from the MASH consultation service.

Overall the view was that there is no common simple framework (the "see, plan, do, review cycle") for all agencies to use when they identify a family may need extra help and support in place. Information is not always shared in a timely way and communication tends to rely on the skills of individual practitioners rather than clear set shared expectations and requirements. There was agreement that having a formal process would help set out information for both staff and parents, support joint decision making and provide clarity about who does what when, which would be an improvement for everybody.

4.3 Theme 3 - Leadership and responsibility

This related to the themes above in that, when there were a number of different agencies involved with a family, there was no clear use of the concept of a "lead professional". Because the CAF tools are viewed as unhelpful, and mostly not used unless or until there is significant enough need and risk to justify a referral to the

Multi-Agency Safeguarding Hub (MASH, the practice of identifying one individual who acts as the "lead professional" for the specific family is rarely followed.

This is coupled with inconsistent understanding of how best to commission and provide multi-agency support services across Milton Keynes rather than as individual agencies. This is particularly true for young people with significant needs of their own who are also parents.

A range of gaps in services were identified, such as the way in which floating support is provided by some forms of accommodation provision and the current complexity in terms of coordinating support when domestic violence, drugs, alcohol and mental health issues are all present . There is also a need for multi-disciplinary mental health support to be provided from easily accessible centres such as children's centres.

There is a need to develop a coordinated set of options and services for young and vulnerable families that are easy to access. A clear integrated approach to services for vulnerable young parents, with a common framework of assessment and intervention tools, and a requirement for a lead professional to coordinate services was also identified as likely to significantly improve practice and improve the impact of services on outcomes for children.

4.5 Theme 4 - Working with vulnerable young people who have been in care

The review identified that when young people have been in care themselves they often need significant additional support to parent well, but not all agencies take the young person's care history into account when assessing the needs of that young person as a parent. The degree to which that information is shared is a sensitive issue, and many young people would not want it known to other professionals such as, for example, midwives. However the degree to which the young parent's own experiences in care can impact on their parenting capacity is significant.

As a consequence of limited information sharing professionals often undertake assessments which do not take into account the consequences of having been in care (including the positive consequences as well as less so). In addition the multiplicity of assessment processes and criteria for access to services as well as risk measurement tools are all focused on different requirements and most are not robust enough to identify significant risks and significant strengths in the way care leavers can parent their own children.

4.7 Theme 5 - Housing provision and support

The current housing crisis in Milton Keynes is both well understood and difficult to address. A variety of national policies have had a significant impact on the availability of housing in Milton Keynes itself especially in relation to homelessness. Significant efforts are being made to address the challenges which are well known. What the review identified was that although there was good work being done in relation to vulnerable young adults, their needs as parents were not being well enough identified and addressed. Risks tended to be identified in terms of risks to the tenancy rather than to the impact of housing on the young people and their children. Nor did housing applications flag tenants who were under 18. The housing provider then being used for young parents was not always suitable for young people with specific additional needs and there is a lack of follow on accommodation.

5. Recommendations

5.1 Action had already been taken by all the agencies involved in the review to address issues and learning from each case as it arose. In particular there has been some effective joint work between housing and children's social care to develop a placements policy which is more child-centred in approach, and which ensures a full assessment of all the circumstances affecting a household.

5.2 The review identified a range of possible solutions to the challenges identified. These were considered and debated by the sub group overseeing the review on behalf of the MKSCB. The following recommendations were made to the Milton Keynes Safeguarding Board, which complemented the recommendations made and agreed by the Health and Wellbeing Board on receipt of the Annual Public Health Report:

- A multi-agency task group needs to be established jointly with the health and wellbeing board (in line with the Annual Public Health Report) to improve outcomes for the children of young families through the development of early intervention services, with clear access routes to multi-agency support and provision
- Work needs to be done to redesign the current approach to early help assessments (the CAF) so that agencies feel confident and skilled enough to use the assessment tools provided to support their practice
- The local integrated framework for coordinating service provision for young parents needs to be redesigned with new shared common multi-agency tools for supporting them

- A new protocol for information sharing on a multi-agency basis needs to be designed by the Safeguarding Board, to ensure assessments, vulnerabilities and risk factors are shared in a timely and effective way
- Housing Services to agree that all vulnerable parents under 20 with children under 2 will be prioritised and provided with housing support in Milton Keynes rather than outside the city

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