



**Redbridge Local Safeguarding Children Board
(LSCB)**

**BABY 'T'
SERIOUS CASE REVIEW (SCR)**

REPORT

Published 14 January 2020

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1. Introduction

1.1 On 5th October 2017 a child who will be referred to in this report as Baby T died in Great Ormond Street Hospital (GOSH), London after sustaining a head injury. The child was eleven months old. Her mother was a Vietnamese asylum seeker and she and Baby T had been placed in the London Borough of Redbridge whilst mother's asylum claim was considered by the Home Office. (Her mother was granted leave to remain in the UK in May 2019). On the day she died Baby T became unwell whilst in the care of another Vietnamese female who had applied for leave to remain in the UK and who lived in the neighbouring London Borough of Barking and Dagenham. This person, who will be referred to in this report as Female C, was convicted of the manslaughter of Baby T in July 2019 and sentenced to six years imprisonment the following month.

1.2 Redbridge Local Safeguarding Children Board (LSCB) agreed to conduct a Serious Case Review (SCR) on the grounds that Baby T had died and abuse was suspected. The progress of the SCR was delayed for a time by the need for specialist medical reports to contribute to the pathologist's report and inform the criminal investigation and Coronial proceedings.

1.3 The SCR was commissioned under the *2015 Working Together* statutory safeguarding children guidance. Since the SCR was commissioned the Children and Social Work Act 2017 has been enacted. This legislation abolished LSCBs and placed the responsibility for multi-agency safeguarding arrangements on three 'safeguarding partners' – the local authority, the police and the Clinical Commissioning Group. Locally to Redbridge, the partners have established a single set of arrangements across Barking and Dagenham, Havering and Redbridge – the BHR Safeguarding Partnership. As stated above, this SCR was commissioned, and has been completed, under the 2015 statutory guidance.

1.4 The LSCB commissioned David Mellor to be the independent reviewer for this SCR. David is a retired chief police officer and former independent chair of safeguarding children and adults boards who has seven years' experience of conducting SCRs and other statutory reviews. He has no connection to Redbridge or any of the agencies involved in this case. A SCR panel was established to oversee this review and membership of this group and a description of the process by which this SCR was carried out is shown in **Appendix A**.

1.5 An inquest into the death of Baby T will take place in due course.

1.6 The members of Redbridge LSCB wish to express heartfelt condolences to the family of Baby T and to thank her mother for her contribution to, and engagement with, the SCR.

2.0 Terms of Reference

2.1 In respect of Baby T and her mother, the SCR will consider events from October 2015, when it is understood that Baby T's mother arrived in the UK, until the death of Baby T on 5th October 2017. In respect of the carer, the SCR will consider events from August 2013, when she first arrived in the UK, until the death of Baby T.

2.2 The purpose of the SCR is to identify any lessons which can be learned about how practitioners and agencies worked together and separately in the case of Baby T.

2.3 The overall focus of the SCR is on the extent to which practitioners and agencies appreciated and sought to mitigate the potential risks to Baby T arising from being the infant child of an asylum seeker who had mental health issues, who was quite isolated, who had limited access to resources, and was liable to be moved at short notice from one part of the country to another.

2.4 At the outset it was agreed that the following issues would be particularly relevant to explore:

- Whether vulnerabilities on the part of Baby T's mother and/or Female C were identified and addressed by the relevant immigration authorities.
- The liaison, if any, between the relevant immigration authorities and health, social care, and any other relevant agencies in those areas in which mother was placed pending consideration of her asylum application; and in areas in which Female C resided after her arrival in the UK.
- The communication, if any, between agencies in different areas as mother and Female C moved from one location to another.
- The involvement of relevant health and welfare agencies, if any, with both mother and Female C, and its effectiveness.
- Whether there were any warning signs of vulnerability or risk, in relation to either or both mother and Female C, which could have been picked up but were not.

- Whether there are any indications or concerns about trafficking in relation to mother and/or Female C, and how any such indications have been responded to.
- The extent to which language, cultural and ethnic identity issues were understood and responded to in the way national and local agencies worked with mother and the carer.
- The accommodation provided for mother and Baby T in Redbridge, who else was living there, and any risks associated with those arrangements.
- Any relevant issues relating to the accommodation secured by Female C.

If appropriate, the SCR will make recommendations to both national and local agencies.

3.0 Glossary

Asylum seeker - a person who has claimed asylum under the [1951 United Nations Convention on the Status of Refugees](#) on the ground that if they are returned to their country of origin they have a well-founded fear of persecution on account of race, religion, nationality, political belief or membership of a particular social group. They remain an asylum seeker for so long as their application or any appeal against refusal of their application is pending.

Cognitive behavioural therapy (CBT) is a talking therapy that can help clients manage their problems by changing the way they think and behave. It is most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.

Immigration & Asylum Act 1999 Section 95 support to asylum seekers for people seeking asylum in the UK, who lack the means to support themselves, are entitled to support while the Home Office is processing their asylum application. This support is called Section 95 (s95) support. Asylum seekers must apply for this type of support on a specified application form and it can take several weeks for the Home Office to process this request.

Section 98 support to asylum seekers, also provided under the Immigration & Asylum Act 1999, is a form of temporary support which is provided to asylum seekers who appear to be destitute and who are awaiting a decision on their application for Section 95 asylum support. A decision on a request for Section 98 (s98) support should be made before the end of the working day on which the application is received.

Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events. Someone with PTSD often relives the traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt. They may also have problems sleeping such as insomnia and finding concentration difficult. These symptoms are often severe and persistent enough to have a significant impact on the person's day-to-day life.

Refugee is a person who has fled their country of origin and is unable or unwilling to return because of a well-founded fear of being persecuted because of their race, religion, nationality, membership of a particular social group or political opinion. An asylum seeker whose claim for asylum or subsequent appeal against initial refusal has been successful is classed as a refugee.

National Referral Mechanism (NRM) is the mechanism through which the National Crime Agency's Modern Slavery Human Trafficking Unit (MSHTU) collects data about victims of human trafficking or modern slavery and ensures that they receive the appropriate support. This information contributes to building a clearer picture about the scope of human trafficking and modern slavery in the UK.

4.0 Case summary

Baby T and her mother

4.1 On 7th June 2016 mother telephoned the Home Office to say that she wished to claim asylum in the UK. Basic details were taken from her and arrangements were made for her to attend a full screening interview at the Home Office Asylum Screening Unit (ASU) in Croydon the following day. A Vietnamese interpreter was present for this interview during which mother disclosed that she had entered the UK illegally on 27th October 2015. She also disclosed that she was four months pregnant with Baby T. She said she had met Baby T's father after her arrival in the UK and he had been supporting her since that time. She said she was living at a private flat in Hackney (address 1), adding that she felt safe there. Mother was given temporary admission to the UK and advised that she had until 22nd June 2016 to state the grounds on which she should be allowed to remain in the UK. She was advised that she would be contacted by a case worker to discuss her asylum claim (This discussion was to have taken place on 28th November 2016 but mother was unable to attend – paragraph 4.23). She was also provided with a letter advising her on how to claim financial support during her asylum claim. Mother was told to report again on 16th June 2016.

4.2 During the interview mother disclosed that she had two children aged five and three who were living with her father in her home village in Vietnam. She said that she had last seen them in 2014 and had had no contact with them since leaving Vietnam. She said that she and her husband and father-in-law had been arrested and detained in prison. She added that she had escaped after her father bribed a prison guard. She said that her husband and father-in-law had died.

4.3 Mother reported to the ASU on 16th June 2016 as directed. Thereafter her reporting frequency was changed to fortnightly and she next attended the ASU on 30th June 2016. She was next required to report to the ASU on 28th July 2016 and monthly thereafter. Mother had been noted to have a legal representative on 24th June 2016.

4.4 On 4th July 2016 Homerton University Hospital midwifery received a Hackney GP referral in respect of mother. Because the GP referral contained limited information, mother was referred to the community midwife in the first instance rather than being triaged directly to the public health midwife who case managed vulnerable pregnant women.

4.5 On 19th July 2016 mother attended a booking appointment with the community midwife who conducted an assessment which identified that she had complex social needs and was referred on to unspecified 'appropriate professionals'.

4.6 On 19th September 2016 mother was seen by the public health midwife and disclosed concerns more fully than during previous appointments. The midwife made a referral to Hackney Children's Social Care in which she stated that mother had entered the UK as an asylum seeker 'eleven months ago' after spending a year in prison in Vietnam. Mother was said to have been asked to leave her current accommodation in the UK where she was staying with a friend. (It is understood that Baby T's father left mother at this time and no longer provided financial support). A First Access Screening Team (FAST) social worker then spoke to mother and advised her to contact the National Asylum Support Service (NASS) helpline as she could be eligible for housing as an asylum seeker. Mother was further advised to 'return back' to Hackney with documentation from the Home Office if she was unable to receive support. Mother's case was then closed to Hackney children's social care on the grounds that mother was likely to be eligible for asylum support. (Hackney FAST is the equivalent of Multi-Agency Safeguarding Hubs (MASH) in other boroughs and is the single point of contact or 'front door' for children and families services.)

4.7 On 22nd September 2016 mother's requirement to report at the ASU was suspended until 26th January 2017 due to her pregnancy and monthly thereafter. It was considered that there were no safeguarding concerns as mother was said to have her own accommodation and the support of the unborn baby's father, although, unknown to the Home Office, this situation had recently changed (see previous paragraph).

4.8 On 29th September 2016 mother's midwife referred her to the Hackney Multi-Agency Team (MAT) for support with her asylum application and obtaining housing and food vouchers from the Home Office. MAT is a children's centre Multi-Agency Team meeting, attended by a virtual team of practitioners from different agencies, who work together to coordinate and monitor family intervention, in order to prevent fragmented service delivery. The MAT monitored mother's case whilst she was living in Hackney and became concerned that she was socially isolated and lacked a support network.

4.9 On 5th October 2016 mother expressed reservations about accepting Home Office asylum support as she was worried about leaving both the Vietnamese community she had been living amongst and the established relationship she had with her midwife. She also expressed concern about the possibility that she could be sent to stay anywhere in the UK. The following day the midwife visited mother in

company with an interpreter to discuss her options. They relocated to a safe space to have the conversation because mother said she felt afraid owing to the alleged inappropriate behaviour of the person who owned the property in which she was staying. Mother decided to access asylum support.

4.10 On 7th October 2016 mother was assisted by Migrant Help, which offers vulnerable migrants, including asylum seekers, advice and support to successfully apply for asylum support. At this time mother was homeless and was said to have become reliant on strangers for food and essentials. The Home Office dealt with the request for emergency accommodation quickly as mother was heavily pregnant and homeless. She was provided with initial accommodation under Section 98 of the Immigration and Asylum Act 1999. This is temporary accommodation when an asylum seeker is destitute. She was taken to emergency overnight accommodation at address 2 which is a hotel.

4.11 The following day mother was moved to a room in address 3 in Croydon which is operated by Clearsprings Ready Homes, a provider of accommodation services to the Home Office. Vietnamese interpreters and a telephone translation service were available there. Migrant Help workers are also based at the address. Mother was referred by Migrant Help workers to the Rainbow Health Centre in Croydon which is a one stop health clinic for refugees and recent migrants to the UK. It is understood that no concerns were highlighted to Clearsprings in respect of mother or her unborn child at this stage.

4.12 On 10th October 2016 the Hackney public health midwife contacted the safeguarding maternity team at Croydon University Hospital to hand over care of mother and her unborn baby. Two days later, contact took place between a Hackney health visitor and her counterpart in Croydon to advise of mother's transfer. On the same date a family support worker from Hackney MAT referred mother to Croydon Early Help service.

4.13 On 13th October 2016 mother had a new registration consultation at the Rainbow Health Centre. The specialised midwife for vulnerable and marginalised women is based within this health centre and she saw mother for a booking appointment the following day. A detailed assessment of her maternal, obstetric, social and psychological history was undertaken. It was documented that mother did not have a previous history of mental illness nor were there any current mental health concerns. Interpreting services would have been used to facilitate this assessment although it is not clear whether this was face-to-face or via Language Line.

4.14 On 18 October 2016, mother was helped by Migrant Help to apply to the Home Office for a maternity grant of £300. This was initially refused in error by the Home Office but subsequently granted (7th November 2016) after mother was supported to appeal. On the same date Croydon maternity services saw mother for booking in respect of her pregnancy.

4.15 On 20th October 2016 Croydon Early Help service referred mother to the Parent Infant Partnership (PIP) which supports attachment and child development in the first 1001 days of a child's life. The service has a therapeutic parent/infant offer, keyworker support and intensive and nurturing group work through a Mellow Parenting offer. Mellow Parenting is a charity which designs and supports the delivery of parenting programmes (see reference (1)). Mother was allocated a key worker.

4.16 On 21st October 2016 the Home Office received an application from mother for longer term asylum support (accommodation and financial) under Section 95 of the Immigration and Asylum Act 1999 and this was granted on 2nd November 2016.

4.17 On 25th October 2016 the PIP key worker began attempting to contact mother by text, using Google Translate, which proved unsuccessful. However, the receptionist at address 3 was able to assist the key worker in arranging a home visit for 31st October 2016 when the PIP key worker visited with an Early Help Best Start senior practitioner. It was identified that the focus of the work would be to support mother to prepare for the imminent birth of her baby (expected due date was 7th November 2016). Mother was noted to have limited items in preparation for the baby's arrival apart from some clothing given by the Vietnamese community in Hackney. The use of Google Translate again proved unsatisfactory and it was decided that an interpreter would to be used for all future visits. The referral of mother from Hackney had not been accompanied by an assessment and due to the relatively short time mother resided in Croydon no Early Help assessment was completed.

4.18 On 4th November 2016 the Croydon PIP key worker made a visit to mother in company with an interpreter. The focus of the work was to support mother to prepare for the birth of her baby and ensure that she could access help within the community.

4.19 On 7th November 2016 mother was admitted to the maternity ward of Croydon University Hospital in labour and she gave birth to Baby T in the early hours of the following morning by spontaneous vertex delivery (normal delivery). The baby was in good health with no concerns reported. Her weight was 3390 grams (7lb 7oz). Mother and Baby T were discharged home during the late afternoon. The discharge

address was initially documented as address 1 but later the same evening this was corrected to address 3. On the same date mother received the £300 maternity grant from the Home Office in the form of a token for her to cash in her local post office within 10 days.

4.20 During November and early December 2016 the Croydon PIP key worker made five weekly visits to mother and Baby T. An interpreter was present for two of these visits.

4.21 On 22nd November 2016 a health visitor visited mother and Baby T at address 3 for a new birth visit but was unable to complete the visit as health visiting administration had booked a Mandarin interpreter rather than a Vietnamese interpreter. (The new baby review/visit should take place between 10-14 days after birth. The Croydon health visitor made the uncompleted new birth visit on the fourteenth day after Baby T's birth).

4.22 On 23rd November 2016 the health visitor had a chance meeting with mother at address 3 whilst seeing another client. Mother had left Baby T on the edge of a bed whilst she was sorting washing in a hallway. The health visitor requested the staff at address 3 to supply mother with a Moses basket as soon as possible. Clearsprings has advised this review that baby items such cot/Moses basket, feeding bottles, sterilizer, baby wipes, nappy bags, nappies and baby formula are supplied on the birth of the child. It is not known why mother has not previously been supplied with a Moses basket. Mother was advised not to leave the baby unattended unless in a Moses basket. A Vietnamese guide to co-sleeping and video were provided to mother.

4.23 On 28th November 2016 mother did not attend an asylum interview with the Home Office as she and Baby T were unwell.

4.24 On 29th November 2016 the health visitor was able to achieve the new birth visit with the assistance of a Vietnamese interpreter. A strengths and needs assessment was completed but from subsequent examination of the responses it appears that the questions and/or answers may not have been adequately interpreted as for example mother is recorded as saying that she was not isolated and had a stable family environment. Mother disclosed a previous history of postnatal depression with her two previous children which was reported to have been self-managed which was inconsistent with an earlier assessment (paragraph 4.13).

4.25 The 'Universal Plus' health visiting service was to be provided to mother and Baby T 'due to (unspecified) accommodation issues'. The health visiting service in England provides three levels of service as follows (2):

- *Universal*: health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- *Universal Plus*: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- *Universal Partnership Plus*: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or additional concerns such as safeguarding, domestic abuse and mental health problems.

Standard practice for 'Universal Plus' should have been another visit at six weeks postnatal but this did not occur and there was no further contact between the Croydon health visitor and mother and Baby T.

4.26 On 7th December 2016 the Home Office wrote to mother to advise that they had been unable to make a decision on her asylum claim within the six months since her original claim. The delay in determining mother's asylum claim was attributed to her having recently given birth. The Home Office were to review her case in three months. Mother took the Home Office letter to Migrant Help which referred her to a law centre where a solicitor obtained a more detailed account of her life in Vietnam, which was shared with her Croydon PIP key worker. Mother disclosed to the solicitor that she had been persecuted because she practiced the Hoa Hao Buddhism religion. She said she had been arrested in 2014 for distributing leaflets promoting the Hoa Hoa faith with her husband. She said that her husband had been tortured by the authorities which had caused his death. Mother disclosed that she had been beaten and instructed to work in the fields. She had also been imprisoned. Mother said that after her husband died, her parents were worried about her safety and her father made arrangements for her to flee Vietnam (bribed the authorities to enable her to get out of prison). It was not considered safe for her children to accompany her out of Vietnam.

4.27 She had travelled via Laos then a flight to France before entering the UK on a lorry. She had met a Vietnamese woman who had let her stay with her and the woman's sister from October until December 2015. She then met a man, described as an agent, who had taken her to Hackney where she met the father of her child. She said that he had been kind to her and provided her with accommodation and

financial and 'moral' support. He had assisted her to claim asylum but later left her. Mother said she had tried to contact him but was unable to get through to him. She did not know why he had left her. Mother said she had delayed claiming asylum because she had been under the control of the agent. She said that she continued to practice her religion although the lack of a temple meant that she could only practice at home. She said that she could not return to Vietnam as she believed that she would be ill-treated and persecuted.

4.28 The Home Office Country Policy and Information Note on Vietnam: Ethnic and religious groups (March 2018) states that Hoa Hoa Buddhism is one of 14 religions which hold full government recognition in Vietnam but many followers refuse to join the government sanctioned Hoa Hoa organisation. Unregistered Hoa Hoa groups are monitored and harassed by the authorities and leaders have been sentenced to lengthy terms of imprisonment (3).

4.29 On 9th December 2016 the Croydon PIP key worker made a weekly visit to mother and Baby T (no interpreter). The PIP key worker found that mother had left Baby T in her room with a male neighbour whilst she went to get breakfast. The key worker advised mother that it was dangerous to leave her baby with a stranger. ClearSprings have advised this review that they were not informed of this concern.

4.30 On 12th December 2016, mother told Migrant Help that she had received a letter from the Home Office advising that she was to be dispersed to West Drayton in the London Borough of Hillingdon on 19 December 2016 to access her longer term accommodation and financial support under Section 95 (paragraph 4.16). Migrant Help gave mother a 'dispersal briefing' but the move was cancelled as Home Office policy was not to disperse a mother and baby before the baby is six weeks old. Baby T would have been one day short of six weeks old on 19th December 2016.

4.31 However, the Home Office decided to disperse mother and Baby T to Cardiff on the same date (19th December 2016). This was not intended to be a permanent dispersal. There was a shortage of bed space in London and so it was decided to move mother and Baby T to Cardiff temporarily until permanent accommodation could be sourced nearer to London. The Home Office Healthcare Needs and Pregnancy Dispersal Policy states that 'for the purposes of this policy, the late stages of pregnancy will be defined as normally running from six weeks before the estimated date of delivery until a clinician has signed off on the postnatal checks. The latter will usually be around six weeks after birth, unless there have been complications'. Therefore, mother and Baby T were moved a day earlier than stated by policy although it is unclear why the move to Hillingdon was postponed and the move to Cardiff approved.

4.32 On 15th and 16th December 2016 the Croydon PIP key worker made visits to mother and Baby T in company with an interpreter prior to their forthcoming relocation to Cardiff. During the period in which she supported mother and Baby T, the key worker carried out the following work:

- Helped mother prepare for the baby's birth by sourcing a moses basket, baby bath, a range of clothing, toys and a buggy;
- Liaised with the Salvation Army who donated items such as breast pads, clothes for mother, and toiletries;
- Collected food from food bank and delivered this to the family;
- Delivered donated Christmas gifts from local charity;
- Referred the family to a Croydon solicitors which specialises in Legal Aid immigration services, and attended appointments with mother;
- Liaised with other professionals including health visitor, interpreter, solicitor, local charities and temporary accommodation receptionist;
- Provided mother with advice on co-sleeping;
- Provided information about baby clinic and ESOL (English for Speakers Of another Language) classes; and
- Supported mother at her meetings with Migrant Help, a charity supporting asylum seekers, refugees and victims of human trafficking and modern slavery.

4.33 On 19th December 2016 mother and Baby T were moved to address 4 in Cardiff where they stayed until 4th January 2017 before being moved to address 5 in Cardiff which is around twelve minute's walk away from address 4. These addresses were linked to Cardiff Section 98 initial accommodation. Mother's Croydon PIP key worker contacted Cardiff Social Care to inform them that mother and Baby T had moved to their area and the following day completed a multi-agency referral form to enable the family to continue receiving support.

4.34 On 21st December 2016 mother took Baby T to a Cardiff GP practice as she was concerned that the child had an eye problem. Baby T was examined and found to be well. Mother said that Baby T had not yet had a BCG vaccination (for TB) and an appointment for this was to be arranged. (BCG appointments were arranged for April and May 2017 which mother did not attend as she had left Cardiff by that time.)

4.35 The following day the Cardiff MASH received the referral from Croydon which raised a number of concerns about mother and Baby T including mother's vulnerability, isolation, loss experienced in Vietnam which she had fled for fear of her life, lack of English, very limited resources and need for support and guidance in caring for Baby T. Reference was made to her following a traditional Vietnamese

approach to parenting including co-sleeping. The MASH noted that mother had been allocated a health visitor, as a result of a referral from Clearsprings, which was also the provider of mother and Baby T's initial accommodation in Cardiff. The MASH health safeguarding nurse advisor contacted the health visitor to advise that mother may need additional support and to make a further referral to children's social care if any safeguarding children concerns arose. The case was then closed to Cardiff Children's Services.

4.36 On 6th January 2017 mother and Baby T attended a clinic for routine eight week health screening and immunisations. Baby T appeared healthy and no concerns were apparent. The level of health visitor service provided to mother and Baby T in Cardiff was the 'universal' Healthy Child Wales Programme. As with health visiting in England, there are three levels of health visitor service which are 'universal' – the core minimum intervention offered to all families, regardless of need, 'enhanced' – additional interventions based on the assessment and analysis of resilience and identification of additional need and 'intensive' – further interventions, built upon ongoing assessment and analysis of greater need.

4.37 On 12th January 2017 Cardiff and Vale University Health Board requested health visitor records for mother and Baby T from Croydon Health Services but these were not transferred to Cardiff until 10th February 2017, by which time mother and Baby T had left.

4.38 On 13 January 2017, Migrant Help spoke to mother's PIP key worker in Croydon and referred her to Oasis, a charity which helps refugees and asylum seekers in Cardiff, and the Welsh Refugee Council.

4.39 On 18th January 2017 mother and Baby T were permanently dispersed to address 6 in Ilford in the London Borough of Redbridge which is a large 8 bedroom property allocated to mothers and children and operated by Clearsprings. On arrival, mother was provided with a starter pack, kitchen pack, cleaning pack and baby pack. Migrant Help continued to offer support to mother which was mostly liaison with the Home Office. Their last contact with mother was on 16th May 2017 to resolve an issue relating to her financial support. In her contribution to this review, mother said that there were four mothers and their children sharing in address 6 (paragraph 5.15).

4.40 On 2nd February 2017 mother presented at Ilford Medical Centre and was given a new patient questionnaire to complete in respect of herself and Baby T. The questionnaire was in English but mother was able to obtain informal interpreting assistance and return the completed questionnaire a few days later. She provided

details of her previous GP practice in Croydon from which her medical records, and those of Baby T, were obtained on 9th and 3rd March 2017 respectively.

4.41 On 6th February 2017 mother contacted her Croydon PIP key worker to tell her that she and Baby T had moved to the London Borough of Barking and Dagenham. Her key worker asked for her new address and identified that it was actually in Redbridge. The key worker then contacted Redbridge Homestart and completed an Early Intervention Panel referral form in respect of mother and Baby T.

4.42 On 8th February 2017 mother saw a practice nurse at Ilford Medical Centre for a new patient assessment. No interpreter was present. Nothing of note was said to have been recorded including 'no family history'.

4.43 On 15th February 2017 the referral made by the Croydon PIP key worker was discussed by the Redbridge Early Intervention Panel, which considers and co-ordinates all requests for early intervention and agrees relevant support and intervention for the child and their family through multi-agency discussion and decision making. The referral stated that mother was a Vietnamese asylum seeker who was described as 'very isolated and vulnerable' and was allocated to an Early Intervention family support worker to complete a Common Assessment Framework (CAF) and Neglect Toolkits, liaise with the Home Office to ascertain mother's legal status, make contact with Baby T's health visitor and, if any trafficking concerns emerged, these were to be heard at an Early Intervention Threshold meeting. (Weekly threshold meetings decide whether escalation of cases to statutory services is required). On the same date mother and Baby T attended the Ilford Medical Centre. Baby T was examined and there were no concerns.

4.44 On 17th February 2017 the Early Intervention family support worker made a home visit to mother, during which Baby T was seen. A CAF was completed which included an action plan which was agreed with mother. It is not known if an interpreter was used. The plan included booking an appointment with a GP practice, registering with a dentist, contacting the Salvation Army to obtain new clothes and essential baby items, attending a children's centre with the baby where mother would also be able to access English for Speakers of Other Languages (ESOL) classes, obtain emotional support by attending a social group and/or seeing a counsellor, reviewing her expenditure by completing a financial assessment and seeking clarity in respect of legal status. Mother would be supported to complete the action plan with the assistance of the family support worker using an interpreter.

4.45 On 20th February 2017 the family support worker contacted NELFT (NELFT was previously the North East London NHS Foundation Trust but when the Trust expanded beyond North East London it was decided that the organisation would be

referred to only as NELFT) to advise that mother and Baby T had moved to Ilford from Croydon. NELFT was advised that mother spoke no English and that her spoken language was Vietnamese. A community nursery nurse carried out an opportunistic home visit the following day. No interpreter had been booked and so the nurse spoke to her with the assistance of another tenant who was able to interpret. The tenant shared her telephone details with the community nursery nurse and agreed to be the point of contact with mother. Mother and Baby T were allocated to a health visitor in order to complete a 'transfer in' with the assistance of a Vietnamese interpreter.

4.46 On 24th February 2017 the Children's Centre family support worker visited mother and Baby T for the first time and helped them register with a local dentist, accompanied them to the Children's Centre and explained what support would be available to her and the child at the centre.

4.47 On 8th March 2017 the health visitor made the 'transfer-in' contact with mother. A Vietnamese interpreter had been booked for this home visit but Language Shop, an agency used by NELFT to book interpreters, had advised that no interpreter was available the day before the home visit. The tenant interpreted once more. Mother reported that Baby T was her 'first child'. No concerns were reported and the health visitor decided that mother and Baby T would receive the 'universal' health visiting service.

4.48 On 21st March 2017 the Early Intervention family support worker reported that mother had not attended any sessions at the Children's Centre with Baby T after being shown the facility and signposted to relevant sessions. It was decided that the Children's Centre family support worker would accompany mother to sessions and would help to facilitate mother attending ESOL classes. The Children's Centre family support worker visited mother and Baby T on 4th April 2017 to encourage her to attend sessions at the Centre, providing a new timetable of activities and a food voucher.

4.49 On 5th April 2017 mother and Baby T attended a clinic for a follow up weight review. Mother was late for the appointment and so the booked Vietnamese interpreter had left prior to her arrival. This appointment is not part of the health visiting 'universal' offer but the health visitor had arranged it to gather further information given the previous interactions without an interpreter. The appointment continued without the interpreter and mother disclosed unspecified emotional wellbeing difficulties which resulted in the health visitor referring her to the improving access to psychological therapies (IAPT) service. IAPT is a primary care psychological therapies service, providing evidence-based treatments for people with depression and anxiety disorders with no comorbidity and complexity.

4.50 On 12th April 2017 the health visitors IAPT referral for mother was received and a face to face triage meeting was arranged and an interpreter booked. A half hour triage appointment is offered in order to identify the main problem and consider whether IAPT can help, to assess risk and to identify if it is safe to treat the patient within the service or if it is required a step up to secondary care.

4.51 On 27th April 2017 mother and Baby T visited the Children's Centre. She was very distressed as the debit card on which her asylum support allowance was loaded had been 'swallowed up' by the ATM. Mother said that she could not understand the information displayed on the ATM screen and must have pressed the wrong button. Both the Children's Centre family support worker and the Early Intervention family support worker were present along with an interpreter. The interpreter made telephone calls to arrange for a replacement debit card to be sent to mother within 3-5 days. Mother was also provided with a food voucher but the Ilford food bank was not open again until Saturday 29th April 2017 (this was two days away). A Children's Centre manager agreed that money from the Centre's 'tea and coffee jar' could be used to buy mother some food to tide her over until the food bank reopened. The health visitor was present and she checked Baby T and said she was a little concerned about the child's weight as she was gaining weight only slowly. She made a further appointment to see mother and Baby T. Because mother had been so distressed, it was decided to postpone the first team around the child (TAC) meeting which had been arranged to take place later the same day. The TAC involves relevant agencies working with the child and family to address unmet needs. Whilst at the Children's Centre mother asked to be linked into counselling as she said she was starting to have nightmares. The health visitor advised colleagues that she had referred mother to IAPT.

4.52 On 16th May 2017 the IAPT triage assessment was completed to ascertain mother's current mental health difficulties and suitability for treatment by primary care. A risk assessment and crisis plan was completed. The risk assessment identified 'risk to self' as mother was said to frequently have thoughts that life was 'not worth living'. Mother was said to have no plans or intentions of suicide or self-harm. An IAPT professional discussion took place the following day at which it was decided that mother met the criteria for Post-Traumatic Stress Disorder (PTSD) and she was allocated as a priority due to her clinical presentation and the fact that she had a six month old baby. She was allocated to the IAPT Step 3 (one to one cognitive behavioural therapy (CBT)) waiting list. The then target for clients to be allocated a therapist for CBT was 16 weeks.

4.53 Also on 16th May 2017 the rescheduled TAC meeting took place. Mother, Baby T and an interpreter were present. During the meeting it was agreed by all

attendees that the Early Intervention and Family Support Service (EI & FSS) would close their involvement with the case and hand over to the Children's Centre family support worker, who was in attendance, to carry out the outstanding actions from the CAF. The outstanding actions were supporting engagement with ESOL, supporting attendance at a social group, completion of a financial assessment (although it had been noted that, as an asylum seeker, mother was in receipt of £70 per week) and contact with Home Office and mother's solicitor. Mother's IAPT referral was noted to be outstanding although it actually took place on the same date. Two Neglect Toolkits had been completed, neither of which indicated any concerns.

4.54 The Children's Centre family support worker continued to support mother and Baby T for a time and on 5th June 2017 provided mother with a letter to take to the Salvation Army 'baby bank' which consists of a collection of good quality second hand baby clothes and equipment available free of charge to help with the costs of having a baby.

4.55 On 25th June 2017 mother took Baby T to Queen's Hospital (part of the Barking, Havering and Redbridge University Hospitals Trust (BHRUT)) ED by private transport. Mother was accompanied by a friend who acted as an interpreter. The identity and gender of the friend were not recorded. Baby T's symptoms were described by mother as vomiting for one day after feeds, high temperature, abdominal pain and reduced appetite. After being examined by a paediatric consultant, Baby T was diagnosed with viral gastroenteritis, prescribed medication and later discharged home. The child protection information sharing system was checked and no alerts were found in respect of baby T. No safeguarding concerns were identified as a result of completion of the ED safeguarding screening tool. Discharge information included verbal advice and a gastroenteritis information leaflet (in English). A routine discharge letter was sent to Baby T's GP practice.

4.56 On the same date (presumably prior to attending Queen's Hospital ED), mother took Baby T to the Barking Community Hospital walk-in centre (managed by NELFT) with vomiting. The latter location is around 5 miles from Queen's Hospital. Mother left the walk-in centre before being seen by the streaming nurse and advanced nurse practitioner. A paediatric information sharing form was sent to Baby T's health visiting team which was recorded as received and allocated to mother's health visitor on 4th July 2017. These forms are sent by post and then placed for an allocations meeting before being allocated to the appropriate health visitor for any action required. There was no recorded follow up and no upload of the document onto the EPR (Electronic Patient Record).

4.57 On 5th July 2017 a Children's Centre family support worker wrote to the Early Intervention family support worker to advise that they had closed mother and baby T's file. By this time the Children's Centre family support worker who had previously been supporting mother and Baby T had left the service. Mother's contact with the Children's Centre thereafter was limited to one visit, on 19th July 2017, to attend a support session.

4.58 On 12th July 2017 mother took Baby T to Ilford Medical Centre as the child had been ill with a fever since the previous day. After examining the child, nasal drops were prescribed. Two small blanching spots (disappear when pressed) were noted on the baby's abdomen. As this was an unplanned GP appointment, no interpreter had been booked and the GP attempted to use google translate. Patients who require an interpreter are asked to bring a friend to interpret if they make an emergency, as opposed to a planned, appointment.

4.59 On 14th July 2017 mother telephoned IAPT to ask about the waiting time for therapy. A message was passed to the IAPT service manager but mother received no response to her query. As previously stated the then target time for allocation to a CBT therapist was 16 weeks and 9 weeks had elapsed since mother's triage appointment.

4.60 On 17th July 2017 mother took Baby T to the Ilford Medical Centre. The baby had been coughing frequently. With the assistance of an interpreter the GP discussed symptoms of viral illness and asked mother to keep a diary of the baby's symptoms for two weeks and return to the GP with it. Mother enquired about the BCG vaccine for Baby T. She had previously been given a helpline number to ring but had been unable to use this without an interpreter. The GP contacted the health visitor who advised that Baby T was in a BCG backlog. Mother went on to disclose difficulty in sleeping and experiencing nightmares in which someone was chasing her. She said she had been prescribed medication by a GP in Cardiff which had helped her to sleep but had caused drowsiness, headaches, nausea and dizziness so she had stopped taking them. She also said she had had postnatal depression. She said she had seen IAPT eight weeks earlier for an initial assessment but had had no contact since then (paragraph 4.51). She said she wanted to die, adding that she had been having thoughts of wanting to step into the traffic. She said she lacked support from relatives or friends. She said she hadn't heard from the Home Office for a year and she didn't feel her lawyer was actively seeking an update on her claim for asylum because of difficulties in obtaining legal aid. The GP referred mother to the Redbridge Access, Assessment & Brief Intervention Team (RAABIT). (RAABIT is a first point of entry for mental health services for adults aged 18-65 in Redbridge and provides an initial mental health assessment and referral or signposting to other organisations or services. If appropriate the service can offer medical review and/or

brief mental health intervention for up to one year. This may include key-working or psych educational groups, support worker input and liaison with other services such as secondary psychology). During the conversation the GP documented that mother had a social worker 'who came once but never came back again'. On this basis the GP made an incorrect assumption that mother and Baby T were already known to children's social care and, as a result, decided not to refer mother and Baby T to children's services.

4.61 RAABIT was telephoned by the GP on the same date. The GP stated that mother had a history of post-natal depression, difficulties sleeping and suicidal ideation. Baby T was recorded to be a 'protective factor'. Mother was awaiting treatment from IAPT. The GP had recorded that mother had a social worker 'when the baby was born' but there was uncertainty over whether there was continuing social worker involvement. The referral was processed as urgent and an assessment arranged within 48 hours. A Vietnamese interpreter was booked and a female interpreter was requested. The GP was to send over the completed referral form.

4.62 On 19th July 2017 mother was assessed by RAABIT with the assistance of a male interpreter. She presented with low mood, feelings of hopelessness and poor appetite. Her cognition appeared intact. It was documented that the impression gained was that mother was suffering from post-natal depression, although she also disclosed trauma arising from rape and imprisonment in Vietnam. She expressed suicidal thoughts but denied any attempt to act on these or harm her baby. She discussed her ongoing immigration issues and said that her future aim was to get these issues 'sorted out' so that she could work in order to provide for herself and her baby.

4.63 The outcome of the assessment was that mother was accepted by RAABIT, a care plan was agreed and her risk was assessed as 'low'. A psychology referral (refugee pathway) - which is a clinical service offering evidence-based, trauma-focused psychological therapy to people experiencing PTSD due to their experiences prior to seeking asylum - was made on 31st July 2017, an appointment was arranged for her with the Refugee and Migrant Forum East London (RAMFEL) so that she could discuss immigration issues and a referral was made to Imagine, which provided a day opportunities service for mental health clients. Mother was to be prescribed Mirtazapine with the dosage increased from 15mg to 30mg after one week. Mirtazapine is an antidepressant medicine. A medical review, with interpreter, was booked for 5th September 2017.

4.64 On 25th July 2017 the Early Intervention case in respect of Baby T was formally closed by a senior family support worker on the basis that all actions had been completed, when in fact they had not (paragraph 4.52). It was recorded in the case

notes that mother was currently no recourse to public funds (NRTPF) and had a case worker at the Home Office. However, it was recorded that the case would remain open in children's centres with a named worker supporting mother and Baby T. (By this time the Children's Centre had closed mother and baby T's file – paragraph 4.57).

4.65 On 31st July 2017 IAPT contacted mother by telephone to arrange the CBT appointment. Mother was unable to understand the call and requested a text be sent to her. An initial appointment was arranged for 7th August 2017, an interpreter booked and an appointment letter sent.

4.66 On 4th August 2017 a RAABIT key worker accompanied mother to her solicitors as she intended to request a change in solicitor. No further role was identified for the RAABIT key worker and so mother was discharged from RAABIT key working, whilst remaining open for the forthcoming RAABIT medical review.

4.67 The 7th August 2017 IAPT appointment with mother did not go ahead as Language Shop advised that there were no interpreters available and mother did not attend. When mother was contacted by telephone, she appeared to be unaware of the appointment. It was decided to confirm a Vietnamese interpreter before attempting to arrange future appointments. Language Shop later advised that they had 'fewer interpreters, especially in this part of London'.

4.68 On the same date mother took Baby T to Ilford medical centre. An interpreter was present. Mother was concerned that the baby had a dry cough and an intermittently blocked nose. The baby was examined and found to be well. Reassurance was provided to mother. Mother disclosed that she had yet to collect the prescription of Mirtazapine (paragraph 4.60) and was advised to do so. She was also advised of possible side-effects. She reported that her sleep pattern remained poor but she had no suicidal ideation. It was planned to review her again in two to three weeks.

4.69 On 17th August 2017 Baby T was seen with mother by a health visitor for a 9-12 months health review at a Children's Centre. No interpreter was present and Language Line was not used. No concerns were noted. Mother reported that Baby T had had a cough and cold for about four weeks. She said medication had been prescribed by her GP with little effect. She was advised to take the child back to see the GP. Mother was also advised to access ESOL classes as she spoke limited English.

4.70 On 21st August 2017 the initial CBT appointment with mother took place. Mother had asked for a female interpreter but this had not been possible to arrange.

The telephone interpreting service was used instead but difficulties were experienced in hearing the interpreter and sustaining the call. Mother's history was obtained, during which she became tearful. She said she had arrived in the UK in October 2015, had later 'met someone' and became pregnant. The father had left her prior to the birth of Baby T. She said he continued to call her 'once in a while' but as she didn't have the father's telephone number, she was unable to contact him. Mother went on to say that she had started to experience anxiety symptoms, nightmares and a 'sense of suffocation'. She added that during the day she was distracted from her thoughts because she was busy with the baby, but at night, or when alone, she felt very anxious. The IAPT high intensity therapist felt mother was very isolated as she spoke no English and appeared to be suffering from trauma-like symptoms. Mother said she had thought about hurting herself but could not do this as she had to take care of her child. She said she was at risk if she was sent back to Vietnam.

4.71 On 25th August 2017 mother's scheduled medical review was postponed from 5th September (paragraph 4.60) until 10th October 2017 as a result of an NELFT policy change which resulted in clinic appointments being reassigned. This policy change arose from a requirement to extend the duration of appointments to facilitate the use of a specific risk assessment by psychiatrists.

4.72 On 4th September 2017 the Language Shop advised IAPT that they remained unable to provide a female Vietnamese interpreter and the IAPT high intensity therapist tried to contact mother by telephone using a telephone interpreter to ask if she was willing to work with a male interpreter. However, no contact could be made. The IAPT plan was to discharge mother from the service if she was unwilling to work with a male interpreter. A female interpreter had been found but she was only available for telephone interpreting which was not considered appropriate as the interpreter would not necessarily be in a confidential location and remote interpreting is not considered conducive to therapeutic work.

4.73 The following day the IAPT high intensity therapist was able to contact mother by phone using the telephone interpreter. It was explained to mother that there was only a male interpreter available who had been used for the 19th July assessment (paragraph 4.59). Mother said she did not wish to work with the male interpreter as she felt he did not like her. It was explained to mother that because another interpreter could not be found, she would be discharged from the IAPT service. Mother was said to understand and accept this. A discharge letter was sent to mother and her GP the following day. (As stated in paragraph 4.63, mother had also been referred to the refugee psychology service. She attended an assessment appointment with this service after the death of Baby T. IAPT is a primary care psychological service whilst the refugee psychology service is a secondary care

psychological service. Patients cannot be open to both primary and secondary care psychological services concurrently).

4.74 During September 2017 mother began working illegally in a nail bar as a nail technician. She began leaving Baby T with a babysitter - Female C - at Address 7 in the London Borough of Barking and Dagenham from around 9.15/9.30am until 7pm on three or four days each week. Female C had begun advertising her services as a babysitter on an online Vietnamese community page that same month and mother was her first client. Mother and Female C had not known each other prior to this time. Mother paid Female C £30 per day to care for Baby T.

4.75 On 5th October 2017 Female C collected Baby T from mother at a bus stop near Address 7 which was the usual arrangement. This was the eleventh time Baby T had been left with the carer. On the previous day (4th October 2017) Baby T had been unwell and a challenge for Female C to look after. It is understood that the child had needed to be held 'all the time'. On 5th October 2017 Baby T was described by Female C as being 'out of sorts', not properly taking her food and twice vomited her food up after her arrival at Address 7. Shortly before noon the London Ambulance Service (LAS) was called to a report of Baby T being unwell whilst being looked after by Female C at address 7. Baby T appeared to be very unwell and to have experienced seizures. Female C was unable to provide any information relating to the identity of Baby T or mother. Baby T was transported to BHRUT Queen's Hospital ED, Romford and the LAS made a referral to Redbridge MASH after contact had been made with mother who arrived at Queen's Hospital shortly after the LAS.

4.76 Queens Hospital ED also made a referral to the Redbridge MASH in which Baby T was described as being 'very poorly' and was later found to have a significant right sided subdural bleed with mid line shift. The referral expressed concern that Baby T, mother and possibly Female C may have been trafficked as two apparently Vietnamese males were with mother at hospital and initially declined to say who they were or what their relationship to mother and Female C was. One of the two men later said that he was the partner of Female C and the other male said that he had transported mother (who he said he did not know) to hospital after seeing her in distress.

4.77 Whilst MASH checks were being carried out in respect of Baby T, it was noticed that there was another child (child 2) living at the same address (address 6 in Ilford) with a similar date of birth. Information held on the Redbridge Early Help system included the following:

- On 14th September 2017, child 2's mother had a problem with her asylum supported accommodation in that two weeks ago the shared kitchen ceiling

collapsed due to a leak and has still has not been fixed. Pieces of plaster were still falling off. The only friends that child 2's mother had were the women living in the same accommodation.

- On 18th September 2017, child 2's mother said that the hole in the kitchen ceiling had still not been fixed and pieces from the ceiling had fallen on her head. The Clearsprings housing manager had advised her that someone would be calling round to repair the ceiling within the week but this hadn't happened. The family support worker agreed to call the housing manager to obtain an update on when the ceiling would be repaired.
- On 29th September 2017, child 2's mother said that scaffolding had been fitted but the repair had not been completed. She was advised to contact the housing manager for an update.

4.78 The outcome of the referrals from LAS and Queen's Hospital in respect of baby T was that her case was allocated to the Child Protection and Assessment Team for a Child and Family Assessment (CAFA) to be completed, and for a strategy discussion with the police to take place as the injury to Baby T was considered unexplained.

4.79 Baby T was later transferred to GOSH where she died later on 5th October 2017 aged almost eleven months.

4.80 On 6th October 2017 the police contacted the Home Office to request a status check in respect of mother and advise that Baby T had died. The Home Office appeared to have had no contact with mother or Baby T since her dispersal to Ilford on 18th January 2017.

The babysitter - Female C - and her child

4.81 Female C is also a Vietnamese national and entered the UK as a tourist on a visitor visa on 23rd August 2013. She stayed for around a month before returning to Vietnam. During her initial stay in the UK, Female C reported that she reconnected with a friend from her childhood in Vietnam who had been living in London for a time. Female C decided to travel back to the UK on the same visitor visa in November 2013 and remained in the UK after the visa expired on 16th February 2014. She began worked illegally in a nail bar in December 2013.

4.82 Female C reported that she met her child's father during the summer of 2014. The father is also of Vietnamese heritage but was brought up in Hong Kong and is understood to be a British citizen. Female C reported seeing her child's father for a

time but didn't regard him as her boyfriend as he 'never showed commitment to her'. She discovered that she was pregnant in February 2015 but when she told the father he suggested she obtain an abortion as he was unable to commit to bringing up a child. Their relationship ended around this time. Female C has reported that she never considered getting an abortion and decided to bring the child up on her own, adding that she began working longer hours to save money for the arrival of the baby.

4.83 Female C's first recorded contact with agencies was a visit to Homerton University Hospital Accident and Emergency (A&E) in Hackney on 18th March 2015 when she would have been approximately seven weeks pregnant. Due to what Homerton Hospital has described as an 'IT anomaly', no information about the reason for her attendance or the treatment she received is available.

4.84 On 27th April 2015 a GP practice referred Female C to Homerton Hospital for antenatal care. It has not been possible to access the referral so no details of the information ascertained by the GP, including whether there were any safeguarding concerns, are available. Female C was offered an initial midwifery antenatal appointment for 8th May 2015 but she rearranged this for 22nd May.

4.85 On 22nd May 2015 Female C attended her antenatal booking appointment. She was considered to be a 'late booker', in that her first midwifery contact was at 16 weeks gestation. No explanation for late booking was documented. She was noted to be twenty three years of age, 'not fluent' in English, unemployed and 'unsupported'. She was noted to be living with friends. No partner details were provided although his nationality was recorded as Vietnamese. The midwife documented that an interpreter would be required for subsequent appointments. It is not known whether Female C was referred to a Public Health midwife who could have provided specialist antenatal care.

4.86 Female C gave birth to her child at Homerton Hospital on 29th October 2015 by spontaneous delivery. The baby was documented to be well with no problems identified. The following day Female C and her child were discharged to an 'out of area' maternity team as Female C was not resident in Hackney.

4.87 Female C applied to the Home Office for leave to remain in the UK on the basis of her right to family/private life on 7th March 2016. At that time she said she had been supported by a friend who had provided food and accommodation since 30th October 2015. At the time of her application for leave to remain she was living at address 8, which she said was the family home of her employer at the nail bar.

4.88 Female C later started a catering business from her home and began advertising on social media as a babysitter at address 7 in Barking and Dagenham in September 2017. She, her partner (who is a Vietnamese national who overstayed a student visa) and her child had moved to that address on 16th September 2017 where they occupied a room in a shared house. As previously stated, Baby T became seriously ill whilst being looked after by Female C at Address 7 the following month

5.0 Mother's Views

5.1 Mother contributed to this review through an interpreter. As the conversation took place prior to the conclusion of criminal proceedings, mother was requested not to discuss any contact she may have had with the baby sitter - female C - including the events which led up to the death of Baby T.

5.2 Mother expressed her appreciation for the support she received in the London Borough of Hackney. When she initially approached services in Hackney she described herself as being in a 'very difficult situation'. She had nowhere to live and didn't know where to go. She said that everyone she came into contact with there, including the GP, the midwife and the 'nurse' tried to help her. She said that she was referred to the 'mother and children support team' which helped her to contact the Home Office. It is assumed that the 'mother and children support team' is either the Hackney First Access Screening Team (FAST) social worker who advised mother to contact the National Asylum Support Service helpline (paragraph 4.6) or the Hackney Multi-Agency Team (MAT) which supported her with her asylum seekers application (paragraph 4.8). Quite understandably, mother had only a vague grasp of the title and roles of many services she came into contact with.

5.3 Mother went on to describe her move to emergency overnight accommodation at address 2 and her initial accommodation at address 3 in Croydon. She recalled staying in the latter address for around two months during which Baby T was born. She said that the support she received from the health visitor in Croydon was 'very good' and that she 'helped her a lot'. It seems certain that she was referring to the Croydon Parent Infant Partnership (PIP) key worker with whom she had substantial contact whilst living in Croydon rather than the health visitor with whom her contact was quite limited.

5.4 She said that she was moved to Cardiff when Baby T was about one month old. She said she shared a room with others whilst in Cardiff but said that she felt 'very lonely' because 'nobody supported her'. She said that whilst she was staying in Cardiff, she rang the 'health visitor' in Croydon (presumed to be the Croydon PIP key

worker) to ask her to help her. She said that the 'health visitor' tried to help her, but 'nobody came to support her' whilst she was in Cardiff.

5.5 Mother said that the reason for her move to Cardiff had been explained to her. She was told that the accommodation in Croydon was not suitable for a mother and baby and that it would be good for her and the baby in Cardiff. She was reassured that she would be staying in Cardiff for only a short period of time.

5.6 After her arrival in Redbridge, mother said that a health visitor offered her support but due to the language barrier, she was unable to understand mother and therefore was not in a position to do anything to help her. Mother's account is consistent with the limited engagement the Redbridge health visitor achieved as a result of the unavailability of an interpreter (paragraph 4.47) and subsequently the booked interpreter leaving prior to mother's late arrival for an appointment (paragraph 4.49).

5.7 Mother went on to describe how another Redbridge 'health visitor' supported her for a time before stopping visiting her without explaining why. It is assumed she is referring to the Early Intervention family support worker who provided her with support between March and May 2017. The Early Intervention support appeared to come to a fairly abrupt end with several tasks outstanding (paragraphs 4.53 and 4.62) and mother clearly picked up on this.

5.8 Mother described how she subsequently sought support from the 'Job Centre' where she says she was provided with food bank vouchers 'a few times' as well as baby clothes and toys. Job Centres are not commissioned to provide services to people who have no recourse to public funds including asylum seekers. They do provide support to refugees whose claim for asylum have been granted and, as a result, are able to obtain a National Insurance card, seek employment and claim mainstream benefits. Mother was asked if she was referring to a Children's Centre rather than a Job Centre but she was adamant that it was the latter. It is possible that mother may be referring to Troubled Families employment advisors who are Job Centre employees who work in partnership with the local authority and others to address the needs of families referred to the Troubled Families team for support. These employment advisors are based in Children's Centres and it is possible that mother may have spoken to them when visiting the Children's Centre.

5.9 Mother went on to say that the Job Centre stopped supporting her after a time and told her that they had closed her case. Again, it seems likely that mother is referring to the Children's Centre rather than the Job Centre. After support from the Early Intervention and Family Support service ceased, the plan was for mother and

Baby T's case to remain open in the Children's Centre but the latter quickly closed her case also (paragraph 4.57).

5.10 When mother was recounting her experiences of the 'health visitor' and the 'Job Centre' ceasing supporting her, it was clear that she had been both worried and confused at this turn of events; worried at how she would cope without their support and confused because she said she had not been told why the support had ended and her case closed. She said that the ending of support had put her in a 'difficult situation' although she seemed unprepared to enlarge on, or further describe, this 'difficult situation' and the lead reviewer decided not to probe this further because of her grief at the death of her child and her continuing mental health issues.

5.11 Mother was critical of Ilford Medical Centre where she and Baby T were registered. She said that she took Baby T to see the GP quite often and saw many different GPs. She said that the GPs were often unable to help her and Baby T because of the absence of interpreters. However, she said that one female GP had been 'very kind' to her and had referred her to mental health services (paragraph 4.58).

5.12 When asked about her experiences of the mental health services in Redbridge to which she had been referred by the GP, mother said that they were 'very good, very helpful'. Mother did not appear to wish to enlarge further. It was clear that she was very satisfied with the support she was currently receiving from a support worker who is also a Vietnamese interpreter.

5.13 Returning to her experiences at Ilford Medical Centre, she was critical of the attitude of reception staff towards her. On one occasion there was no interpreter available and so mother telephoned a friend who was a Vietnamese national who could speak English. However, mother said that the reception staff laughed at her and refused to talk to her friend on the telephone. There was no mention of Baby T being with her on this occasion. Ilford Medical Centre has responded to mother's criticisms by saying that it would be out of character for administration staff to laugh at any patient as they are trained in how to deal with patients who cannot speak English. They are also trained to deal with vulnerable patients professionally and sensitively.

5.14 Mother recounted another visit to the same GP practice. She said Baby T was ill and once again she was unable to communicate with reception staff. She said she then began waiting in the GP practice, her baby was ill and she couldn't explain what the problem was to the reception staff. She said that after a time she began to cry and people around her noticed her distress and that she was unable to speak

English and 'raised their voices'. She said that this led to a doctor calling her into a room and arranging an interpreter. It is unclear from the chronology of contact between Ilford Medical Centre and mother and Baby T when this incident may have occurred. Ilford Medical Centre has responded to mother's criticisms by saying that all practice staff undergo mandatory training to enable them to be alert to any signs of a distressed patient in the waiting area. Additionally it is their policy for practice staff to inform the duty doctor if an unwell patient is brought into the surgery, in order that the patient can be triaged and treated accordingly.

5.15 She expressed satisfaction with the accommodation in Redbridge in which she and Baby T were placed. She said that there were four mothers and their children sharing there, adding that one of the other asylum seeker mothers was also Vietnamese which she seemed to value. She added that the other Vietnamese asylum seeker had been supported by the same support worker as her and that her case had also been closed abruptly. When asked about the state of repair of the property, mother said that the ceiling of the kitchen was 'broken a little bit' but that this had been fixed.

5.16 When asked about interpreting services generally, mother said that they were very good in Hackney and Croydon. She said that whenever anyone came to see her they always had an interpreter with them (Interpreters were often, but not always, available to practitioners in Hackney and Croydon when communicating with mother). She said that whilst living in Cardiff, she received no support so was unable to comment on the quality of interpreters there. Mother described the availability of interpreters in Redbridge as 'not good'.

5.17 When asked about the support she received from Migrant Help, mother said that she was so happy and thankful for the support they gave her and Baby T. She said that when she went to them she had nowhere to live and no documents to allow her to live in the UK. She said that Migrant Help were 'very ready' to help her.

5.18 She said that when Baby T died she didn't know how to make funeral arrangements. She said she returned to the 'Job Centre' but they reiterated that they had closed her case and said that they couldn't do anything to support her. She said that after Baby T died she was visited once or twice by the 'health visitor' who asked her if she needed any support but then she 'disappeared' and didn't contact her anymore.

5.19 When asked to reflect on the support she had received as a pregnant asylum seeker and as an asylum seeker with a young child and suggest any improvements which could be considered, mother said she felt very grateful for the support she had received. She was particularly appreciative of the support she had received

when she was pregnant and when Baby T was first born. She said that the practitioners she had come into contact with had been kind and helpful. She mentioned only one thing which she felt could be improved which was what she described as the 'disappearance' of support in Redbridge. She said that when she arrived in Redbridge, she and Baby T received support for a time but then it had ended without notice or explanation.

6.0 Learning Themes

6.1 In this section the learning themes emerging from this review will be explored which will also enable the specific terms of reference questions set out in **Section 2** of this report to be addressed.

Decisions made by the Home Office (and services commissioned or funded by the Home Office) in response to Mother's claim for asylum and later application for asylum support

6.2 At the time mother initiated her asylum claim, the Home Office considered her circumstances to be relatively stable in that she was living in a private flat in Hackney with the father of the unborn Baby T. It was established that the father was a UK citizen and was said to be supporting mother financially. Mother was provided with written advice on how to apply for financial support whilst her asylum claim was decided upon by the Home Office, but she made no claim for financial support at that time. The Home Office did not believe that she had been, or was being exploited in any way.

6.3 When mother's circumstances changed after the father of Baby T left her and withdrew financial support, the Home Office promptly approved emergency accommodation and subsequently longer term asylum financial and accommodation support. However, the Home Office later lost sight of mother and Baby T. They wrote to her on 7th December 2016 to advise that they had been unable to make a decision on her asylum claim within six months of her original claim and intended to review her case in three months (paragraph 4.26). This review did not take place and so the Home Office exercised no further oversight of mother and Baby T's case until notified of the death of Baby T in October 2017. The Home Office has advised this SCR that during this period they were experiencing resource issues as a result of high turnover of decision making staff and, at national level, the asylum directorate was struggling with the increasing age and volume of what are described as non-straightforward cases.

6.4 Therefore during the period from December 2016 to October 2017 the Home Office was not in a position to assure themselves that they were complying with Section 55 of the Borders, Citizenship and Immigration Act 2009, which requires them to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children in the UK. It is accepted that once mother and Baby T had moved from initial accommodation to longer term asylum support (accommodation and financial) in Redbridge in January 2017, their circumstances had stabilised to an extent and they were receiving support from Clearsprings and could access support from Migrant Help. However, mother remained vulnerable due to her social isolation, lack of English, limited resources, risk of exploitation and the loss she experienced in Vietnam in terms of the death of her husband and the loss of contact with her older children. Baby T's vulnerability was directly linked to that of her mother who had demonstrated that she would need support and guidance in parenting the child. The Home Office *Healthcare Needs and Pregnancy Dispersal Policy* (4) further describes the potential vulnerability of mothers and young babies in terms that are very similar to mother and Baby T's potential vulnerability (paragraph 6.15) and research on asylum seekers in the UK (paragraph 6.62) further emphasises potential vulnerabilities. If Home Office case workers making decisions about cases such as mother and Baby T are considered to contribute to safeguarding and promoting the welfare of the children of asylum seekers in the UK, then they did not do so for the majority of Baby T's short life.

6.5 Nor were they in a position to contribute to the Home Office Adults at Risk Safeguarding Strategy in respect of mother during the same period. The Home Office established an Asylum Safeguarding Hub in autumn 2016 to implement the Adults at Risk strategy by engaging with the NHS, social services and police to promote intervention and support for customers in respect of *safeguarding*, trafficking and modern slavery. Had Home Office case workers become aware of the deterioration in mother's mental health, they could have referred her to the aforementioned Asylum Safeguarding Hub to consider the necessary response including a referral to another agency such as health or social care (5). Additionally, the deterioration in mother's mental health had the potential to expose Baby T to harm which may have merited a child safeguarding referral by the Home Office.

6.6 Turning to the decision to disperse mother and Baby T to Cardiff, clearly they needed to move from their initial accommodation in address 3 to accommodation in which longer term asylum accommodation and support could be provided. The justification for the move to Cardiff was that there is a limited supply of accommodation within London and South East England and that it was a temporary dispersal until suitable accommodation could be sourced nearer to London. However, dispersal to accommodation in the London Borough of Hillingdon had initially been planned for the same day that mother and Baby T were dispersed to

Cardiff and called off because it was one day prior to the six weeks following birth during which Home Office policy states a move should not take place. It is not known why Hillingdon was rejected whilst Cardiff was chosen, although the Clearsprings Group, which is one of three companies which each hold two of the six regional contracts for providing asylum seeker accommodation in the UK, has the contracts for London and South East England and Wales and South West England.

6.7 Home Office *Healthcare Needs and Pregnancy Dispersal Policy* states that, on dispersal, they aim to assist in ensuring the 'effective handover of care' but the policy goes on to stress the 'critical role' of the applicant (mother) in helping to ensure continuity of their care during dispersal, by divulging healthcare needs to the Home Office 'as well as providing dispersal information to treating clinicians/midwives' (6). Mother, supported by Migrant Help, notified the agencies which were supporting her in Croydon of her impending dispersal to Cardiff but the process by which agencies in one area share information with agencies in another area to which vulnerable people are moving is not without risk. In mother's case Croydon Early Help promptly made referrals to Cardiff but Croydon health visiting service did not appear to make any referral, despite providing a 'Universal Plus' service to mother and Baby T, and eventually only provided information to their counterparts in Cardiff after mother had moved on from Cardiff to Redbridge. Migrant Help referred mother to their equivalent agency in Cardiff five days before she left Cardiff although this review has been advised that Migrant Help personnel are based within the accommodation to which mother was 'dispersed' in Cardiff and would therefore have been readily available to provide support to mother and Baby T.

6.8 It is not possible to reach any conclusion other than the dispersal of mother and Baby T to Cardiff exposed them to risk. Although mother was able to access services in Cardiff, she was moved again during her short stay in the city which was completely inappropriate. 'Dispersal' to Cardiff terminated the post-natal support network on which mother and Baby T had come to rely in Croydon and increased her vulnerability. It was unrealistic to expect her Croydon support network to be quickly recreated in Cardiff, particularly as effective support is founded on clarity in respect of needs and positive human relationships, both of which take time to develop. Mother said that she felt lonely and unsupported during her stay in Cardiff. Additionally, the dispersal to Cardiff took place just prior to the Christmas/New Year holiday period during which many services operate at diminished levels including public transport. Given that the plan was for the dispersal to Cardiff to be a temporary move prior to a return to accommodation nearer London, it is unclear why consideration was not given to leaving mother and Baby T in their initial accommodation in Croydon until the move to longer term asylum support in, or

near, London could be achieved, particularly as the accommodation in Cardiff was also initial accommodation.

6.9 The House of Commons Home Affairs Committee noted that 'Initial accommodation is not suitable or intended for long term use. However, the reality is that asylum seekers are housed in initial accommodation for far longer than the target of nineteen days' (7). Mother stayed in initial accommodation at address 3 from 8th October 2016 until 19th December 2016 (Baby T was with mother in the accommodation from her birth on 7th November 2016) which is a total of 72 days. The Home Affairs Committee has also advised that 'there should be as little disturbance as possible to the routine of pregnant women and new mothers, particularly in terms of their relationship with health professionals but if this means a stay in initial accommodation is prolonged then that accommodation must provide the appropriate support' (8). The key factor in mother greatly exceeding the 19 day target was her pregnancy and postnatal care. Given that the target had already been exceeded to such an extent, the decision to move mother and Baby T to Cardiff rather than allowing them to remain in initial accommodation in Croydon for a further month appears even less justifiable.

6.10 Concerns arose about the condition of the asylum accommodation mother and Baby T shared with other asylum seeking mothers and children in Ilford (paragraph 4.75). These concerns were not linked to mother and Baby T until shortly after the child's death. A hole in the kitchen ceiling of the property had developed during September 2017 which did not appear to have been promptly addressed by Clearsprings as the provider.

6.11 Reports from the National Audit Office, the Home Affairs Committee and the Independent Chief Inspector of Borders and Immigration have raised concerns about the standard of asylum accommodation, the arrangements for inspection and the arrangements for recording and responding to complaints from tenants. The Home Affairs Committee has observed that the number of complaints about accommodation issues varies enormously between asylum accommodation providers. Private contractors - G4S, Serco and Clearsprings - each held two of the six UK asylum accommodation provider contracts. In 2015 G4S received 42,783 complaints, Serco received 127 and Clearsprings just 25. The Home Affairs Committee took the view that the low level of complaints recorded by Serco and Clearsprings were not a true reflection of the number of complaints made by asylum seekers.

6.12 Clearsprings have advised this SCR that the accommodation in which mother and Baby T were placed in Ilford was provided by Clearsprings via a sub-contracted agent. The agent had a contractual agreement with Clearsprings to carry out periodic inspections of the property, and to rectify any defects found during such

inspections. Clearsprings also carried out monthly audits of sub-contracted properties. During 2018 the Asylum Accommodation and Support Services Contracts (AASC) were open to tender. During the tender and bidding period, Clearsprings state that they reviewed their sub-contractor contracts and made the operational decision to bring all property inspections and defect rectification logging in-house. Clearsprings add that whilst they continue to obtain properties from various sources, all property inspections, defect logging, and maintenance is managed directly within the Clearsprings Repairs and Maintenance Team. Any defects logged will be categorised and allocated to the appropriate tradesperson and will be completed within agreed timescales, thereby providing for more efficient management of all Asylum properties across the portfolio. All defects that are landlord responsibility (wear and tear) are sent to the sub-contractors and monitored by Clearsprings.

6.13 Clearsprings go on to add that Migrant Help has been awarded the contract to provide an Advice, Issue Reporting and Eligibility Service (AIRE) to all asylum seekers in the UK which they say provides for a greater level of transparency in the reporting of issues in all asylum properties, and an enhanced process for all service users to report any issues that affect their journey through the asylum process.

6.14 Mother accessed the support of Migrant Help on several occasions. They assisted her to obtain emergency accommodation, longer term asylum accommodation and financial assistance, the maternity payment and with transport to appointments. Migrant Help's involvement with mother diminished following her transfer to Redbridge as it was assumed that she was less likely to need their support once her long term asylum support was in place.

The effectiveness of the interface between Home Office asylum seeker support services and 'mainstream' health and social care services

6.15 Mother was four months pregnant with Baby T at the time she made her asylum claim. The Home Office *Healthcare Needs and Pregnancy Dispersal Policy* makes clear that pregnant asylum seeking women may be affected not only by complex social factors within the UK (lack of knowledge of the health system; problems with interpretation), but also by poor health and other medical concerns arising as a result of pre-arrival issues, such as a poor overall health status, underlying and possibly unrecognised medical conditions, possible female genital mutilation (FGM) issues, psychological and medical effects of flight from war torn countries, fears about immigration and languages difficulties (9). The policy also recognises that maternal stress in pregnancy has a detrimental effect on subsequent childhood development (10).

6.16 Mother spoke no English, was likely to be unfamiliar with the manner in which services were accessed in the UK, appeared to be wholly dependent on the father of Child T and may have experienced trauma as a result of what she disclosed about

her previous life in Vietnam. As mother was vulnerable, then it followed that her unborn baby could also be vulnerable. However, no signposting to services or referral appears to have been considered by the Home Office at the time mother initiated her asylum claim. Whilst it is accepted that mother was being supported by the father of Baby T at the time she made her asylum claim, the possibility that these arrangements may prove to be fragile could have been considered.

6.17 In his 2018 inspection of the Home Office's approach to the identification and safeguarding of vulnerable adults, the Chief Inspector of Borders and Immigration stated that where a particular vulnerability is identified or suspected during initial asylum screening, the interviewer should refer the case to the Asylum Safeguarding Hub to consider the necessary response, including a possible referral to other agencies. The particular vulnerabilities referred to by the Chief Inspector include pregnancy (11).

6.18 When mother's claim for emergency asylum support was approved and she was placed in initial asylum support accommodation in Croydon, the Home Office, via the asylum accommodation provider ClearSprings, liaised with relevant agencies in the local area in which mother was placed. ClearSprings prompt referral of mother to local agencies helped mitigate the risks associated with moving mother, whose estimated delivery date was under a month away, from Hackney to Croydon.

6.19 The decision to disperse mother and Baby T to Cardiff exposed them to the risk that postnatal care and other support would be disrupted. As stated in paragraph 6.6, Home Office policy states that, on dispersal, they aim to assist in ensuring the 'effective handover of care.' Migrant Help supported mother to prepare for the move to Cardiff but the onus was primarily placed on mother and the 'mainstream' agencies supporting her to do all they could to ensure the 'effective handover of care' although it is accepted that mother and Baby T were able to access support from Clearsprings and Migrant Help in her asylum accommodation in Cardiff.

6.20 The Home Office has advised this review that dispersals can be halted at the request of an applicant with the backing of a midwife or medical professional should it be required due to 'complications/needs of mother and baby'. Additionally, the manager of the Rainbow Health Centre in Croydon can withhold dispersal of clients if there is a 'high need' such as fleeing domestic violence or there is a complex medical need for child or adult. The manager did not feel that mother and Baby T met the 'high need' criteria. However, there is no indication that other agencies involved in supporting mother and Baby T in Croydon at that time were aware that they had the option of requesting the halting of their dispersal to Cardiff.

6.21 Information sharing in support of mother and Baby T's transfer from Cardiff to Redbridge was also problematic. Clearsprings, as the provider of her longer term asylum support accommodation in Ilford, did not refer mother and Baby T to any local services when she arrived in Redbridge on 18th January 2017. The Home Office *Healthcare Needs and Pregnancy Dispersal Policy* states the provider of dispersal accommodation is contractually obliged to take a supported person to a GP within 5 working days of their arrival at the dispersal address if the person has a pre-existing condition or is in need of an urgent GP appointment. (11B) The policy states that children under nine months are covered by this arrangement. Mother appears to have had no contact with local agencies until 2nd February 2017 when she went to Ilford Medical Centre with Baby T. In their contribution to this review Clearsprings have advised that they would have signposted mother and Baby T to local services such as 'health'. (Clearsprings appear to have been more proactive in referring mother to local services when she moved into initial asylum accommodation in Croydon). Clearsprings also state that they were unaware of the concerns which arose about mother's mental health whilst she and Baby T were living in Ilford and were unaware of the support being provided by the Redbridge Early Intervention and Family Support Service and subsequently the Children's Centre. Mother's consent would have been required for agencies providing support to her and Baby T to share information with Clearsprings but there is no indication that engaging with Clearsprings as mother's asylum accommodation and support provider was considered. This was a missed opportunity. Clearsprings have further advised this review that had agencies shared any concerns about mother and Baby T with them, the Clearsprings safeguarding manager could have become involved.

6.22 The asylum accommodation occupied by mother and Baby T in Ilford is a large eight bedroom property and the other rooms were also occupied by mothers and babies. The London Borough of Redbridge has no involvement with the property and it is not usual practice for the National Asylum Support Service (NASS) to advise the Borough's Housing Service if they place a family in Redbridge. It is understood that the Housing Service will usually only hear about a family living in a local property when they approach Redbridge to advise that NASS is about to evict them.

6.23 The Home Affairs Committee concluded that the 'poor condition of a significant minority' of asylum support properties led them to conclude that the current compliance regime (inspections primarily by the Home Office and the provider's housing inspectors) was not fit for purpose'. The Home Affairs Committee went on to recommend that the inspection duties carried out by the Home Office should be transferred to local authorities although this was subsequently rejected by the Home Office.

6.24 Concern has been expressed that asylum seeking mothers and children are living together in properties such as address 6 and that services may to a large extent be unaware of their presence in the Borough. In mother's case she and Baby T had been in contact with a range of local services in Redbridge although by the time of Baby T's death they were in contact only with primary health services. Whilst bringing together a number of vulnerable mothers and children under one roof may bring some benefits, such as mutual support, and in mother's case informal interpreting from another Vietnamese asylum seeker, there is the potential for some risks to increase, including the risk of exploitation by others.

6.25 In their contribution to this review, Homerton Hospital recommend that practitioners providing support to asylum seekers should receive bespoke training on the nuances and complexities of the asylum system. Whilst existing safeguarding training highlights the vulnerabilities of asylum seekers it may need to be enhanced so that practitioners can better support vulnerable people such as mother and Baby T.

The support provided to mother and Baby T by mainstream health and social care agencies

6.26 There is no indication that mother had contact with any agencies during the period following her stated arrival in the UK (27th October 2015) and her contact with the Home Office to claim asylum over seven months later (7th June 2016).

6.27 Once mother presented to a Hackney GP on or around 4th July 2016 she was referred to midwifery services although little detail was obtained about her circumstances by the GP practice. Homerton public health midwifery provided effective support once mother's vulnerabilities had been ascertained. Health visiting in Hackney became aware of mother after the public health midwife referred her to the children's centre multi-agency team (MAT) meeting which the health visitor attended. It would have been good practice for there to have been a discussion of mother's case between the midwife and health visitor and possibly a joint assessment. Homerton Hospital has advised this SCR that the health visiting service was carrying an increased number of vacancies and undergoing a restructure at the time of mother's involvement with midwifery services. Additionally, the pathway from midwifery to health visiting for notification of vulnerable pregnant women was less clear than it is reported to be now.

6.28 When mother moved to Croydon she received Early Help support although there was a significant delay in making the first contact with her (from 10th to 31st October 2016). The work with mother and Baby T was of a practical nature, ensuring the family was accessing health services, midwifery, health visiting and legal support through Migrant Help. Whilst the support was provided over a short

period of time, it was intensive with very regular visits which often included interpreters. However, because of the anticipated length of time mother and Baby T were placed in Croydon, work did not progress beyond ensuring that the practicalities were in place and so there was limited opportunity to support mother through nurturing or therapeutic support. Nor was the keyworker able to complete an early help assessment although she was able to use assessment tools to begin to explore the needs and strengths of the family and mother's hopes and dreams for her baby. However, mother actually stayed in Croydon from 8th October until 19th December 2016 which may have been sufficient time for an early help assessment to have been carried out.

6.29 There is no indication that any discussion about mother took place between the specialised midwife and specialist health visitor for homeless families in Croydon during the antenatal period. The health visitor was unable to fully complete the new birth visit within accepted timescales due to the wrong interpreter being booked and the further visit expected for a family being provided with a 'universal plus' service did not take place. Croydon health services have advised this SCR that there was a shortage of health visitors at the clinic where the specialist health visitor for homeless families was based which may have resulted in the specialist health visitor covering both 'universal' and 'universal plus' families at that time. This may also have been a factor in the delay in providing health visitor records to Cardiff. Croydon Health Services have advised this review that their health visitor staffing levels have continued to fluctuate with each health visitor carrying caseloads of over 600 children.

6.30 In Cardiff mother was able to access GP services and the Croydon's PIP keyworker's prompt referral to Cardiff MASH ensured that her and Baby T's vulnerabilities were brought to the attention of a health visitor. Mother and Baby T received a 'universal' level of health visitor service whilst in Cardiff which was not informed by their health visitor records from Croydon as these did not arrive until they had left for Redbridge.

6.31 Mother and later Baby T's periods of residence in Hackney (three months and four days after first accessing services there), Croydon (two months and ten days) and Cardiff (one month which included the Christmas/New Year holiday period) were very brief and made it difficult for mother to make connections, achieve even a limited degree of independence and resulted in work having to be started all over again each time she and the child were moved. The brevity of the stays also put pressure on agencies to work quite rapidly with the family whilst limiting the depth and intensity of the work it was possible to accomplish.

6.32 The transfer to longer term asylum accommodation and support in Redbridge provided agencies with the opportunity to work with mother and Baby T over a longer period. However, the Early Intervention and Family Support Service was only involved with mother and Baby T from February until May 2017 despite several tasks identified from the initial CAF remaining incomplete and concerns about mother's mental health having arisen by the stage their case was closed. The plan was for mother and Baby T's case to remain open to the Children's Centre but, inexplicably, their case was closed by the Children's Centre on 5th July 2017 (paragraph 4.57), a decision which coincided with the departure of the Children's Centre family support worker who had been supporting mother and Baby T. Although mother and Baby T were able to continue to access sessions at the Children's Centre, what mother described in her contribution to this SCR as the 'disappearance' of her support (paragraph 5.19), appeared to affect her adversely.

6.33 It is understood that Early Intervention and Family Support were going through changes to structure and staffing at the time they closed mother and Baby T's case. This SCR has been advised that the Early Intervention and Family Support Service now benefits from a stable and experienced management team and that there is now a Triage team which accepts cases requiring short pieces of targeted support. This has resulted in caseloads for individual family support workers dropping from thirty families to an average of twenty.

6.34 Mother and Baby T were provided with a 'universal' health visiting service in Redbridge. Arguably the family should have received a 'universal plus' service as they did in Croydon. An important factor in deciding which level of service was appropriate was the initial transfer-in visit by the health visitor during which interpreting was provided by one of mother's fellow tenants. The lack of an interpreter may have contributed to a lack of pertinent information ascertained from mother who may have been reluctant to share sensitive information with the other tenant. There may also have been a lack of professional curiosity by the practitioner.

6.35 However, there was an opportunity to review the level of support being provided to mother and Baby T at a subsequent appointment (paragraph 4.49) when mother's disclosures about her emotional wellbeing led to the health visitor making a referral to IAPT. Lack of professional curiosity was again in evidence when there was no health visitor follow up to the paediatric information sharing form after mother left Barking Community Hospital walk-in centre without Baby T being seen (paragraph 4.55). The health visitor conducted the 9-12 month review of Baby T without an interpreter or the use of Language Line (paragraph 4.67) which could have prevented the review being completed as fully as possible including discussion of pertinent issues such as mother's emotional wellbeing following the health visitor's earlier IAPT referral.

6.36 The IAPT triage assessment of mother in May 2017 determined that mother met the criteria for PTSD and she was considered to be a priority due to her clinical presentation and the fact that she was caring for a six month old baby. Mother was seen within the 16 week target for priority clients to be allocated a CBT therapist, although when, after waiting 9 weeks, she rang IAPT to ask about the waiting time, she received no reply. The 16 weeks target for priority clients has now been set at four weeks. However, practitioners who attended the learning event organised to inform and validate this SCR, questioned whether NELFT was resourced to deliver this revised target.

6.37 Whilst waiting for her CBT appointment from IAPT, mother was referred to RAABIT by her GP. On this occasion she was diagnosed with post-natal depression and was prescribed an antidepressant. The referring GP gained the impression that mother was being supported by a social worker which was never clarified by either the GP or RAABIT and appears to have persuaded the GP that a referral to children's social care was unnecessary. This was a missed opportunity for a referral to have been made to the MASH.

6.38 Mother was rapidly discharged from RAABIT key working although the key worker appeared to have quite a limited remit which was to ensure medication was started in accordance with the instructions of the psychiatrist and to refer mother onto other services. The key worker is a non-medical practitioner allocated to a service user requiring support for a limited time period and aims to support the service user to try and prevent a crisis situation developing.

6.39 Mother was later discharged from IAPT services after just one session with the CBT therapist during which a fairly full history was obtained despite the use of the telephone interpreting service which made sustaining the interaction with mother problematic. Mother had objected to a male Vietnamese interpreter used earlier and efforts to source a female interpreter had been unsuccessful. Mother's reasons for objecting to the male interpreter, beyond saying that she felt he did not like her, could have been further explored. The Director of the Vietnamese Mental Health Service, which is based in the London Borough of Southwark, has contributed to this review. The service provides mental health support to people from Vietnam (including asylum seekers and refugees) who are living in the UK. He observed that Vietnamese women would be reluctant to accept a male interpreter to discuss personal or intimate medical issues. NELFT did not discuss mother's case with her health visitor, who had made the IAPT referral, prior to discharging mother although her GP was notified.

The impact of the frequent moves of mother and Baby T from one local authority area to another

6.40 Mother moved from the London Borough of Hackney (where she had first claimed asylum) to Croydon (where she was placed in initial asylum support accommodation) and from Croydon to Cardiff before being placed in longer term asylum supported accommodation in the London Borough of Redbridge. Communication between services in Hackney and Croydon was very effective. Mother left Hackney on Friday 7th October 2016 and on the next working day (Monday 10th October 2016) the Hackney public health midwife contacted the safeguarding maternity team at Croydon University Hospital to handover the care of mother and her unborn baby. Two days later, contact took place between a Hackney health visitor and her counterpart in Croydon to advise of mother's transfer. On the same date a family support worker from Hackney referred mother to Croydon Early Help service. It is unclear whether mother's GP records transferred from Hackney to the Croydon GP practice.

6.41 When mother and Baby T were dispersed from Croydon to Cardiff, mother's Croydon PIP key worker promptly contacted Cardiff Social Care to inform them that mother and Baby T had moved to their area and the following day completed a multi-agency referral form to enable the family to continue receiving support. There is no indication that mother and Baby T's medical records were transferred from Croydon to the Cardiff GP practice she accessed whilst there. It seems unlikely that mother and child registered with a GP practice in Cardiff. Croydon Health Services did not transfer health visitor records to Cardiff until after mother and Baby T had moved on to Redbridge.

6.42 Mother and Baby T were permanently dispersed from Cardiff to the London Borough of Redbridge on 18th January 2017 but did not access any local services for over two weeks until mother presented at Ilford Medical Centre with Baby T on 2nd February 2017. Ilford Medical Centre was informed by mother that she and Baby T had previously been registered with the Rainbow Health Centre in Croydon and both sets of medical records were transferred to Ilford quite promptly.

6.43 Ilford Medical Centre did not refer mother or Baby T to any agency on initial registration. A GP from the Medical Centre has advised this review that a GP could have referred mother and Baby T to the health visitor or mother could have self-referred. A GP referral was less likely given the very limited information obtained from mother at the time she registered herself and Baby T at the Medical Centre. The medical records for mother and child arrived at Ilford Medical Centre on 9th and 2nd March 2017 respectively and so there was an opportunity to review the records and consider referrals at that stage but this was not done.

6.44 Mother telephoned her Croydon PIP key worker on 6th February 2017 to tell her that she had returned to London, although she mistakenly thought she had been sent to the London Borough of Barking and Dagenham. After establishing that mother was in Redbridge, the Croydon PIP key worker completed an Early Intervention Panel referral in respect of mother and Baby T. This led to the involvement of a family support worker who notified the health visitor of the arrival of mother and Baby T.

6.45 Mother and Baby T's dispersal to Cardiff not only increased their vulnerability whilst staying in that city but it also adversely affected information sharing with Redbridge. Mother found herself having to start again in Redbridge as she had not been in Cardiff long enough for any service there to 'take ownership' of her case and assume responsibility for contacting services in Redbridge. It was fortunate for mother that she had retained the contact details of the Croydon PIP key worker, who promptly referred her to the Redbridge Early Intervention and Family Support Service.

Use of interpreting services in supporting mother and Baby T

6.46 NHS England set out principles for high quality interpreting and translation services in Primary Care Services (12) which have wider applicability. The principles are as follows:

- Patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.
- Staff working in primary care provider services should be aware of how to book interpreters across all languages, including sign language, and book them when required.
- Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.
- Patients should expect a personalised approach to their language and communication requirements recognising that 'one size does not fit all'.
- High ethical standards, a duty of confidentiality and safeguarding responsibilities are mandatory in primary care and this duty extends to interpreters
- Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their first or preferred language and formats (written, spoken, signed etc)

- Documents which help professionals provide effective health care or that support patients to manage their own health should be available in appropriate formats when needed
- The interpreting service should be systematically monitored as part of commissioning and contract management procedures and users should be engaged to support quality assurance and continuous improvement and to ensure it remains high quality and relevant to local needs.

6.47 There were several occasions when agencies struggled to achieve these standards when working with mother.

6.48 On the two occasions on which the Home Office had face to face contact with mother a qualified Vietnamese interpreter was provided. The initial accommodation in which mother was placed in Croydon had access to Vietnamese interpreters. Migrant Help also used interpreters to communicate with mother.

6.49 The Croydon Early Help PIP keyworker initially attempted to use Google Translate to communicate with mother. When it became clear that this was not effective, it was decided that an interpreter would be booked for subsequent meetings. Of the nine further meetings with mother, interpreters were available for five of them.

6.50 The Redbridge Early Intervention family support worker was able to obtain the services of an interpreter when she met with mother and Baby T at the Children's Centre on 27th April 2017 and when she held the TAC meeting on 16th May 2017. Otherwise the involvement of interpreters is unknown.

6.51 There were several occasions when mother's interpreting needs were not, or not fully, addressed leading to less than satisfactory outcomes including her initial registration with Ilford Medical Centre which led to little information being obtained from her. This may have been a factor in the absence of any referrals of mother and Baby T to local services by the GP practice. Additionally, the absence of interpreting services appears to have been a factor in preventing the Redbridge health visitor in gaining a fuller understanding of mother and Baby T's needs and which influenced the decision to offer only a 'universal' health visiting service.

6.52 There were several occasions when mother's interpreting needs were not, or not fully, addressed leading to delayed appointments (paragraphs 4.17) or instances when the purpose of the meeting could not be achieved (paragraph 4.42). On one occasion a Mandarin interpreter was booked by mistake which meant that the Croydon health visitor was unable to complete a new birth visit (paragraph 4.21).

6.53 There were several occasions when a Vietnamese interpreter had been booked but the agency contracted to provide the interpreter was unable to do so

(paragraphs 4.47, 4.65 and 4.68), often at very short notice. The provider suggested that there was a shortage of Vietnamese interpreters in this part of London. One meeting arranged between mother, NELFT and the lead reviewer to enable mother to contribute to this review was cancelled at very short notice through interpreter unavailability.

6.54 On another occasion the Vietnamese interpreter may not have had adequate skills, although this does not appear to have been picked up on by the Croydon health visitor using the interpreter to communicate with mother (paragraph 4.24). Mother was recorded as saying that she wasn't isolated and had a stable family environment which seem unlikely to have been her actual responses.

6.55 On occasions practitioners made use of the services of a friend of mother's who is believed to have been a fellow Vietnamese asylum seeker who could speak English. The friend proved an effective point of contact to make and confirm appointments with mother but on at least one occasion was used for a wider interpreting role which may not have been entirely appropriate due to the friend's lack of training and the potential risk that she may have added, omitted or edited information. However, Ilford Medical Centre's policy is to advise patients who need an interpreter and are making an emergency, as opposed to a planned appointment, to bring a friend to interpret for them.

6.56 Mother was discharged from the IAPT service because the agency which supplied interpreters to NELFT were unable to source a female interpreter as requested by mother. Mother's rejection of the male interpreter provided during an earlier contact with IAPT created a dilemma for the service. It would have been helpful to explore her reasons for objecting to the male interpreter as it seems likely that there were cultural factors involved (paragraph 6.39). However, no discussion took place with mother or with any of the other services involved with mother to try and find a solution.

6.57 Various practitioners signposted mother to ESOL (English for Speakers of another Language) but there is no indication that mother accessed this service. It would have been helpful to work with mother to overcome any barriers to accessing the classes such as the cost of public transport and the availability of creche facilities. The Learning and Work Institute mapped ESOL provision across Greater London in May 2017 (13) and found that reductions in Adult Education funding had seen participation in ESOL learning fall between 2010 and 2016 although many providers reported high levels of demand. The mapping exercise found that ESOL classes in Redbridge were over-subscribed with evidence of particular demand for provision at lower levels of understanding of English.

The effectiveness of single and multi-agency responses to safeguarding concerns in respect of mother and Baby T

6.58 The short periods during which mother was known to services in Hackney, Croydon and Cardiff limited the completion of detailed assessments. As a result, a reasonably full picture of mother's vulnerabilities was only obtained over time. Potential indications of trafficking will be considered later in this report as will the lack of information obtained about father and the circumstances in which he appeared to abandon mother.

6.59 The fullest information about mother's past life in Vietnam was obtained by her then solicitor in December 2016 and shared with her Croydon PIP key worker (paragraphs 4.26 to 4.28). This indicated that mother may have experienced considerable trauma as a result of the arrest of her husband and herself and their treatment whilst in detention which apparently led to the death of her husband. Mother may also have experienced separation and loss arising from leaving her two older children and her parents in Vietnam. The IAPT triage assessment of mother in May 2017 found that she met the criteria for PTSD (paragraph 4.65). She was offered CBT but only one session took place – in August 2017 – before she was discharged from the service. She was also prescribed an antidepressant.

6.60 Mother also disclosed a previous history of postnatal depression to her Croydon health visitor (paragraph 4.24) which she was reported to have self-managed. She said she was experiencing postnatal depression following the birth of Baby T when she saw the Ilford Medical Centre GP in July 2017 (paragraph 4.58) which appeared to be confirmed by the subsequent RAABIT assessment (paragraph 4.60).

6.61 During the July 2017 conversation with her GP, mother said she wanted to die, adding that she had been having thoughts of wanting to step into the traffic. When assessed by the RAABIT practitioner two days later she presented with low mood and a sense of hopelessness. She expressed suicidal thoughts but denied any intent to act on these or harm her child. When she met the CBT therapist in August 2017 (paragraph 4.68) mother disclosed anxiety symptoms, nightmares and a 'sense of suffocation'. She said she had thought about hurting herself but could not do this as she had to take care of her child.

6.62 Social isolation also appeared to be a key factor in mother's presentation. She told the Redbridge GP that she lacked support from relatives or friends and the IAPT high intensity therapist felt mother was very isolated as she spoke no English. Mother's lack of connectedness to the world in which she then lived including having nowhere she could visit to practice her religion. Social isolation, dependence and

boredom have frequently been found to be present in the UK asylum seeker experience, together with high rates of self-harm and risk of suicide (14).

6.63 The impact on mother's parenting of Baby T of her mental health issues and the effects of her life as an asylum seeker did not appear to be fully considered by agencies in contact with her. At the time of the GP referral to RAABIT, the child was perceived to be a 'protective factor' in respect of mother's mental health. Previous SCRs have found that whenever practitioners perceive children as 'protective factors' in respect of parental mental health, the unintended outcome is invariably to increase risks for the children who in this case was a six month old baby (15). Whilst there is no evidence that mother's mental health issues affected her parenting of Baby T, perceiving the child to be a 'protective factor' may have been a factor in the absence of a referral to children's social care at the time her GP referred her to mental health services in July 2017.

6.64 It is important to note that most parents or carers who experience mental ill health will not abuse or neglect their children. However, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured parental mental health problems (16). Additionally, the risks to children are greater when parental mental health problems exist alongside problems such as unemployment, financial hardship, poor housing, discrimination and a lack of social support (17). Together, these problems can make it very hard for parents to provide their children with safe and loving care (18). In mother's case her mental health problems were accompanied by unemployment, financial hardship, some evidence of housing which was in an unsatisfactory state of repair and social isolation.

6.65 As previously stated there was a missed opportunity for either mother's GP or NELFT to make a referral to children's social care when mother's mental health appeared to further deteriorate in July 2017 (paragraphs 4.60 and 4.61). Additionally Redbridge Early Intervention and Family Support and the Children's Centre closed mother and Baby T's case at a time when they were aware that mother had been referred to IAPT, but they were unaware of the outcome of IAPT referral.

6.66 Concerns about mother's parenting had arisen from time to time including co-sleeping, leaving her baby on the edge of the bed and leaving the baby with a male resident of address 3 who was unknown to her. Such concerns as did arise were not linked to mother's mental health issues. Mother's co-sleeping with Baby T was attributed to Vietnamese culture and advice was provided to her. However, the Redbridge Early Intervention family support worker completed two Neglect Toolkits, neither of which indicated any concerns. Additionally, mother was assiduous in seeking medical assistance when Baby T became ill.

6.67 Services in contact with mother and Baby T were consistent in perceiving the child's level of need to be at Level 2 ('Children with Additional Need') in that she needed additional support to ensure her health and development needs were met (19). This additional support is referred to as 'early help' or 'early intervention' and can often consist of family support and children's centre support as received by mother and Baby T in Croydon and Redbridge. Baby T's needs were never assessed as reaching Level 3 ('Children with Complex Multiple Needs') which may have led to the drawing up a 'child in need plan'. Arguably the multiple challenges facing asylum seeking mothers and their infant children could propel them from Level 2 to Level 3. In Baby T's case, her mother's deteriorating and ultimately untreated mental health issues should have led to a reconsideration of the decisions taken by Redbridge Early Intervention and Family Support and the Children's Centre to close her case. Had referrals been made to children's social care by mother's GP or NELFT when her mental health deteriorated in July 2017, or by NELFT when mother was discharged from their IAPT service in September 2017, it seems likely that the decision to close Baby T's case would have been reconsidered and support at Level 2 resumed.

6.68 'Contextual safeguarding' is an approach to safeguarding children and young people which recognises and responds to more than individual and familial risks (20). The concept has generally been applied to adolescents because as they get older they spend increasing amounts of time outside the family home and experience greater influence from their peer group for example. It may be that the 'contextual safeguarding' concept could be usefully applied to the children of asylum seekers such as Baby T because of a range of factors which can impact upon their safety and wellbeing. Arguably poverty drove mother to work illegally which necessitated leaving Baby T in the care of an unregistered childminder also working in the illicit economy in which the framework of standards, inspection and scrutiny do not apply.

6.69 The fragility of Baby T's existence is illustrated by the events described in paragraph 4.51. As an asylum seeker mother could not open a UK bank account. However, mother's weekly allowance was loaded onto a debit card which was 'swallowed up' by an ATM after she inadvertently pressed the wrong buttons whilst attempting to obtain cash for food. Mother, with Baby T, went to the Children's Centre in a 'distraught' state. She is recorded as saying 'tired', 'headache' and 'I hungry'. There she received very good support. An interpreter arranged for a replacement debit card to be sent to her within 3-5 days, which is a very long time to be without any money to buy food. An appropriate offer of food bank vouchers did not help her as the Ilford food bank was closed on that day and the next. Eventually the Children's Centre family support worker was authorised by a manager

to take money from their 'tea and coffee' jar to purchase vegetables, meat and fish to tide her and Baby T over until the food bank opened two days later.

6.70 The social model of disability, which recognises the role of disabling environments as contributory factors, recognises poverty as a risk factor for mental illness (21). The level of asylum support (currently £37.75 per week for each person in the household plus an additional £5 per week for a baby under one year of age) compared to mainstream welfare benefits is intended to reflect the fact that asylum seekers in accommodation do not have to pay for utilities. However, lack of resources often leads to an inability to plan for the future, living each day as it comes, dependency on others and experiencing hunger (22) as this case discloses. Mother eventually decided to take the risk of working illegally in order to increase her income, as did the babysitter – female C.

6.71 Mother's decision to leave Baby T with the babysitter Female C whilst she began working as a nail technician appears to have been motivated by the desire to improve her financial circumstances but obviously carried risk. The babysitting service provided by Female C was unregulated and mother had no prior knowledge of her. Mother was her first customer so it was not possible to obtain any testimonials from other parents who had used the service. It is assumed that mother took comfort from the fact that Female C was Vietnamese - and would therefore provide a culturally acceptable service – and was also the mother of a young child herself.

The 'lived experience' of Baby T

6.72 Baby T was eleven months old when she died. The child lived with mother in initial asylum accommodation at address 3 for the first six weeks of her life. This is not accommodation which is intended for very young children so the environment is unlikely to have been particularly child-friendly.

6.73 She was 'dispersed' with her mother to Cardiff for a month during which there was a further change of address. Mother has said she felt alone and unsupported in Cardiff. The frequent moves in the first months of Baby T's life militated against tranquillity and stability. Baby T's father played no part in her life.

6.74 Baby T had a more stable existence once she and mother moved to Redbridge in January 2017. The accommodation was shared with other mothers and babies so Baby T may have enjoyed the company of other infant children.

6.75 Mother became mentally unwell from April 2017 but she was able to prioritise the needs of Baby T over those of her own and promptly sought medical care for the

child whenever she was ill. It is unclear what effect mother's post-traumatic stress disorder and postnatal depression had upon Baby T. There is an absence of observations about the attachment between mother and Baby T in the records shared with this review. The barriers of language and culture may have been factors in this as may the relatively short periods during which agencies engaged with mother and Baby T. The Redbridge Children's Centre which provided support to mother and Baby T for a time recently shared records with this review which provide some insight into the development of Baby T and her attachment to her mother. Baby T was described as a happy and contented child who was alert and attentive. She regularly smiled when she was given attention. She was clean and well dressed. Mother very responsive to her daughter's needs, calming her when she cried, placing her on her lap when she awoke and animatedly reading stories to her.

6.76 Mother had limited funds for food and clothing and the health visitor expressed concern at one stage that Baby T was not gaining weight as quickly as might have been expected (paragraph 4.51).

6.77 During September 2017 mother began leaving Baby T in the care of the babysitter Female C whilst she worked long hours in a nail bar. It was during the eleventh day on which she had been left in the care of Female C that Baby T sustained the traumatic injury which caused her death. The quality of care provided to Baby T by the female C prior to the incident is not known. Female C was caring for her own child so there should have been an opportunity for Baby T to interact with another young child. However, Female C appeared to have become accustomed to living 'under the radar' and so Baby T seems unlikely to have been taken to relevant groups in the community whilst Female C was caring for her. Female C may also have been distracted by the demands of the catering business she also ran from the home in which she cared for Baby T.

Indications of trafficking or exploitation concerns and agency responses

6.78 When mother telephoned the Home Office to initiate her claim for asylum on 7th June 2016, she was asked if she had been subject to exploitation on the way to, or in, the UK and whether the agent who facilitated her journey to the UK had forced her to do anything she did not want to. She answered in the negative.

6.79 During her screening interview the following day, mother was asked 'in your country of origin, on the way to the UK or within the UK, have you ever been subject to exploitation? For example, being forced into prostitution, forced labour, or do you have reason to believe you were going to be exploited?' Again, mother answered in the negative.

6.80 However, in an asylum interview conducted after the death of Baby T, mother said that when she arrived in the UK she was taken to a family by the person she travelled with and helped them tidying the house, cooking, taking care of children and after a period of time befriended the father of Baby T and he arranged accommodation for her. This response raised some potential trafficking concerns and so follow up questions could have been asked to clarify if mother had been exploited or if she had simply being helpful to the family who had taken her in. An evidence and policy review conducted by the University of Birmingham entitled *Poverty among refugees and asylum seekers in the UK* found that destitute women were sometimes subject to sexual exploitation in exchange for resources such as housing or food (23).

6.81 When mother was seen by the specialised midwife at the Rainbow Health Centre in Croydon (paragraph 4.13) there is no documentation to indicate that the midwife explored mother's whereabouts from the stated date of entry into the UK and no reference to her demeanour given that the victims of modern slavery can appear withdrawn whilst providing vague information about their personal, social or medical history. The Rainbow Health Centre did not use a specific template to assess for modern slavery in 2016 although the review has been advised that this has since been rectified. The short periods mother was known to services in Hackney, Croydon and Cardiff limited the completion of detailed assessments as stated earlier. It also limited the opportunity to explore less obvious vulnerabilities such as trafficking or exploitation. There was also a lack of inquisitiveness about trafficking and exploitation by practitioners on other occasions, including the period when Redbridge Early Intervention Service was working with mother and made no contact with either the Home Office or her solicitor, which were actions which went unaddressed. Nor did the Early Intervention Service assist mother with a planned financial assessment other than noting she was then in receipt of £70 weekly in the form of Asylum support.

6.82 Concerns about exploitation arose at the time of the fatal injury to Baby T. Queens Hospital included these concerns in their referral to Redbridge MASH (paragraph 4.74). Two apparently Vietnamese males were with mother at the hospital and initially declined to say who they were or what was their relationship to mother and Female C. One of the two men later identified himself as the partner of Female C and the other male said that he had transported mother (who he said he did not know) to hospital after seeing her in distress.

6.83 In his contribution to this review the Director of Vietnamese Mental Health Services said that Vietnamese nationals who had been helped to flee the country often incurred a debt as a result which could be as high as twenty thousand pounds depending on the route taken. It is not known whether mother was in debt to

anyone involved in helping her to travel from Vietnam to the UK, although she disclosed that her parents had paid bribes to secure her release from prison. A 2019 research study into the causes, dynamics and vulnerabilities to human trafficking in Albania, Vietnam and Nigeria (24) – countries which have consistently been amongst the top countries of origin for potential trafficked persons referred to the National Referral Mechanism – found the amounts being requested to pay for journeys to the UK were often unlikely to be paid upfront. Whilst small deposits might be made upfront or at different stages in the journey, the extortionate amounts being demanded for the journeys were accepted as debts. This meant individuals were debt bonded and highly vulnerable to being coerced into forced labour upon arrival. In mother's case it seems likely that any debt would be deducted from her earnings in the UK.

'Hidden Males'

6.84 There was insufficient professional curiosity about Baby T's father's details, questioning of father's role, or of anyone else who may care for Baby T, which would have informed both clinical and safeguarding risk.

6.85 The issue of 'hidden males' in families is a recurrent theme in SCRs conducted when children die or suffer significant harm (25). These SCRs have frequently found that practitioners rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children. Another 'hidden male' finding is that practitioners do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in practitioners missing crucial information and failing to spot inconsistencies in the mother's account. Baby T's father appeared to completely disengage from his relationship with mother prior to the birth of the child but there was generally a lack of professional curiosity about him particularly as he seemed to be a presence in mother's life as late as August 2017 when mother disclosed to the IAPT therapist that father continued to call her 'once in a while' but as she didn't have his telephone number, she was unable to contact him (paragraph 4.70).

Managerial oversight/Supervision

6.86 There were a number of instances where there appears to have been a lack of managerial oversight or supervision.

6.87 The Home Office decision to decline mother's application for maternity grant was incorrect. Given that mother was being supported under the Immigration and Asylum Act 1999 at the time of her application and that the application was made

within eight weeks of mother's estimated delivery date, there were no grounds to refuse it. The application was refused by a junior member of staff at a time when mother was considered to be destitute. The only way the matter appeared capable of remedy was for mother to be supported by Migrant Help to make an appeal which was successful. The question arises as to whether it would have been preferable for there to have been some checking of the decision to refuse which would have prevented the stress and uncertainty likely to have been experienced by mother in having her application refused which necessitated an appeal. The Home Office has advised this review that the member of staff who mistakenly turned down mother's maternity grant application has received managerial advice and that training in this area has improved.

6.88 In Croydon there is limited evidence of supervision oversight on mother's file, which is being addressed as a whole service priority in line with their children's improvement plan. However, from discussion with the PIP keyworker, she sought and was offered supervision support after visits to mother, but these were not recorded.

6.89 Croydon Health Services have advised this SCR that there was a shortage of safeguarding supervisors during period October to December 2016 and so there may not have been a robust system in place to provide three monthly safeguarding supervision to health visitors (who were themselves under pressure) and records for this period are not available. Recording of supervision was revised in 2018 and is now considered to be more robust.

6.90 NELFT has advised this review that there is no record of the Redbridge health visitor taking the case of mother and Baby T to any form of supervision for discussion, which would have been good practice given the known vulnerabilities of mother and the involvement of the Early Intervention family support worker and the health visitor's involvement in the TAC process.

6.91 There was a delay of over two months in a senior family support worker closing mother and Baby T's case, and adding management comments, due to workloads in the service at the time. This case closure did not prompt any query about the outcome of mother's IAPT referral.

Information Sharing

6.92 The routine sharing of information between BHRUT and universal services within NELFT for routine ED attendances did not occur from April 2016 until September 2017. At that time BHRUT became concerned about the amount of data being shared between BHRUT and NELFT with no apparent information governance

arrangements in place and so this was ceased pending a review. It is understood that at that stage NELFT were unable to provide BHRUT with an information sharing agreement that had been duly signed off by both organisations.

6.93 Prior to April 2016 the process at BHRUT Queen's and King George Hospitals was for a report to be generated daily from Symphony (Emergency Department System) which showed details of children living in Havering, Barking & Dagenham and Redbridge and included the triage notes and previous attendances for all children who presented the previous day. This also included clinical and demographic information. This information was sent to NELFT who provided this information to their health visitors and the school nursing service in respect of children under five years. This sharing of information was ceased from April 2016 although BHRUT has advised this SCR that any safeguarding concern would be raised 'in the normal way' to children's social care, independently of this process. However, information sharing about ED attendances of children, whilst not justifying a safeguarding referral, may contribute vital information towards building a fuller picture of developing safeguarding concerns.

6.94 In respect of mother and Baby T the health visitor does not appear to have been made aware of their 25th June 2017 attendance at Queen's Hospital ED. However, when Baby T was admitted to Queen's Hospital ED on the date of her death, the ED safeguarding advisor completed an ED community health visitor and school nurse notification form notifying the health visitor of the attendance.

The babysitter - Female C and her child

6.95 Female C appears to have largely avoided contact with services until she became pregnant. Her GP referred her to Homerton Hospital for antenatal care. There was a lack of professional curiosity in respect of the reasons for her late booking and there appears to have been no referral to the specialist public health midwife despite the fact that Female C met the criteria for this to have been considered.

6.96 Her child was delivered in Homerton Hospital and the baby was documented to be well with no problems identified. No details of post-natal support have been provided to the review.

6.97 Female C had no recourse to public funds (NRTPF) and made no approach to the London Borough of Barking and Dagenham NRTPF team for any assistance. Overall, her contact with services appears to have been limited. She did not register her child with a GP until May 2016. Although Female C's interaction with agencies was limited, her pregnancy and the birth of her child increased her contact with

services quite substantially for a time. During this period there appeared to be limited exploration of what the implications of Female C's NRTPF status could be for her and her new born child, including the risk of accommodation instability, destitution and exploitation. NRTPF means that an individual has no entitlement to welfare benefits, social housing, no ability to hold a driving licence, open a bank account, go to college or university or gain employment. A previous Serious Case Review which was commissioned following the deaths of a woman and her two year old child who had been refused leave to remain in the UK and then 'over-stayed', found that the ordinary safety-net represented by relatives, friends, neighbours, nursery school etc. may be entirely absent for a familyseeking to avoid attention.. (26). There is no indication that Female C was referred to the local NRTPF team or that referrals to any local specialist voluntary organisations were considered.

6.98 Female C applied for leave to remain in the UK on 7th March 2016. Her child was four months old at this time. She told the Home Office that she was being supported by a friend who provided food and accommodation. Her application was submitted in paper form. There was no face to face or telephone contact with the Home Office at that time. The Home Office have advised the SCR that, at the time of Baby T's death nineteen months after she made her application, checks were continuing in respect of Female C's application for leave to remain in the UK and that further information had been requested of her, which she had not provided. As with mother and Baby T, the length of time it can take for applications to be processed means that there is a possibility that the circumstances of a vulnerable mother and child can deteriorate during the intervening time.

6.99 The Home Office did not consider it necessary to make contact with health or social care agencies in respect of Female C or her child because no vulnerability concerns were evident from the paper application submitted. Female C was never accommodated by the Home Office and any address changes she made following her arrival in the UK were assumed to have been of her own volition.

6.100 Female C initially worked illegally in a nail bar prior to the birth of her child and later started a catering business from her home and began advertising on social media as a baby sitter at address 7 in Barking and Dagenham in September 2017. She had only recently begun acting as an unregistered childminder a short time before Baby T died following a traumatic injury whilst in her care. No agency became aware of the babysitting service she was providing until Baby T's injury.

6.101 This review has not been advised of any risk that Female C might present to children had previously been observed by any practitioner in contact with her or her child. However, Female C did not engage with mainstream services until the onset of

her pregnancy and the details of her contact with GP services, midwifery and health visiting provided to this review is brief.

6.102 Female C was noted to have limited English and it understood that interpreters were booked for antenatal appointments although the limited information shared with this review means that it is not possible to confirm this.

Good Practice

- The quality of care offered to mother and the unborn Baby T once referred to Hackney maternity services was good. There was evidence of good and effective interagency working between maternity and children's social care family support services, and timely referral and handover of care between maternity units and family support services from Hackney to Croydon.
- Mother, though destitute, appeared very reluctant to leave the support she was receiving in Hackney, particularly that which was being provided to her by the public health midwife, which suggests that she valued the support she was receiving.
- The Home Office made a prompt decision to provide support to mother when she became destitute and implemented the decision very quickly to ensure that she was provided with emergency accommodation the same night.
- The hotel receptionist at address 3 – a Migrant Help employee was a key part of the support offered and was in regular contact with the keyworker, including informing her of the birth of the baby.
- Croydon sent mother for early obstetric assessment which is in line with local recommendations particularly for women that are recent migrants to the UK to allow for additional obstetric/medical assessment. This appears to go beyond NICE guidelines (27).
- The Croydon PIP keyworker not only provided valuable support to mother and Baby T whilst they were living in Croydon but made a prompt referral to services in Cardiff when mother and Baby T were 'dispersed' there. When subsequently contacted by mother after she arrived in Redbridge, she again promptly referred mother to Early Help services.
- The response of the Early Intervention and Children's Centre family support workers to mother's distress when she was without money, food and without access to the local foodbank was both resourceful, caring and kind.

- There was evidence of effective use of the BHRUT A & E Safeguarding Children Trigger Checklist and checks of the Child Protection Information Sharing (CP-IS) in respect of both attendances and evidence of staff considering potential safeguarding concerns.

7.0 Findings and recommendations

Home Office initial response to mother's asylum claim

7.1 When mother initiated her asylum claim in June 2016 she disclosed she was four months pregnant with Baby T. She, and therefore the unborn baby, were vulnerable for multiple reasons such as lack of understanding of the English language, lack of knowledge of the UK health system and mother may have been suffering psychological issues arising from the circumstances surrounding her departure from Vietnam. Although the father of the child was supporting her financially, mother was completely dependent upon this support. At around four months gestation, mother was already late for obtaining antenatal support.

7.2 In the event mother presented to a GP practice within a relatively short period of time (early July), was referred to midwifery and was able thereafter to access specialised antenatal care. However, it would have contributed to mother and the unborn baby's health and welfare if the Home Office had referred her to local primary health services at the time she first initiated her asylum claim. As stated in paragraph 6.18, mother should have been referred to the Home Office's Asylum Safeguarding Hub, which may have led to a referral to local primary health services. It is recommended that BHR Safeguarding Partners request the Home Office take proactive steps to ensure that pregnant asylum seekers and asylum seekers with young children are referred to local primary care services at the point of first contact.

Recommendation 1

That the Home Office take proactive steps to ensure that pregnant asylum seekers and asylum seekers with young children are referred to local primary care services at the point of first contact.

Lack of Home Office oversight of mother's case

7.3 The Home Office exercised no oversight of mother's asylum claim from 26th January 2017 until they were notified of the death of Baby T in October of that year.

This impacted upon their ability to assure themselves that they were complying with Section 55 of the Borders, Citizenship and Immigration Act 2009, which requires them to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children in the UK (paragraph 6.4). Although mother and Baby T had been 'dispersed' to longer term asylum support accommodation at address 6 in Ilford earlier in January 2017, the vulnerabilities of an asylum seeker mother with an infant child are numerous and well documented in Home Office guidance. The Home Office has advised this review that they were experiencing heavy demand and high turnover of relevant staff (paragraph 6.4) at that time.

7.4 The Home Office has advised this review that they have implemented clearer guidance for reviewing cases which would prevent the drift in oversight of mother's case after further review of her case was deferred for three months after the birth of Baby T (paragraph 4.26). The BHR Safeguarding Partners may wish to seek assurance from the Home Office that the new guidance has had the desired effect in preventing the drift in oversight of cases involving very young children.

Recommendation 2

That the Home Office provide assurance that new guidance has had the desired effect in preventing the absence of oversight in cases such as that of mother and Baby T.

Home Office decision to 'disperse' mother and Baby T to Cardiff

7.5 The decision to 'disperse' mother and Baby T from Croydon to Cardiff when the child was 5 weeks and 6 days old interrupted the care and support being provided to mother and child and increased the risks to which they were exposed. NICE guidelines entitled *Postnatal care up to 8 weeks after birth* (28) identify the essential core (routine) care which every woman and her baby should receive in the first 6-8 weeks after birth. It is therefore welcome that, in their contribution to this review, the Home Office has acknowledged that the current six week policy should be extended to eight weeks or on receipt of sign off by the clinician of postnatal checks in order to facilitate the continuity of postnatal care to its conclusion.

7.6 However, in this case the 'dispersal' was intended to be temporary and so it proved to be when mother and Baby T were moved back to London after a month in Cardiff. Whilst it is acknowledged that there is considerable pressure on asylum support accommodation in London and the South East of England, to 'disperse' mother and Baby T to Cardiff appears to have been an unreasonable decision compounded by a further accommodation move in Cardiff. The practitioner learning

event arranged to inform and validate this SCR strongly endorsed the view that the primary Home Office focus appeared to be on processing mother as an asylum seeker and that the needs of Baby T received less attention. This has emerged as a central theme of this SCR. It is recommended that the BHR Safeguarding Partners supports the Home Office recommendation that asylum seeking mothers and their baby are never moved before the child is eight weeks old or the relevant clinician confirms that essential core postnatal care has been completed, whichever is the longer. It is also recommended that the BHR Safeguarding Partners request the Home Office rule out the temporary 'dispersals' of asylum seeking mothers and very young children.

Recommendation 3

That the BHR Safeguarding Partners write to the Home Office in support of their recommendation that asylum seeking mothers and their baby are never moved before the child is eight weeks old or the relevant clinician confirms that essential core postnatal care has been completed, whichever is the longer.

Recommendation 4

That the Home Office should consider ruling out the temporary 'dispersals' of asylum seeking mothers and very young children.

Requests to halt 'dispersals'

7.7 This review has been advised that practitioners are empowered to request the 'dispersal' of an asylum seeking mother and baby due to 'complications/needs of mother and baby'. It seems unlikely that mainstream agencies involved in supporting mother and Baby T in Croydon would have been aware that they could request the halting of their dispersal to Cardiff.

7.8 Whilst existing safeguarding training highlights the vulnerabilities of asylum seekers it needs to be enhanced so that practitioners can better support vulnerable people such as mother and Baby T. There are more supported asylum seekers relative to population in Redbridge than any other London Borough, with the exception of Barking and Dagenham (29). Practitioners providing support to asylum seekers would benefit from receiving bespoke training on the nuances and complexities of the asylum system. Raising awareness that practitioners can challenge dispersal decisions and the grounds on which they may do so should be included in any enhanced training provided. It is therefore recommended that the BHR Safeguarding Partners consider the provision of enhanced training on the

complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children. On the basis of this SCR, there is a need for this type of training across a number of London Boroughs and in other areas in which asylum seekers are placed.

Recommendation 5

That the BHR Safeguarding Partners considers the provision of enhanced training on the complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children.

Recommendation 6

That the BHR Safeguarding Partners share this SCR report with the London Safeguarding Board so that the provision of enhanced training on the complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children can be considered by other London Boroughs.

Role of asylum accommodation provider in making referrals to local services

7.9 Mother's asylum accommodation provider, Clearsprings Ready Homes was very proactive in promptly referring mother to local services when she was provided with initial asylum support accommodation in Croydon. However, when mother and Baby T were moved to longer term asylum support accommodation in Redbridge, there is no indication that Clearsprings referred or supported mother to access local services. There was a delay of over two weeks before she and Baby T registered with a GP and it took the intervention of mother's former PIP keyworker in Croydon to refer her for Early Help. As stated in paragraph 6.22, this delay was in breach of the accommodation provider's contractual obligations.

7.10 It is possible that the contrast between the help mother was provided with by Clearsprings in Croydon and Redbridge is related to the fact that the former accommodation is initial asylum accommodation in which Migrant Help staff are located whilst the latter was longer term accommodation in which mother, who was now in receipt of asylum financial support for food and clothing etc. was expected to manage her affairs more independently. However, mother clearly needed support to access local services and it does not seem unreasonable to expect her specialist accommodation provider to assist her. Helping her access services as quickly as possible would have helped her to become more independent.

7.11 It is recommended that the BHR Safeguarding Partners requests the Home Office to ensure they have robust mechanisms in place to ensure that providers of asylum support accommodation fulfil their contractual obligations to ensure pregnant

asylum seekers and asylum seekers with young children access primary care without delay, accompanying them where this is stipulated in the contract.

Recommendation 7

That the Home Office ensure they have robust mechanisms in place to ensure that providers of asylum support accommodation fulfil their contractual obligations to ensure pregnant asylum seekers and asylum seekers with young children access primary care without delay, accompanying them where this is stipulated in the contract.

7.12 In their contribution to this review Clearsprings have observed that no agency supporting mother and Baby T in Redbridge shared any concerns with them as their asylum accommodation provider. This would have required the consent of mother but no agency appears to have considered the potential benefits of sharing information with Clearsprings via their sub-contracted accommodation provider. It is therefore recommended that this issue is addressed when the learning from this case is disseminated to practitioners. Practitioners who attended the learning event which informed and validated this SCR felt that the Home Office could encourage appropriate information sharing by publicising information about their safeguarding role and arrangements and how local health and social care practitioners can best engage with Home Office safeguarding services.

Recommendation 8

It is therefore recommended that when the BHR Safeguarding Partners disseminate the learning from this case to practitioners the potential benefits of sharing information with asylum accommodation providers is highlighted.

Recommendation 9

That the Home Office publicise information about their safeguarding role and arrangements and how local health and social care practitioners can best engage with those Home Office safeguarding services.

Registration of asylum seekers with GP practices

7.12 The GP practices in Hackney and Redbridge were not successful in obtaining comprehensive information from mother about her health needs (and those of Baby T in respect of Redbridge). This may well be linked to the lack of use of interpreters. In Redbridge, the Ilford Medical Centre gave mother the new patient questionnaire in English to take away and she later returned it after obtaining help to complete it from a fellow Vietnamese national who had some English. When Female C visited a

UK GP for the first time after becoming pregnant, the information obtained from her appeared to be quite limited.

7.13 Given the importance of the role of the general practitioner as a provider of primary care and as a key gateway through which specialist health services are accessed, it is vital that as comprehensive a picture of the health needs of pregnant asylum seekers and asylum seekers with infant children are ascertained. In Redbridge the GP practice was able to obtain mother and Baby T's medical records from their Croydon GP within a reasonable amount of time but the lack of information initially gathered from mother prevented a prompt referral to the health visitor.

7.14 It is recommended that Redbridge Clinical Commissioning Group ensure that all GP practices within the Borough are made aware of the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children on registration so that all health needs can be addressed. It is also recommended that the BHR Safeguarding Partners request NHS England to emphasise the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children to all GP practices in England.

Recommendation 10

That Redbridge Clinical Commissioning Group make all GP practices within the Borough aware of the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children on registration so that all health needs can be addressed without delay.

Recommendation 11

That the BHR Safeguarding Partners requests NHS England to emphasise the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children to all GP practices in England.

Effectiveness of support provided to mother and Baby T

7.15 Mother received excellent support from the specialist public health midwife in Hackney, indicating that people in specialist dedicated roles can make a real difference. The Parent Infant Partnership key worker in Croydon also provided very effective support to mother and Baby T, in Croydon and in helping them access services in Cardiff and Redbridge.

7.16 However, agencies often struggled to engage effectively with mother and Baby T because they had limited time in which to build a relationship and conduct assessments. This was particularly the case in Croydon and Cardiff although the delay in dispersing mother and Baby T from their initial accommodation in Croydon probably provided early intervention services with the necessary time to carry out more in-depth work including an assessment. Health visiting services did not engage fully effectively with mother and Baby T in any of the three London Boroughs in which mother resided although mother and Baby T were correctly recognised to require the 'Universal Plus' service in Croydon although this level of service was not delivered. Once mother and Baby T arrived in longer term asylum supported accommodation in Redbridge, agencies had the opportunity to provide more than a 'stop-gap' service but both the Early Help and Family Support service and the Children's Centre closed mother and Baby T's case prematurely. In respect of the former service there were several actions outstanding and the outcome of mother's referral to IAPT was unknown. In respect of the latter service it had been agreed that they would keep mother and Baby T's case open but they did this for only a brief period. The premature closure of her case caused mother a degree of anxiety at a time when she was experiencing mental health issues.

7.17 Many of the services which mother and Baby T came into contact with in Redbridge often worked in isolation from one another. The exception to this was the TAC process which brought Early Intervention and Family Support, the health visitor and the Children's Centre together, although as stated above, the outcome of this partnership working was not effective. Effective communication took place when mother's GP referred her to RAABIT although neither service clarified whether or not mother and Baby T were in contact with a social worker and an opportunity to refer them to the Multi-Agency Safeguarding Hub (MASH) was lost. The discharge of mother from the IAPT service without her mental health needs being met should have generated a conversation with her health visitor at the very least.

7.18 It is recommended that this SCR report is shared with the Safeguarding Children Partners in the London Boroughs of Hackney and Croydon and in Cardiff so that they can consider the report and advise of any needs for improvements in practice which they identify, and the action they propose to take.

Recommendation 12

That the BHR Safeguarding Partners share this SCR report with the Safeguarding Children Partners in the London Boroughs of Hackney and Croydon and in Cardiff so that they can consider the report and advise of any needs for improvements in practice which they identify, and the action they propose to take.

7.19 It is also recommended that Redbridge Early Intervention and Family Support (now the Family Together Service) should review its arrangements for case closure, to ensure that cases are not closed without confirmation that all planned actions have been carried out and wherever possible planned outcomes have been achieved.

Recommendation 13

That Redbridge Family Together Service reviews its arrangements for case closure, to ensure that cases are not closed without confirmation that all planned actions have been carried out and wherever possible planned outcomes have been achieved.

Impact of mother's mental health on Baby T

7.20 When mother began presenting with mental health issues including post-traumatic stress disorder, postnatal depression and suicidal ideation, the impact of these issues on her parenting capacity went largely unconsidered by practitioners. Both Redbridge Early Intervention and Family Support and the Children's Centre without ascertaining the outcome of mother's referral to IAPT. The only inter-agency communication about mother's mental health were the referrals by the health visitor to IAPT and by the GP to RAABIT. The only multi-agency discussion about the potential impact of mother's mental health on her parenting took place between the GP and RAABIT when Baby T was inappropriately seen as a 'protective factor' in respect of mother's mental health. As previously stated a referral to children's social care was considered but ruled out on the erroneous and unverified belief that mother and Baby T were already being supported by a social worker.

7.21 Research indicates a number of key issues for practitioners to take into account when assessing the risks that parental mental health could present to any child within the household including (30) the paramount importance of focusing on the child; that assessment should be informed by the parent or carer's background, medical history and current circumstances with attention paid to other risk factors alongside mental ill health such as financial hardship; always taking threats of suicide seriously; and assessment should be a shared task between children's social workers and adult mental health practitioners.

7.22 It is recommended that the BHR Safeguarding Partners seek assurance over the level of practitioner awareness of the issues to be considered when parents present with mental health issues. Dissemination of the learning from this SCR may provide an opportunity for a range of disciplines, including adult mental health

practitioners to reflect on the potential impact of parental mental health on their children.

Recommendation 14

When disseminating the learning from this SCR, that the BHR Safeguarding Partners ensure that the key issues for practitioners to take into account when assessing the risks that parental mental health could present to any child within the household are prominently included.

Access to interpreter services

7.23 Whilst many agencies which came into contact with mother made effective use of interpreter services to engage with her and better understand her needs, there were several occasions when mother's needs were not fully understood or her access to services was delayed or limited as a result of lack of use, or access to, interpreter services. Any barriers to communication with mother had the potential to increase her vulnerability and as she was the mother of Baby T, put the child at risk as well.

7.24 It is recommended that the BHR Safeguarding Partners (which covers the local authority areas of Barking and Dagenham, Havering and Redbridge across which a single set of multi-agency safeguarding arrangements are being introduced) develop and implement as a matter of priority a strategy for improving the availability of appropriate interpreting services across the three local authority areas.

Recommendation 15

That the BHR Safeguarding Partners develop and implement as a matter of priority a strategy for improving the availability of effective interpreting services across the London Boroughs of Barking and Dagenham, Havering and Redbridge.

7.25 The court which convicted Female C of the manslaughter of Baby T found that she shook the child hard and probably also threw her. Shaken baby syndrome or abusive head trauma (AHT) is the leading cause of death and long term disability for babies who are harmed (31). Research suggests a demonstrable relationship between the normal period of peak crying in babies and the incidence of babies subject to AHT. There is a higher level of cases of AHT in the first month of life, a peak at 6 weeks of age and a decline in cases during the third to fifth month of a baby's life. Baby T was eleven months old at the time of her death although it is known that she had been unwell on the day before her death and that the babysitter had found caring for her quite challenging on that occasion. Excessive crying in babies can be difficult to manage for parents and carers and they need to be

advised on how to manage episodes of prolonged crying. It is not known whether the babysitter had been provided with advice on how to handle excessive crying by any of the practitioners she came into contact with when her own child was born. In Redbridge advice on how to manage crying and sleepless babies is available online and a Google translate facility on the website allows the information to be accessed in Vietnamese. This translate facility does not appear to be available in the Boroughs of Barking and Dagenham and Havering.

7.26 The BHR Safeguarding Partners may wish to seek assurance that advice to parents on caring for crying and sleepless babies is accessible in all community languages.

Recommendation 16

That the BHR Safeguarding Partners seek assurance that advice to parents on caring for crying and sleepless babies is accessible in all community languages.

Asylum Seeker Accommodation in Redbridge

7.27 Following the death of Baby T concerns arose about potential unmet needs and risks faced by asylum seekers, particularly pregnant asylum seekers or asylum seekers with children who are placed in the London Borough of Redbridge without local services being necessarily aware of their presence. Particular concern has been expressed about the potential vulnerability of numbers of vulnerable asylum seekers placed together in multiple occupancy properties such as the address in which mother and Baby T were living at the time of the child's death.

7.28 The BHR Safeguarding Partners may wish to consult with Redbridge Housing and other partners about how the learning from this review can inform approaches to address the risks associated with the placing of asylum seekers with dependent children in the Borough.

Recommendation 17

That the BHR Safeguarding Partners consult with local housing providers about how the learning from this review can inform approaches to address the risks associated with the placing of asylum seekers with dependent children in the Borough.

Practitioner awareness of modern slavery

7.29 In general, there was a lack of curiosity about mother's whereabouts from the time she entered the UK until she claimed asylum, the dynamics of the relationship

with Baby T's father who supported her financially for a time before abandoning her and the likelihood that mother and/or her family had incurred a debt for her flight to the UK which put her at risk of financial exploitation.

7.30 When the learning from this SCR is disseminated to practitioners this may present an opportunity to remind practitioners about indications of modern slavery and the expected response. It is therefore recommended that when the BHR Safeguarding Partners disseminate the learning from this SCR, the opportunity is taken to remind practitioners about policy and practice in respect of modern slavery.

Recommendation 18

That the BHR Safeguarding Partners widely disseminate the learning from this SCR and take that opportunity to remind practitioners about policy and practice in respect of modern slavery.

7.31 When this SCR report was presented to the final meeting of Redbridge Local Safeguarding Children Board, the Board decided to make the following additional recommendation:

Recommendation 19

That the Government should introduce legislation which would require the Home Office to inform a local authority of the details of any child placed or dispersed to their area with an asylum seeker parent or parents.

8. References

(1) Retrieved from

<https://www.mellowparenting.org>

(2) Retrieved from

<https://www.england.nhs.uk/wp-content/uploads/2014/03/hv-serv-spec.pdf>

(3) Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/695864/Vietnam_-_Ethnic_and_Religious_groups_-_CPIN_v2.0_ex.pdf

(4) Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496911/new_Healthcare_Needs_and_Pregnancy_Dispersal_Policy_EXTERNAL_v3_0.pdf

(5) Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769849/ICIBI_inspection_of_the_Home_Office_safeguarding_of_Vulnerable_Adults_Feb-May_2018.pdf

(6) Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496911/new_Healthcare_Needs_and_Pregnancy_Dispersal_Policy_EXTERNAL_v3_0.pdf

(7) Retrieved from

<https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/637/637.pdf>

(8) *ibid*

(9) Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496911/new_Healthcare_Needs_and_Pregnancy_Dispersal_Policy_EXTERNAL_v3_0.pdf

(10) *ibid*

(11) Retrieved from
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769849/ICIBI_inspection_of_the_Home_Office_safeguarding_of_Vulnerable_Adults_Feb-May_2018.pdf

(12) Retrieved from
<https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf>

(13) Retrieved from
https://www.london.gov.uk/sites/default/files/gla_esol_mapping.pdf

(14) Retrieved from
<https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2014/working-paper-series/IRiS-WP-1-2014.pdf>

(15) Retrieved from
F58F-42AD-B89A
96A4A692DF77&searchterm=maternal%20mental%20health&Fields=%40&Media=%23&Bool=AND&SearchPrecision=20&SortOrder=Y1&Offset=10&Direction=%2E&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

(16) Retrieved from
<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/>

(17) ibid

(18) ibid

(19) Retrieved from
<http://www.redbridgelscb.org.uk/wp-content/uploads/2015/09/Redbridge-LSCB-Multi-Agency-Thresholds-Documents-September-2018-Final.pdf>

(20) Retrieved from
<https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding>

(21) Retrieved from
<https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2014/working-paper-series/IRiS-WP-1-2014.pdf>

(22) ibid

(23) *ibid*

(24) Retrieved from

<https://www.antislaverycommissioner.co.uk/media/1277/between-two-fires-understanding-vulnerabilities-and-the-support-needs-of-people-from-albania-vietnam-and-nigeria-who-have-experienced-human-trafficking-into-the-uk.pdf>

(25) Retrieved from

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/>

(26) Retrieved from

<https://www.msrb.org.uk/msrb/downloads/file/163/2018-serious-case-review---ellie-overview-report>

(27) Retrieved from

[pregnancy-and-complex-social-factors-service-provision-pregnant-women-who-are-recent-migrants-asylum-seekers-or-refugees-or-have-difficulty-reading-or-speaking-english-service-provision.pdf](https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/)

(28) Retrieved from

<https://www.nice.org.uk/guidance/cg37/resources/postnatal-care-up-to-8-weeks-after-birth-pdf-975391596997>

(29) Retrieved from

<https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN01403#fullreport>

(30) Retrieved from

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/>

(31) Abusive head trauma: mechanisms, triggers and the case for prevention – presentation by Dr S. Smith March 2017.

Appendix A

SCR Process and Panel Membership

An SCR Panel of senior managers from partner agencies was established to oversee the SCR which was chaired by the independent chair of Redbridge LSCB. The membership of the panel was as follows:

Independent Chair (Chair)	Redbridge LSCB
Court Progression Manager	London Borough of Barking and Dagenham
Operational Director, Children & Families	London Borough of Redbridge
Director, Integrated Care	NELFT
Designated Doctor for Child Death	NELFT/Redbridge CCG
Specialist Crime Review Group (SCRG) Representatives	Metropolitan Police Service (MPS)
Principal Social Care Lawyer	Legal Services, London Borough of Redbridge
Contract & Compliance Manager – COMPASS	UK Visas & Immigration, Home Office
Designated Nurse Safeguarding Children and LAC	NHS Redbridge Clinical Commissioning Group (CCG)
Business Manager (Secretariat)	Redbridge LSCB
David Mellor	Independent Lead Reviewer

It was decided to adopt a systems approach to conducting this SCR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Agency reports including chronologies and agency reports which described and analysed relevant contacts with Baby T, his mother, Female C and her child were completed by the following agencies:

- HM Government Home Office
- LB Redbridge Early Intervention and Family Support Service (EI&FSS)

- NHS Redbridge Clinical Commissioning Group
- NELFT NHS Foundation Trust
- Barking, Havering and Redbridge University Hospitals Trust (BHRUT)
- LB Barking and Dagenham
- Metropolitan Police Service (MPS)
- London Ambulance Service (LAS)
- Croydon Health Services
- Croydon Early Help
- Homerton University Hospital

The provider of mother and Baby T's accommodation, Clearsprings Ready Homes contributed to the review by commenting on a late draft of the SCR report. Migrant Help contributed through a telephone conversation with the independent reviewer. The Director of the Vietnamese Mental Health Services also contributed valuable insights to this review via a meeting with the lead reviewer.

Mother contributed to this review through a conversation with the lead reviewer with the assistance of an interpreter. NELFT were providing support to mother at that time and the lead reviewer is grateful to her NELFT social workers for their assistance. It is planned for a summary of this SCR report to be translated into Vietnamese and shared with mother in due course.

A practitioner learning event was held to inform and validate the learning emerging from the SCR. This was an extremely well attended event to which colleagues travelled from Cardiff and the London Boroughs in which mother and Baby T lived.

The lead reviewer developed a draft report. With the assistance of the SCR Panel, the report was further developed into a final version and presented to Redbridge Local Safeguarding Children Board on 15th October 2019.