Bristol Safeguarding Children Board

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Baby L
Serious Case Review
April 2017

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1 INTRODUCTION

Why this case is being reviewed

1.1 This review is being undertaken because Baby L was found dead at the home where her Mother lived. Mother had denied a pregnancy and had gone to hospital with a suspected miscarriage. In the criminal proceedings Mother claimed that Baby L was not born alive, but medical evidence suggested she was alive at birth and Mother was convicted of the baby's manslaughter with diminished responsibility as a result of a "pathological denial of pregnancy"[1]. She received a sentence of a Community Order with a supervision requirement.

Methodology of the review

1.2 This review was undertaken using a systems methodology consistent with the requirements of Working Together 2013 and undertaken by two lead reviewers; one who is independent and one who is a manager employed by Bristol City Council. See below for their biographies.

1.3 The period of time reviewed was from when Mother moved to live in Bristol up to the day of the critical incident. This timescale was subsequently extended to include the events surrounding the discovery of Baby L as a result of information from the Child Death Overview Process that was recently made available to this review. This has caused a delay in the review process.

1.4 Chronologies and information was sought from all involved agencies. Interviews were undertaken with the majority of professionals who worked with Mother and her children before the critical incident and with some of those who dealt with the circumstances that lead to the discovery of the death of Baby L. Key documents were also reviewed. See Appendix 1 for a list of involved agencies.

1.5 There has been additional learning through the Child Death Overview Process; one aspect of the learning from this review is the importance of linking the SCR process and the Child Death Overview process with the aim of sharing knowledge and improving learning.

The Reviewers

1.6 Angela Clarke is currently Deputy Service Director Care and Support Children and Families for Bristol City Council. She qualified as a Social Worker in 1988, and since then has worked in a range of practitioner and managerial roles in 5 Local Authorities. She had no direct managerial responsibility for the professional input with this family.

[1] Jenkins, A et al (2011) Denial of Pregnancy: a literature review and discussion of ethical and legal issues: http://www.ncbi.nlm.nih.gov/pubmed/21725094

1.7 Jane Wiffin is a freelance social care consultant and has a professional background as a social worker, with extensive experience of safeguarding practice, developing policy and delivering pre- and post-qualifying education. She is an experienced Serious Case Review author, having completed over 45 reviews. She is an accredited SCIE Learning Together Reviewer. She is independent of all services locally.

1.8 A small reference group has provided peer review to the SCR process and made comment on drafts of the report.

Family Composition

	Age at time of critical incident	Ethnicity
Baby L	Deceased	Dual Heritage
Mother of all the children	33 years	Black African
Father of siblings 1 & 2	34 years	White/European
Sibling 1	5	Dual Heritage
Sibling 2	3	Dual Heritage
Half-sibling	Not known	Black African
Half-sibling	Not known	Black African
Half-sibling	Not known	Black African
Sister – Maternal Aunt to Baby L		Black African

Family Involvement in the review

1.9 Contact was made with Mother early on in the review process and she was seen by the two reviewers and an interpreter. Mother said she did not want to talk about the circumstances that led to the baby's death, and asked that the reviewers talk to her solicitor. This was done. The solicitor shared her view that Mother had a learning disability, very poor English and had struggled to understand what had happened. She confirmed this was the view of the psychiatrist and a psychologist who assessed her during the criminal proceedings. Father 2 (Father of Sibling 1 and Sibling 2) was interviewed as part of the review, and as his first language is not English his social worker acted as an interpreter. He had very little information to share, as he had not seen Mother for some time. The reviewers also met Maternal Aunt briefly and some of her children. Since her sentencing, Mother has spoken to her Probation officer about the Father of Baby L and reported that the pregnancy was a result of a brief liaison.

Family History

1.10 Mother originates from a country in Africa and she has three older children who still live there, cared for by Maternal Grandmother. Mother moved to a European country and met Father 2 by whom she had two children, Sibling 1 & Sibling 2. When the siblings were very young Mother came to the UK and met a new partner, who was domestically abusive to her, and she ended this relationship and moved to live with her sister

(Maternal Aunt) and her three children in very cramped housing conditions. Sibling 1 and Sibling 2 are now living overseas with Father 2 and their Maternal Grandmother and they are doing very well.

2 PROFESSIONAL INVOLVEMENT WITH THE FAMILY

2.1 This section provides a narrative summary of the professional involvement with Baby L focusing on an appraisal of the practice response at different points across the timeframe.

2.2 Mother moved to live with her sister when Sibling 1 was approximately two years old and Sibling 2 was around 6 months old. Mother sought advice from her GP at this time regarding a health concern for Sibling 2 which was addressed, and also because she was feeling tired. Mother's sister accompanied her for these appointments to act as an interpreter as Mother's first language was not English.

2.3 Eight weeks later the health visitor did an introductory visit to complete the routine Family Health Needs Assessment[2] and the 8-12 month developmental check[3] for Sibling 2. Mother's sister acted as an interpreter and the family history was shared. Both children were assessed as developing appropriately, and a good relationship was observed between the children and Mother. Mother reported feeling slightly depressed and anxious, and she said she had some minor health problems, such as back ache. Mother was advised to see her GP regarding feeling depressed. The health visitor made an application to some charities for household items. Although the flat was clean and tidy, it was quite sparse. Mother was also given information about local groups and a referral was made for a nursery place for Sibling 1. The family were assessed as requiring routine health visiting support.

2.4 Three months after this contact Mother sought help from a voluntary organisation that provided help regarding domestic abuse. Mother's sister acted as an interpreter. Mother reported that her ex-partner in London had been physically and verbally abusive to her and she had ended the relationship, and moved away to live with her sister. A DASH[4] assessment was undertaken and a caseworker allocated. An initial support plan was completed by the caseworker with Mother a month later, which included support regarding entitlement to benefits, accessing a national health number and English as a second language classes. These were appropriately progressed during a subsequent home visit, but the caseworker then struggled to make contact with the

[2] The Family Health Needs Assessment (FHNA) is an assessment of family health needs based on the 'Framework for assessment for children in need and their families' (DOH 2000) and includes assessment of the child's developmental needs, parenting capacity, family health and environmental factors. It is underpinned by The Healthy Child Programme (HCP) (2009).

[3] The Healthy Child Programme (HCP) (2009).

[4] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model is a common checklist for identifying and assessing risk: http://www.dashriskchecklist.co.uk/

family, and Mother was not seen again for several months. During the next home visit by the case worker housing options were discussed, but after this contact was again difficult, and the voluntary organisation decided to close the case. They sent Mother a letter informing her of this decision, and suggested she would be welcome to make contact in the future if she needed help.

2.5 Seven months later a Community Nursery Nurse (CNN)[5] made a home visit to undertake the two year developmental review for Sibling 2. Mother's sister acted as interpreter for the visit. Sibling 2 was found to be developing appropriately and a good relationship was observed between Mother and the two children. It was reported that Sibling 1 had some nose and throat problems, and an appointment was organised to address this. The CNN visited the next day to complete a nursery application for Sibling 1 and Mother discussed that an ex-partner had been domestically abusive, and she felt that Father 2 was very controlling, despite living in another country. Mother said that she was experiencing depression and back problems. The house was described as tidy, but overcrowded. The CNN suggested Mother make contact with Shelter regarding housing issues; when the CNN realised they did not accept self-referrals, she completed the referral herself.

2.6 The referral for nursery provision was sent to the Children's Centre. This included the information known about the family circumstances: Mother's depression and bad back; a controlling partner overseas; and that Mother had little support. Establishing initial contact with Mother took the Children's Centre repeated attempts with barriers to communication including language, but a few months later Sibling 2 was re-referred. The Children's Centre undertook a home visit before Sibling 2 started at the nursery. The Children's Centre had regular contact with Mother and the children, and noted that they were struggling because of financial difficulties and poor housing. At this time Shelter were also trying to address housing issues, unsuccessfully.

2.7 Three months after Sibling 2 started to attend the nursery at the Children's Centre they became concerned about the family's situation because of isolation, overcrowding, some worries about the wider family social circumstances, in particular their impoverished situation, and some concern that they might be subject to exploitation or Human Trafficking[6]. The Children's Centre spoke to Mother about seeking support from Children and Families services, and she agreed to this. This was facilitated by a worker from the nursery who spoke a similar language to Mother. A referral was made and passed to the Early Help team[7] and was responded to two months later. This delay in response was caused by capacity issues at this time and the need to prioritise more

[5] Community nursery nurses work with families and children (usually from birth to age eight) within community nursing, health visiting and family support teams. They use their specialist knowledge of children's health needs to support parents and boost the child's development.

[6] Human Trafficking is the recruitment or movement of persons, by means of the threat or use of force, deception or coercion for the purpose of exploitation. http://www.stopthetraffik.org/uk/page/what-is-human-trafficking-uk

[7] https://www.bristol.gov.uk/resources-professionals/changes-children-and-young-peoples-services-children-first

urgent needs. The Children's Centre were asked to continue supporting the family, and a letter was sent to Mother outlining this, and also suggesting that the health visitor could consider if the family needed any additional support. There was no evidence of exploitation or Human Trafficking identified.

2.8 At this time Mother would have been in the early stages of her pregnancy, but she did not share this information with any professional, nor with anyone else as far is known. The Children's Centre continued to support the family, and Sibling 1 also began to attend nursery. There were concerns regarding attendance, particularly lateness, and after discussing this with Mother the children were offered afternoon slots at a centre closer to the family home and attendance improved. This was effective practice. There were some infrequent concerns that Sibling 2 came to nursery hungry because of financial issues; housing remained a concern and there was some conflict between the adults in the home. Maternal Aunt was now pregnant and the Children Centre were aware that this would create further pressures for the whole family group. The children were observed to be developing well, and a good relationship was always noted between Mother and the children.

2.9 Nine months after Sibling 2 had started at the nursery, Mother's sister asked about a nursery place for the child of another sister. This sister planned to leave the child in the UK whilst she returned to Europe to work and look after her older children. The Children's Centre were concerned about this because of overcrowding, the number of adults in the household and that there remained a vulnerability regarding possible exploitation and Human Trafficking. The Children's Centre made contact with First Response[8] and were advised to contact the Early Help team. This prompted a home visit by a social worker, a family support worker and an interpreter. The sister was seen alone, and appropriately all documents were checked. The outcome was that there were no concerns, that the sister had not yet made a decision about whether to leave her child in the care of her sisters, and that although the flat was overcrowded, the sisters wanted to help. The conclusion of this assessment was that "*the family present as a caring, supportive family unit who are taking responsibility for their younger sister and providing her with the support she needs*" and no further action was considered necessary. The Children's Centre continued to have some concerns about the family's need for larger accommodation and their social isolation and they continued to support Mother and the children.

2.10 Soon after this the Ambulance Service received a 999 call from one of the sisters (unclear which one) reporting that Mother was bleeding, and may be pregnant. An ambulance was despatched and the ambulance crew found a situation of chaos, with a party underway, and many children present. They attempted to communicate, but the whole family spoke in their own language and the ambulance crew attempted to

contact the language service provider and were told there were no translators available for this common European language. Mother spoke some words of English and denied pregnancy and the ambulance crew found no obvious signs of labour or that a baby had been delivered, and it appeared that Mother had had a miscarriage. The ambulance crew sought help from the out of hours GP service, and the overnight maternity service. They also asked that a manager from the ambulance service attend to assist with the very chaotic situation. They were told a manager was not available. There was evidence that Mother had been bleeding heavily and the ambulance crew continued to try and persuade Mother to go to hospital. Mother refused and they called the police to assist, but when they arrived Mother agreed to be transported to hospital. This was two hours later.

2.11 Mother was seen in hospital by a senior registrar from obstetrics whose assessment was that she had likely had an early miscarriage, given her presentation and the early clinical results. Mother was admitted to a ward overnight. In the morning a scan was carried out at the hospital which was inconclusive, but suggested a later miscarriage might have occurred. It was agreed that discussions needed to be had with Mother with the aid of an interpreter, but this could not be organised until the next day. Mother denied that the pregnancy had been longer than had first been indicated and she gave a past problematic gynaecological history as an explanation for the inconclusive medical evidence.

2.12 The next day Mother's sister called the police because of her concerns and when the flat was searched a concealed dead baby girl was found. Mother was arrested the next day; she denied murder, but reported that Baby L had been still born.

2.13 A full forensic post-mortem was undertaken and the cause of death was unascertainable because of the time delay in finding Baby L. The pathologist found a piece of tissue inserted in Baby L's mouth and the conclusion was that this could provide an explanation for the death of Baby L.

2.14 It has been flagged in the GP and Hospital records that if Mother presents as pregnant or her sister presents with any concerns about a future pregnancy for Mother that immediate action needs to be taken. This will also be highlighted in the children's records should they return to the UK.

3 ANALYSIS AND CONCLUSIONS

3.1 The death of Baby L was both sad and unexpected. Mother did not acknowledge her pregnancy, and no professional was aware of it. Mother's sister had talked in passing to a health professional about the possibility of a sister being pregnant, but did not specify which sister and never discussed this again. Nothing about this interaction caused concern for the health professional and there was no indication of a need for any response.

3.2 All those who had contact with Mother and provided her with support were profoundly shocked by the death of Baby L. As part of the criminal proceedings after the death of Baby L, Mother was assessed as having "pathological denial of pregnancy", a condition which affects a small number of women each year, and which has significantly negative consequences, but which is almost impossible to predict or foresee[i]. The psychiatrist who assessed her said that the pathological denial of pregnancy had led to a state of panic and an absence of clear thinking when the baby was born. It is clear that no professional could have prevented the death of Baby L and appropriate action was taken to secure the safety and wellbeing of the surviving siblings. After a full assessment the children now live with their Father and Maternal Grandmother.

3.3 Although this family had deprived social circumstances, Mother was always observed to provide warm and loving care to the two children who lived with her. They were poor and disadvantaged by being relatively newly arrived in the UK. Mother had experienced domestic abuse and depression in the past, but it was only after the critical incident that led to this review that professionals become aware that Mother had a learning disability, and the extent of this appears to have been masked by having English as a second language and the support and interpreting skills of her sister. Despite these difficulties, Mother and her sister sought out and received appropriate help from a number of agencies.

3.4 The voluntary agency who provided early support responded quickly, and ensured all practical matters regarding benefits were addressed. They persisted in the face of some non-engagement. The health visiting service carried out universal health provision, and advised Mother to seek advice if her feelings of depression persisted. This depression was considered to be situational, and linked to the family's very difficult social circumstances, but was seen not to impact on either her care for the children, or Mother's contact with professionals. Shelter tried hard to address Housing concerns, but changes in legislation in relation to those recently arrived in the UK meant that there was little that could be done.

3.5 The Children's Centre were proactive in supporting Mother and were aware of the family circumstances. This led to worries about whether Mother might be vulnerable to exploitation or Human Trafficking, and appropriately they sought external help, particularly when a new family member moved into the already overcrowded home. The Early Help team assessed that there were no concerns regarding any child's safety and well-being, and they were impressed by the quality of care provided in difficult circumstances. All agencies were aware that Mother had English as a Second Language and that her English language skills were poor. Mother's sister provided support through interpretation. When the Early Help team undertook a home visit it was appropriate that they brought an interpreter with them. No professional was aware that Mother had a learning disability, although this does not appear to have impacted on Mother's ability to seek advice and support.

3.6 The ambulance crew who attended dealt calmly and professionally with a complex situation and ensured that Mother received medical help. Mother was admitted to hospital and appropriate medical tests were conducted.

4 REVIEW FINDINGS

4.1 This review has found that there was no action that could or should have been taken by any professionals, and that the sad death of Baby L was neither predictable nor preventable. The purpose of any serious case review is to establish whether there is any learning that can aid improvements in safeguarding practice in the future. This review has highlighted four key themes which would continue to promote effective practice with families in the future. These are:

- Noticing and addressing maternal depression;
- Working effectively with families where English is a second language;
- Professional awareness and action regarding denied or concealed pregnancy;
- Professional awareness of vulnerability to exploitation and Human Trafficking.

Noticing and addressing maternal depression

4.2 Maternal depression is a significant issue impacting on the well-being of women, their parenting capacity and their care and relationships with their children[ii]. There is significant evidence that poor maternal mental health can have a profound negative impact on children's outcomes in the short and long term. The Healthy Child Programme[9] has highlighted the importance of antenatal and postnatal professionals screening for depression[10]. This was done by the CNN in this case and Mother was provided with an opportunity to talk about feelings of depression; the CNN recognised that this was an issue for Mother, but that there was no evidence that this was impacting negatively on her or the children at that time. Mother was encouraged to seek advice from her GP and best practice would have been to follow this up to ensure Mother had sought help if she said she continued to feel depressed. The NICE guidance[11] [12]regarding mild depression suggests that there are a range of self-help processes which help and these could have been suggested to Mother[13] [14].

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[9] The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children: DH (2009) Healthy Child Programme – Pregnancy and the first five years; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

[10] The NICE guidance on antenatal and postnatal mental health (NICE 2014a, guideline CG192), recommends healthcare professional should consider asking the two Whooley depression identification questions and the GAD-2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf

[11] https://www.nice.org.uk/guidance/cg192/chapter/Key-priorities-for-implementation#principles-of-care-in-pregnancy-and-the-postnatal-period

The Board should consider whether professionals in the city need reminding of the importance of screening and self-help in relation to maternal depression.

Working effectively with families where English is a second language

4.3 Research and serious case reviews[iii] highlight that professionals sometimes lack the knowledge and confidence to work with children and their families from different cultures and religions. This can impact on professional capacity to offer appropriate help and support to these communities. Research has suggested that it is important that all frontline professionals develop Cultural Competence[iv] and confidence in talking[v] about cultural differences and practices in a way which respects communities but remains open to challenging oppressive practices that can be disguised as cultural issues.

4.4 Part of cultural competence is recognising the communication needs of families and working appropriately where English is a second language. It is important that professionals use interpreting services and follow the local guidance[15] and national advice[16] regarding this. It is important that professionals distinguish when it is appropriate to rely on family members and when formal interpreting/translating services are required. It is clear that children should never be asked to interpret/translate. In this case much of the contact professionals had with Mother was in the context of her self-directed need for support and she proposed that her sister act as a translator in that context. When a referral was made and a visit made by the Early Help service, they appropriately brought an interpreter as this was to make enquiries regarding issues of concern.

4.5 The ambulance crew appropriately sought help from the language service provider and were told there was no one available late on a Friday night. The medical team also struggled to get an interpreter over the weekend, but were eventually successful.

4.6 This case does highlight how English as a second language can mask the identification of other parenting capacity issues such as a learning disability. Research is clear that professionals need to adapt their approach and communication style to work well with learning disabled parents, but a critical part of that is identification and assessment of needs[vi] [17]. This is much harder when you are communicating through a third party and

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[12] https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#treatment-choice-based-on-depression-subtypes-and-personal-characteristics

[13] NICE (2009) Treating depression in adults Information for the public: https://www.nice.org.uk/guidance/cg90/resources/treating-depression-in-adults-316004588485

[14] http://www.mind.org.uk/information-support/types-of-mental-health-problems/depression/self-help-treatment-and-support/#.VxdiH0wrLX4

[15] http://www.proceduresonline.com/swcpp/bristol/p_work_interpret.html?zoom_highlight=cultural+competence

[16] http://www.communitycare.co.uk/blogs/childrens-services-blog/2012/06/working-with-interpreters/#.VxdwnEwrLX4

[17] http://www.changepeople.org/

thought should be given to whether poor understanding is to do with language or cognitive capacity.

4.7 Overall, the evidence suggests that the family's cultural context was respectfully recognised and openly discussed. Practice could have been enhanced by the use of the culturagram[viiviii] [18] to explore Mother and the children's cultural context in more detail.

The Board could consider prompting the use of tools and frameworks which build effective culturally competent practice in the context of the signs of safety approach.

Professional awareness and action regarding denied or concealed pregnancy

4.8 Denial of pregnancy is a serious issue which affects around 1 in 2,500 pregnancies. This is a similar profile to women with eclampsia[ix]. The outcomes for the unborn babies are often serious, with evidence of abuse, neglect and infanticide. However, this is a condition which is hard to identify, and the profile of women who present with denied pregnancy is quite diverse making it also an unpredictable issue.

4.9 Given the very negative outcomes it is important that professionals are aware of the significance and frequency of denial of pregnancy, in order that it is recognised and appropriate action taken. When previous denial of pregnancy is known, it is also important that action is taken to ensure that professionals and family members are alert to any future pregnancies.

There is clear guidance about the action to be taken regarding suspicion of denial of pregnancy in the BSCB safeguarding procedures but the Board may wish to raise awareness of this in the context of this case.

Awareness of vulnerability to exploitation and Human Trafficking

4.10 Human Trafficking is recognised by the Government[x] as an important issue which has a profound impact on a number of vulnerable people and children in the UK. The Home Office has highlighted the importance of an awareness of this issue amongst all professionals in order to identify and protect those at risk of harm and offer them appropriate support and they have produced guidance on this issue[19]. The National Crime Agency has developed a clear process for referrals to be made which is known as

[18] http://socialworkculturagram.weebly.com/culturagrams.html

[19] Home Office (2013) Practical Guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181550/Human_Trafficking_practical_guidance.pdf

The National Referral Mechanism (NRM)[20] and they have also produced Best Practice Guidance[21]. The NSPCC has produced a specific guide regarding child trafficking[22] . Despite all this activity Human Trafficking remains a hidden problem and it is good practice that the Children's Centre recognised that this might be an issue impacting on this family. They took appropriate action in line with the national referral mechanism. They did not, however, always feel that others recognised that their concerns were legitimate. In this case there was subsequently no evidence that indicated this was a concern for this family, but it was clearly an important question to ask. This highlights the need for raising awareness of Human Trafficking.

The Board could consider raising awareness of Human Trafficking and the associated best practice guides as part of its current work on sexual exploitation.

[20] http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism

[21] NCA Best Practice Guide: http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/best-practice-guide

[22] NSPCC: Child trafficking and slavery: advice for social workers: https://www.nspcc.org.uk/globalassets/documents/advice-and-info/child-trafficking-advice-social-workers.pdf

Appendix 1

Agencies involved in the review:

- Bristol CCG – General Practitioner
- North Bristol Trust - Health Visiting
- University Hospitals Bristol NHS Foundation Trust – Midwifery service, Bristol Royal Infirmary
- South West Ambulance Service NHS Foundation Trust
- Bristol City Council – Children services.
- Bristol City Council – children's centre
- Avon Fire and Rescue Service
- NextLink

Endnotes

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[i] Jenkins, A et al (2011) Denial of Pregnancy: a literature review and discussion of ethical and legal issues: http://www.ncbi.nlm.nih.gov/pubmed/21725094

[ii] Aldgate, J et al (2011) Children's Needs – Parenting Capacity Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence: 2nd edition: The Stationary Office. Downloadable at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

[iii] NSPCC: Culture and faith: learning from case reviews: Summary of risk factors and learning for improved practice around culture and faith: Published on line @ https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/culture-faith/

[iv] Gilligan P (2013) Exploring neglected elements of cultural competence in social work practice. Promoting and developing understanding of religion, belief and culture. Bradford: University of Bradford

[v] Bowyer, S (2015) Confident practice with cultural diversity: Frontline Briefing: Research in Practice https://www.rip.org.uk/resources/publications/frontline-resources/confident-practice-with-cultural-diversity-frontline-briefing-2015/

[vivi] Morris, J (2007) Good practice guidance on working with parents with a learning disability: DfE http://webarchive.nationalarchives.gov.uk/20080910224541/dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075119

[vii] Congress, E. (2004). Cultural and Ethical Issues in Working with Culturally Diverse Patients and Their Families: The Use of the Culturagram to Promote Cultural Competent Practice in Health Care Settings. Social Work in Health Care,39(3/4), 249-262.

[viii] Parker, J and Bradley, G (2010) Social Work Practice: Assessment, Planning, Intervention and Review (Transforming Social Work Practice Series); Learning Matters

[ix] Jenkins, A et al (2011) Denial of Pregnancy: a literature review and discussion of ethical and legal issues: http://www.ncbi.nlm.nih.gov/pubmed/21725094

[x] Home Office (2012) Human trafficking: inter-departmental ministerial group report https://www.gov.uk/government/publications/human-trafficking-inter-departmental-ministerial-group-report-2012