JS

Serious Case Review

Final Report

Sandwell SCR 2017

Contents

EXECUTIVE SUMMARY

Initiation of Serious Case Review

This review was initiated by Sandwell Safeguarding Children Board. JS had suffered serious physical harm and there were concerns the child may have suffered neglect. JS had been taken to hospital by their parents because JS was not sleeping or feeding properly. A urine sample taken during admission identified JS had morphine in their system.

Both parents were arrested and a decision as to whether there were grounds for a criminal prosecution was made by the CPS.

The criminal proceedings on this matter concluded in January 2019 with the father being convicted of wilful neglect of JS.

Summary of Case

JS was the first born child for both parents, the pregnancy was unplanned.

The period covered by this serious case review begins from the conception of JS until JS was 6 months old.

JS's mother was 16 and father 18 when JS was conceived; they received intensive support through the Family Nurse Programme. There was no children's social care involvement.

Early in the pregnancy mother expressed excitement about becoming a parent and was very welcoming of professional help and support.

Mother received limited support from MGM but father's wider family appeared supportive. A disagreement between mother and MGM in early pregnancy led to mother being homeless, spending weeks living with father's brother and family. There followed a move to live with PGF and PGM 2.

During pregnancy there were concerns about baby's growth and as a result mother had a series of growth monitoring scans. Mother was subsequently induced at 37 weeks into the pregnancy and JS was born.

After some initial weight loss, JS's weight stabilised and JS developed as expected.

Housing Services became involved when the couple applied for a house in father's name. Mother, father and JS moved to independent living when JS was nearly 3 months old.

Following the move, there were increasing concerns as mother and father started to disengage from services and there was an increasing number of indicators of neglect. No Multi-Agency Referral was made.

JS had five admissions to hospital. The fourth admission was particularly significant. Aged 5 months, JS was admitted to the Paediatric Intensive Care Unit (PICU). JS was very ill and required help with breathing for 24 hours. JS was thought to have had a chest infection, but they recovered unusually quickly.

The last admission was as an emergency. JS was brought with a history of poor feeding and lethargy for 2 days. JS was noted to be pale and lethargic. No cause could be established. A urine sample was sent for toxicology which identified morphine in JS's urine. A MARF[1] was

[1] Multi Agency Referral Form

completed. Child protection systems commenced with a joint investigation between the police and children's social care, to protect JS sustaining further harm.

The Morphine in JS's system could only have been administered by an adult. Morphine had been previously prescribed to the paternal grandfather.

Summary of Learning

It is clear that the professionals working with JS and family had not anticipated JS would come to physical harm. There is evidence of professionals being proactive and working hard to support mother and father during the mother's pregnancy and in the weeks following the birth of JS. There was a need for more joined-up thinking and recognition that this was a child and a couple who needed, and would have benefited from, a multi-agency approach, including housing, and a comprehensive plan both during and post pregnancy.

The following are the areas of learning from this serious case review:

- There was not recognition by all health professionals that this case required a multi-agency approach. The FNP service acted as a repository for everyone's concerns; the FN did receive information of missed appointments and admissions and discharges to hospital. The allocated FN followed up the concerns raised by secondary and tertiary care staff with mother and father, when they permitted. In short, the FN was placed in a position of taking full responsibility for everyone's concerns without full support from multi-agency partners.
- Agencies involved with the couple and JS did not recognise they had a crucial role in supporting the move from home to independent living.
- Professionals should have given more consideration as to whether their service was best placed to address the presenting issue. They did not follow guidance and make use of tools which might have helped them in their assessments and decision making. The routine use of recognised tools (e.g. significant events charts, chronologies, home condition assessments) would have assisted; however in particular there was no neglect tool for professionals to use. Perceptions around the threshold for MARF, expectations on individual practitioners from the FNP service, and concerns regarding the potential negative impact on the family unit if practitioners shared information gleaned during home visits, all inhibited practitioners from reaching out to partner agencies for help. The lack of a neglect tool and training on the use of the available tools contributed to the lack of exploration as to whether the threshold for onward referral for early help or child protection had been met.
- There was a lack of recognition of what constitutes a safeguarding concern and when there is the need to access support and supervision from safeguarding health professionals. As a result, support and supervision was not sought by professionals at appropriate points. Supervisors, whilst in an advisory capacity, needed to make greater use of the SSCB threshold policy.
- There needed to be more robust challenge by all practitioners when parents did not listen to advice and instructions.
- The policies and procedures provided sufficient guidance, but professionals did not effectively recognise the safeguarding factors and implement the SSCB procedures

- The extent that families take each other's prescribed medication is not known, however it is not a new phenomenon. It is vital that opportunities that present, for professionals to directly challenge any administration of a medication that has not been prescribed for a child, are taken. Safety advice is given by GPs at the time of prescribing and by pharmacists at the time prescriptions are collected. This is a learning point for health professionals.
- The actions of the acute hospital in discharging JS were in line with expected practice. Consideration needs to be given to whether all children who attend with excessive drowsiness without an immediately identifiable cause should have their urines sent for toxicology.

Recommendations

The Lead Reviewer has made the following recommendations endorsed by the Serious Case Review Panel:

Recommendation 1

SSCB should be assured that the pre-birth protocol is embedded and used in all relevant cases to ensure that young mothers and babies are able to access all relevant services.

Recommendation 2

The SSCB should be assured that the Threshold document is fully understood, and practitioners have confidence in it.

Recommendation 3

The SSCB and partners should agree and roll out a tool to assist professionals in the identification and grading of neglect to ensure that appropriate referrals are made, and action taken.

Recommendation 4

The SSCB should be assured by health partners that:

i) that they have in place robust provisions for supervision and
ii) ii) that they have in place robust 'Did not attend' (DNA) policies.

Recommendation 5

The SSCB should seek assurance from Housing Services (Neighbourhoods) that their officers are trained in safeguarding and think safeguarding in its widest sense, to include neglect and this should include the use of the Post Tenancy Sustainability Assessment form. The SSCB should also seek assurance from Neighbourhoods that their review of the tenancy management processes now gives their staff guidance and a process on how issues/vulnerabilities presented by individuals/families are identified and responded to.

Recommendation 6

The SSCB should enquire with the Director for Public Health about the launch of a prevention campaign aimed at parents/carers of safe handling and storage of drugs. This should include the dangers of taking them whilst they have care for children.

What will the SSCB do in response to this?

The SSCB and partner agencies have prepared SMART action plans which describe the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.

1 INTRODUCTION

1.1 Initiation of Serious Case Review

1.1.1 This review was initiated by Sandwell Safeguarding Children Board (SSCB) following concerns that JS had been seriously physically harmed. JS was six months old when these concerns arose and was the only child of mother and father. JS was taken into Local Authority Care following the arrest and subsequent bail of mother and father.

1.1.2 JS had been taken to hospital in January 2017; they were presented by their parents because they were not feeding and sleeping properly. A urine sample taken during admission identified JS had morphine in their system. The morphine was at a level the paediatrician considered could have had an effect on the breathing ability of JS, and which could have caused death.

1.1.3 There were additional concerns expressed by a police officer who attended the family home related to the environment in which JS was being cared for. The officer considered the family may be struggling to cope. The conditions were indicative of neglect.

1.1.4 Notification of the case was timely; from notification to the decision to conduct a Serious Case Review (SCR) was just six weeks. The case was discussed at an extraordinary meeting of the SCR sub-group on and it was recommended to the acting Independent Chair of the SSCB that the case met the criteria for a SCR. The acting Independent Chair made the decision to initiate the Serious Case Review. Nicki Walker-Hall, from a health background, was appointed as the Lead Reviewer.

1.2 Agencies and local authorities involved

1.2.1 The following is a list of the agencies involved with the family and the services they offered. Where abbreviations have been identified these will be used throughout the report to denote the organisation the reviewer is referring to:

Sandwell and West Birmingham NHS Trust:

Community Services

- Midwifery
- Family Nurse Partnership (FNP)

Hospital Services

- Emergency Department (ED)
- Paediatric Department

Sandwell and West Birmingham Clinical Commissioning Group

- GP Services

West Midlands Police Child Abuse Investigation Unit

Sandwell Metropolitan Borough Council

- Children's Social Care
- Housing – Neighbourhoods

Local Pharmacy

Royal Stoke University Hospital

- Paediatric Intensive Care Unit (PICU)

1.3 The process

1.3.1 This has been a systems review, focusing on the strengths and weaknesses of the multi-agency system in supporting young families and safeguarding children.

1.3.2 The review was managed by a review panel (see Appendix 1), consisting of senior managers of the involved agencies, working with the independent Lead Reviewer.

1.3.3 The membership of the panel was agreed at the beginning of the process to include representation of the main agencies involved, and/or of those that commission their services.

Period of Review

1.3.4 The period of review is from the beginning of mother's pregnancy with JS in 2015 –to the date of the incident in January 2017. It was agreed reference would be made briefly about the extent of agency involvement prior to this period if relevant and appropriate. Agencies that identified significant background history (where relevant) on family members predating the review period, and subsequently, were invited to submit a brief summary account of that history.

Terms of Reference

1.3.5 The Serious Case Review Sub-group and the Panel decided the key focus points for the review and highlighted the following lines of enquiry for consideration:

1.3.6 The Terms of Reference (TOR) are as described in Working Together[2] (see Appendix 2 for full TOR).

Key Lines of Enquiry and Scope of the Review

1.3.7 The following key lines of enquiry were agreed.

- Was support offered to the family appropriate and adequate?
- Was the family's transition to independent living appropriately managed?
- Was help from additional sources considered appropriately?
- Was there appropriate safeguarding supervision of frontline practitioners?
- Was there sufficient challenge by practitioners if the parents did not comply with advice and instructions?
- What policy and procedures do agencies use when clients request cessation of involvement of a service being provided to ensure a child is safeguarded?
- How did JS come to have prescription medication in their system?

1.3.8 The process used included:

- Chronologies from all involved agencies
- Two practitioners' events where those involved with the family met with the lead reviewer and a member of the review panel to consider their involvement. (Appendix 3) This staff participation enabled understanding of

[2] DFE (2015) Working Together to Safeguard Children.

what lay behind actions and decisions taken at the time, as well as enabling staff contribution and feedback to the analysis and findings of this review

- The Lead Reviewer was given access to key documents, policies and procedures

Timeline

1st Serious Case Review Panel set up meeting 9th May

- Development of chronologies by 30th June 2017

2nd Serious Case Review Panel 15th August 2017

- Development of the narrative

Practitioners' event 27th September 2017

- Development of the first draft report

3rd Serious Case Review Panel 31st October 2017

- Development of the second draft report

Practitioners' event 7th November 2017

- Agreement of the final report

4th Serious Case Review Panel 21st November 2017

SSCB Presentation – 12th December 2017

1.3.9 The timeframe from the outset promoted compliance with statutory timescales. Lead Reviewer sickness led to a one-month delay with the 4th panel meeting taking place on 21st December 2017 and the SSCB presentation on 25th January 2018.

Parallel Processes

1.3.10 There were two parallel processes during this review, the first being the criminal investigation of the parents and the second being the care proceedings in respect of JS.

Family participation

1.3.11 Mother and Father were made aware from the outset that this review had been initiated. It had been hoped that during the review decisions on whether there were sufficient grounds to bring criminal charges would be made. In light of the fact that no definitive decision had been made by the Crown Prosecution Service (CPS) during the review, the SCR Panel made a decision that it would not be advisable or appropriate for either parent to take an active part in this review.

Limitations

1.3.12 The criminal investigation impacted on this review. The Lead Reviewer would have welcomed an opportunity to speak to Mother, Father and the wider family, believing this would have provided insight and a greater understanding of the family's circumstances and their experiences of services during the period under review. This might have provided richness to the learning, as well as informing the findings and recommendations.

1.4 Structure of the report

1.4.1 The report is structured as follows:

Chapter 2 provides a summary of the overall context:

- a summary of what happened
- details of family members and a description of what was known about the family, in particular JS

Chapter 3 describes what happened from the perspective of the professionals involved at the time, explains the rationale for actions and decisions.

Chapter 4 provides an analysis of the themes emerging from the practice in this case, overall learning and recommendations

Chapter 5 provides the conclusions

2 CONTEXT

2.1 The Family

Term used in report	Relationship to child	Age at the beginning January 2017
JS	Subject of the review	6 months
Mother	Mother of JS	17
Father	Father of JS	20
MGM	Maternal Grandmother	N/A
MGF 1	Maternal Grandfather	N/A
MGF 2	Maternal Grandfather 2	N/A
PGM 1	Paternal Grandmother	N/A
PGF	Paternal Grandfather	N/A
PGM 2	Paternal Step Grandmother	N/A

2.2 Summary of what happened

Parental background

2.2.1 MGM and MGF's relationship ended prior to the birth of Mother. Mother was brought up by MGM and her MGF 2, without any knowledge of MGF until she was 12. On learning of her biological father's existence, mother opted to live with him, however the relationship broke down and mother returned to MGM and MGF 2s care. Mother was known by MGF 2's surname changing it, during her pregnancy with JS, to MGF's name.

2.2.2 The GP system indicates safeguarding services had been involved with mother from 2001 to 2011. The details of concerns at that time were not on recording systems, and therefore not known to professionals subsequently involved.

2.2.3 Professionals understood mother had been self-caring much of her life, adopting an adult role in childhood. Mother was the more mature and confident one of JS's parents.

2.2.4 Mother had three significantly younger half siblings, one of whom had health concerns and was referred to Children's Social Care (CSC).

2.2.5 Father had one sibling and was described by the professionals involved as "not very confident. Father's mother had died when he was young; he spoke of her often. Father was brought up by PGF and PGM 2.

Background prior to the period under review

2.2.6 None of the professionals involved with the couple had any involvement with mother, father or the wider family prior to the period under review. Mother was 16 years old, had left school and was serving an apprenticeship in the retail industry. Father was 19 and employed as a bricklayer.

2.2.7 Mother informed the midwife that she had experienced anxiety and depression; her symptoms, as described to the midwife (MW), "sounded like panic attacks". Mother reported a "history of anxiety and mental health issues" to the Health Visitor (HV). Mother had been referred for counselling but had failed to attend.

Period under review

2.2.8 The period covered by this serious case review begins from the conception of JS until the date of the significant incident when JS was 6 months old.

2.2.9 During this period there were significant changes in the parents' lives and a number of anxieties for the couple.

2.2.10 Early in the pregnancy mother was excited about becoming a parent and very welcoming of professional help and support. The couple were making plans; mother planned to continue her apprenticeship whilst father was going to stop work and care for JS. Mother was saving and preparing for JS's birth.

2.2.11 Mother was receiving limited support from MGM but father's wider family appeared supportive. A disgareement between mother and MGM in early pregnancy led to weeks spent living with father's brother and family. There then followed a move to live with PGF and PGM 2 before the couple settled into their own property three months after the birth of JS.

2.2.12 Mother's pregnancy was not straightforward; there were concerns about baby's growth and as a result mother had a series of growth monitoring scans. Mother was subsequently induced and went through a lengthy labour.

2.2.13 JS had five admissions to hospital in the first six months of life:

1. JS was jaundiced[3] post birth and required a 24-hour inpatient admission for phototherapy[4].
2. The GP referred JS to hospital aged 5 weeks as JS presented with fever, was unwell and crying and was admitted. JS was diagnosed with a kidney infection and commenced on antibiotic treatment (trimethoprim) until they had renal scans and been reviewed in out-patients. Aged 6 weeks JS had a renal scan, the findings were satisfactory. JS's symptoms likely related to a bacterial infection and therefore they continued prophylactic antibiotics as planned.
3. JS was admitted aged 4 months via their GP for inconsolable crying. JS remained in hospital for one day, nothing of note was found so JS was discharged home.
4. The following month JS was admitted to the Paediatric Intensive Care Unit (PICU) via the Emergency Department (ED) after father's GP referredthem. Father had been at a routine GP appointment and asked his GP to review JS as he was concerned. JS was unknown to this GP. JS was acutely unwell and having breathing difficulties. JS's oxygen saturations were 78%, very low, so an ambulance was called. On arrival at the ED, JS was very ill so was immediately intubated[5] and ventilated[6] for 24 hours, a CT head scan was normal. JS was thought to have had a chest infection but they recovered unusually quickly. JS

[3] Jaundice is a term used to describe the yellowing of the skin and the whites of the eyes. It's caused by a build-up of a substance called bilirubin in the blood and body's tissues and is very common in newborns due to the immaturity of their livers.

[4] Phototherapy - a special type of light shines on the skin, which alters the bilirubin into a form that can be more easily broken down by the liver

[5] Intubated - Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea (the large airway from the mouth to the lungs).

[6] Ventilated - refers to pulmonary ventilation, the movement of air in and out of the lungs, whether during normal breathing, or by artificial means

was then cared for on children's ward for a day or two and was very unsettled with spikes in temperature. JS eventually settled with treatment and was discharged home with follow up in out-patients.

5. The last admission was via ED. JS was brought in with a history of poor feeding and lethargy for 2 days. They were noted to be pale and lethargic. JS's chest was clear, urine sample was clear for infection, and blood tests were unremarkable. A urine sample was sent for toxicology[7] and JS was to be followed up by the team following discharge. Later the same day JS was re-admitted due to finding morphine in JS's urine toxicology screen. A Multi-Agency Referral Form (MARF) was completed. Following this, a further urine sample was taken which confirmed morphine (not prescribed) and trimethoprim (the prescribed antibiotic).

2.2.14 During JS's first six months, there were increasing concerns as mother and father started to disengage from services and there was an increasing number of indicators of JS being neglected. This was never made the subject of a referral.

2.2.15 JS is the first child for both parents. The practitioners described JS as happy, responsive and verbally stimulated, indicating some positives to mother and father's parenting.

[7] Toxicology - the branch of science concerned with the nature, effects, and detection of poisons

3 NARRATIVE AND APPRAISAL OF PRACTICE

3.1 Introduction

3.1.1 Section 3 provides a commentary on professional practice during the period under review.

3.1.2 The information is mainly derived from agency records, however to understand the rationale for professional practice what happened is described, where possible, from the perspective of those professionals involved at the time. Information provided after the morphine was discovered in JS's urine is also considered.

3.1.3 For ease the author has broken information into three sections:

1. Pre-birth
2. Birth until Independent Living
3. Independent Living until the critical incident

3.1.4 The commentary within the shaded boxes is an appraisal of professional practice. Where such appraisal and explanation reflect a recurrent theme regarding the service provided, there is a cross reference to subsequent analysis and/or findings.

3.2 Key Events

Pre-birth

3.2.1 In late 2015, mother aged 16 attended the GP to confirm her pregnancy; she indicated she was in a stable relationship with her boyfriend who was attending college and was aged 18 (almost 19 years old). GP records indicated mother was living with MGM and working full time. Mother was advised to book a midwifery appointment and commenced on vitamins.

3.2.2 Two weeks later the midwife went to the baby's father's brother's house to complete a booking appointment with mother. Mother indicated she had fallen out with her mother over the pregnancy as MGM did not like father. The household seemed very "normal" to the midwife. Living in the house were father's brother (paternal uncle), his partner (paternal uncle's partner) and their children. Mother was sleeping on a separate bed in the children's room.

3.2.3 The booking assessment was completed by the specialist midwife for teenage pregnancy and included:

- advice on symptoms to be concerned about
- discussion re birth preferences
- blood test forms were given. Mother declined testing for Down's syndrome.
- scans were offered and accepted
- observations and a physical examination – these were completed and satisfactory.
- mental health assessment – mother reported previous anxiety and depression.

3.2.4 Teenage pregnancy was noted and the Family Nurse Programme (FNP) was offered and accepted. The midwife followed the appropriate guidelines[8] which meant mother (aged 16) would be eligible for frequent routine scans as she was under 19, had a low BMI and was still growing herself.

3.2.5 Two weeks later the FN carried out a recruitment visit at paternal uncle's house; the couple and their children were present. The FNP was discussed and mother agreed to join the programme.

3.2.6 Mother indicated she was awaiting a dating scan appointment and wanted help with housing, she didn't want supported accommodation and thus this was not pursued as her age prevented any alternate housing option. Mother indicated she was working full time so late appointments were given.

3.2.7 In January 2016, mother reported to the FN she had made up with her own mother and was now visiting her regularly. Mother indicated her main emotional support came from her partner, mother and fathers brother. Mother discussed recent contact with her father whom she had not spoken to for 2 years. Her father now lived outside of the West Midlands, but travelled to attend one of mother's baby scans.

3.2.8 Mother reported a history of anxiety and mental health issues; she had been referred by her General Practitioner (GP) several years previously for counselling, but did not attend. Mother indicated she continued to experience some difficulties when stressed – (e.g. shortness of breath), the FN thought these might be panic attacks. PGF was now supportive but PGM 2 was disapproving of mother and father's relationship. Mother was reported to be moody at times but father reported he ignored moody episodes.

3.2.9 Mother and father planned to make a joint application for supported housing. Mother worked full time so was experiencing difficulty making the initial application. The option of father attending and starting the application process was discussed. Father reported he didn't feel confident to go by himself; his uncle's partner agreed to attend council offices with father to start the housing application.

3.2.10 The following day mother telephoned SMBC 'contact centre' and completed a Housing Options Triage form stating that her mother was asking her to leave the family home – mother gave MGM's address. There was no further contact with housing.

3.2.11 In January 2016, mother cancelled an appointment with the midwife stating she was going on a residential course for 3 days with college as part of her apprenticeship.

3.2.12 Whilst on a residential placement mother had stabbing type pains in her side. Five days later mother was reviewed by the midwife. Mother reported the pain in her side was much improved and she had an appointment at antenatal clinic the following day.

3.2.13 Mother reported her relationship with her mother had now improved but she was still living at father's brothers. Mother declined screening for congenital disorders.

[8] The guidelines for the management of young parents aged 19 and under

3.2.14 Mother reported to the FN she had moody episodes but these were now less often. Mother reported she had an appointment with a psychiatrist following a referral by the midwife at booking. Mother indicated she did not believe she needed any input at that time; her initial anxiety occurred in 2014 as a result of difficulties when living with her father. The FN completed a depression assessment, some anxiety was noted and mother was encouraged to look at methods of relaxation which she could use.

3.2.15 Mother and father reported they have been arguing regularly; a lengthy discussion on relationships followed. Mother's pregnancy was reported to be going well. Mother continued to work as an apprentice in retail management. Finance was reported to be difficult but they were trying to save to move into their own place. Father reported good support from his brother and his parents. Mother had some support but her mother had personal difficulties so was not able to offer much support.

3.2.16 Four days later the FN made a home visit. Mother reported good emotional support from father and his family and that her moods were much better, father agreed.

3.2.17 Mother indicated to the midwife she had gone back to live with her mother and her three younger siblings at their house. The midwife completed a Young Persons Needs Assessment and action plan. Mother indicated she would possibly stay with father and his family once the baby was born.

3.2.18 In April mother attended an ante-natal follow up with father, she forgot her handheld baby growth records (second occasion). Baby was active, the importance of foetal movement was discussed, and no concerns were expressed. The plan was to review mother in three weeks. Four days later mother failed to attend the appointment with the GP.

3.2.19 In May ante-natal staff became concerned about the baby's growth which was below the 10th centile. Two weeks later mother attended triage, with a first episode of diminished foetal movement.

3.2.20 Following a second episode of diminished foetal movement with associated abdominal pain, a scan confirmed baby's growth continued along the 10th centile. Mother was requested to stay in for steroids and bloods; she initially agreed but then declined. The doctor impressed on her the need for monitoring and investigating the cause of her abdominal pain but mother declined, giving no reason. Practitioners tried to explore mother's concerns but she refused to give them answers. An in-depth explanation of the risks of pre-term labour and other causes of abdominal pain was given and mother was told these needed investigation and management; mother accepted these risks. Mother was deemed to be competent with capacity and was able to understand and retain the information given. Mother signed a self-discharge form.

Birth

3.2.21 In the last few weeks prior to JS's birth, mother and baby were monitored each week. Growth scans were conducted and monitoring of foetal movement.

3.2.22 During this period mother failed to attend a further appointment with the GP for an HB blood test, and failed to attend an appointment at the young mum's clinic. Mother cited having weekly scans as the reason for non-attendance and declined

any follow up appointments at the young mum's clinic as she was attending the antenatal clinic.

3.2.23 In June 2016 (36 weeks plus 6 days into the pregnancy) a serial scan showed growth was all under 10th centile. Mother's blood test was still outstanding; a form was given to mother and she was strongly advised to get her Full Blood Count done. The doctor planned to chase the results. However, the case was then discussed with the consultant and a decision made to induce the birth.

3.2.24 Mother attended the labour ward for 'Introduction of Labour' for Inter Uterine Growth Retardation (IUGR), accompanied by father and a friend. Mother reported good foetal movement, she had no other concerns and her observations were satisfactory. Foetal monitoring was completed, there were no concerns. Mother was admitted to hospital.

3.2.25 Two days into mother's admission, MGM complained to the midwife that she wasn't happy with the care that mother was receiving; she thought mother had been refused food all day and had been waiting for two days to have her waters broken. The midwife explained the 'Induction of Labour' process. Mother told staff not to take any further calls from MGM and both she and father apologised.

3.2.26 As labour progressed mother was not coping very well and becoming distressed. Mother eventually agreed to an epidural and after a protracted labour JS was born by normal delivery at 37 weeks and 3 days. JS weighed 2.57 kg (25th centile).

3.2.27 Mother and JS went to the post-natal ward. Mother was shown basic care and handling. JS was bottle feeding every 3 hours. JS had some facial congestion which reduced during admission. JS was discharged home with their parents to PGF and PGM 2s house. Mother was given the red book[9], discharge papers, and information regarding cot safety, birth registration, GP registration, the role of Health Visitor and contraception. Mother and JS were to attend a 6-8 week review and Post Natal Check with the GP.

3.2.28 Mother swiftly registered JS with the GP. The midwife continued to visit, JS developed neonatal jaundice. The family were informed of the importance of regular feeding with regards to jaundice. On day five JS's SBR[10] was taken, (weight was down to 2.48 kg – 9th centile) the result indicated JS needed to be admitted for treatment. Four attempts were made to reach mother but she was not answering her phone. An attempt to telephone father also failed so the midwife went to the home at 20:00 to inform mother that JS needs to come in for treatment. JS was admitted and received phototherapy and a swab was taken for sticky right eye.

3.2.29 The next day JS was seen by the FN on the ward, she observed mother making a feed up with hot water from the tap; mother said staff had told her this was OK. The FN checked with ward staff and confirmed this was not the case.

3.2.30 JS responded well to phototherapy and was discharged after 24 hours; the eye swab yielded no growth.

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[9] Red book is the book health staff record baby's growth and developmental progress

[10] SBR (Serum Bilirubin) – All newborn babies have a raised SBR (Jaundice) This is caused by the liver not being fully developed and not yet fully functioning properly.

3.2.31 The midwife continued to home visit delivering post-natal care, advice and support. The midwife planned a transfer of care to the health visitor at day 12 but remained involved for a further week as JS had not regained their birth weight. At point of discharge, JS's weight had increased to 2.59 kg. Mother reported JS was feeding well, and indicated her moods were good and she was feeling happy; she was not feeling low or down.

3.2.32 The FN visited on day 13 and they discussed. Mother indicated she was feeling very protective towards JS.

3.2.33 During these early weeks, mother and father appeared to have good family support. JS's development was appropriate. JS was clean and dressed appropriately. JS was alert and responsive to family member's voice and appeared to be attempting to smile. JS was feeding and gaining weight (0.4th centile), and was observed asleep in their Moses basket on their back. Three weeks post birth mother reported she was feeling well, she acknowledged she had felt extremely tearful and tired for the first two weeks but extended family had been empathetic and supportive, baby-sitting to give the couple a break. Mother and father reported parenthood was going well generally and was easier than they had anticipated. Father was finding waking up at night difficult but reported mother woke him if needed. Father took some annual leave. JS was reported to be a very settled baby.

3.2.34 JS went to the Paediatric Assessment Unit at City Hospital accompanied by mother and father aged 5 weeks. JS had been referred by the GP with a fever, unwell and crying. JS was diagnosed as a likely pyelonephritis[11] based on an initial urine dipstick check. Treatment for a Urine Tract Infection (UTI) was commenced. JS was very irritable and had a raised heart beat in ED so a full infection screen was completed to rule out meningitis.

3.2.35 The following day JS was reviewed, mother and father had stayed overnight and reported JS had been settled but was awake more. MGM took over JS's care for a while until parents returned and resumed JS's care. JS was transferred to a longer stay paediatric ward where they settled well.

3.2.36 The FN visited JS on the ward. Mother and father reported they had been anxious over the weekend but were now more relaxed. Mother reported she had lost her appetite postnatally and was encouraged to eat regular meals. JS was discharged home with oral antibiotics for 5 days. JS was to have a renal scan and their GP was to prescribe prophylactic antibiotics.

3.2.37 The FN continued to visit the family weekly until JS was six weeks old and fortnightly thereafter as per the FN programme.

3.2.38 Mother failed to attend a GP appointment, despite the FN sending a text reminder, but did then attend her post-natal check-up. Mother reported she had good support from her partner and family.

3.2.39 When JS was six weeks old mother telephoned SMBC contact centre to request an application form for housing, she completed a Housing Options Triage form stating that partner's family were no longer able to accommodate them as the house was

[11] Pyelonephritis - inflammation of the kidney as a result of bacterial infection

overcrowded by 3 people. The address she gave was MGM's; she was seeking rehousing with father and JS.

3.2.40 Housing Options contacted mother and established that PGF was asking the family unit to leave the property. PGF confirmed this to the Housing Options worker stating that the situation was having an impact on the wider family, that he had health issues of his own relating to mobility issues; he used a wheelchair and required adaptations to the property which could not be undertaken at that time. The homeless process was explained and advice was given around registering for housing, providing proof of local connection and the possibility of the application being fast-tracked because of their circumstances. Mother was advised to complete an application form and return with the appropriate proofs.

3.2.41 JS attended for their 6-8 weeks check and 1st immunisations with mother at the GP practice.

3.2.42 Housing Options gave the case Band 3 priority to prevent a crisis presentation. Five days later Housing Choice made an offer of a house to father. There followed an accompanied viewing. The couple indicated that they had family support and therefore had no need for extra support; their income and expenditure were deemed ok. The couple indicated father would be JS's main carer.

Independent Living

3.2.43 Mother commenced weaning of JS, aged 11 weeks. The following week the FN saw JS at MGM's. Mother was now living with father in their own housing. There had been some episodes of noisy neighbours, but the neighbour reduced the noise when requested. Mother reported financial worries; she was worried about paying the bills as she was not receiving any housing benefits. The FN completed a budgeting facilitator with mother. The couple had not sorted council tax payments and were encouraged to include this in the budget and commence payment as soon as possible.

3.2.44 A week later JS was seen in the couple's new home by the FN for the first time; JS was in a baby chair. JS was alert and making lots of vocal interaction with their mother. JS appeared cleanly dressed, small but well looking.

3.2.45 Good family support was noted as PGM 2 was going to care for JS over the weekend as parents were going away with friends camping. The bedroom was checked, a small pillow was noted in the Moses basket next to parents' bed; mother was advised to remove this. JS was developmentally age appropriate. JS was reported to be feeding, their weight continued to thrive along the 0.4th centile chart.

3.2.46 In September 2016 MGM was seen by her GP with low moods and re-occurring depression. This may have had an impact on the support she was able to offer her daughter. JS attended their routine 12-week immunisations with mother. JS was reported to be well.

3.2.47 JS was seen by the FN for their 4 month Ages and Stages Questionnaire (aged 15 weeks), all areas of development were showing delay, the FN planned to review this in 1-2 months. Mother was encouraged to engage JS in floor play and more toys were advised as only 1 or 2 toys were observed in the living room. JS was dressed appropriately and satisfactory though. Mother and father had just woken up and

appeared a little subdued. Mother reported JS had seen the GP recently because they were experiencing constipation. Mother reported she gave JS extra fluids and also sugar in their water but with no success so JS was seen by the GP and Lactulose prescribed.

3.2.48 The front room looked unkempt with dirty empty baby bottles and empty packets. It was untidy and the table was dusty. The floor also appeared unclean and dusty. A full kitten litter tray was observed in the corner of room. Mother reported she could only do any work when JS was sleeping. No cleaning appeared to have been done for a while. The kitchen did not appear too cluttered – father was observed doing some washing up during the visit. The couple were encouraged to share the housework.

3.2.49 The FN discussed the case in routine clinical supervision due to concerns over unkempt home, environment and lack of toys. The FN was advised to consider completing a home conditions assessment to identify whether the house was at an acceptable level of cleanliness, whether mother needed support to understand how to clean and tidy a house through either referral to other services to request family support or to complete an FNP session where she could support mother to make a plan as to how to manage a house. The FN was to discuss with mother how her own parents cleaned her previous home to understand mother's level of understanding and then support and role model as required.

3.2.50 In October 2016, JS was not brought for their medical review with the GP despite mother having been sent a text reminder by the FN. The GP informed the FN who followed this up with a text to mother. Mother returned a text saying "With all due respect I'm not going to bring JS to any appointment…to be checked over as I know my (child) and I know (their) weight is perfectly fine due to the family and size of us. (They) won't be going to an appointment as it not needed. Thank you for the concern xxxxx".

3.2.51 On 22nd October 2016, JS was admitted to hospital, aged16 weeks, having been referred by the GP for inconsolable crying whenever they were put on their back or when they had their nappy changed. Mother appeared very anxious indicating JS would cry whenever they were put down. MGM expressed concerns re: JS's hip; she felt JS held their leg up. Nothing specific was found and JS was discharged the following day with an appointment to attend for a hip scan. JS's weight had decreased to 4.85kg below 0.4th centile.

3.2.52 The FN visited a couple of days later as planned. Mother and father expressed they sometimes got on better when they had some time apart – generally both were supportive of each other. Mother reported she has been feeling stressed and uptight which had been recognised by family members. Mother reported she didn't feel depressed but did feel stressed. She was due to return to work. Mother was advised to monitor her stress and see her GP if she continued to feel the same. Mother discussed all the emotional challenges since becoming pregnant.

3.2.53 The front room appeared to have been cleared up, the table top had been cleared up and there was no longer kitten litter in the room. Kitchen surfaces and floor were clear and a baby sterilizer with bottles was noted. Mother and father reported they had tidied the flat the previous day. The floor and bits of carpet were however covered with bits and dust. There was a large black Labrador in the flat; mother reported she was looking after the dog whilst MGM was away. The couple were

aware they are not allowed to have pet dogs in the flat and were advised not to leave the dog unaccompanied with JS.

3.2.54 Extended family (father's) were to care for JS when mother went back to work as father was working but his hours were unreliable. Mother admitted feeling extremely worried when JS became unwell and was unsure what to expect when JS attended hospital.

3.2.55 On 26th October 2016, JS missed appointments with the GP and nurse.

3.2.56 The next visit from the FN took place after mother had returned to work In November 2016. JS, now 4 months old, was dressed appropriately in clean clothes but the FN noted JS's nails were filled with dirt. Mother and father stated they bathed JS 2-3 times per week. JS's blanket was grubby. JS was outstanding their 3rd immunisations, mother reported she had not missed an appointment, but planned to re-arrange. Mother and father apologised for the mess of their flat. The front room and kitchen were observed. Kittens were seen darting around; the floor was covered with debris, foods, bits and objects. The coffee table was covered with empty crockery. The bedroom door was slightly ajar as the FN was leaving the property; she noted clothes scattered around the room and all chest of drawers open with clothes hanging out.

3.2.57 Mother and father reported "they were both working, father leaving about 6am and mother slightly later to drop JS off prior to going to work"; both admitted to "not keeping on top of housework and would do it in the evening on their return from work". The FN felt it was difficult to see when the flat was last cleaned as it appeared to have not been tidied for a while. Father was observed washing up during the visit and sorting bottles for the sterilizer. Mother and father reported the kittens were going to a new home that evening.

3.2.58 JS had missed an Ultra Sound Scan (USS) appointment; the FN stressed the importance of attending appointment. The FN discussed the discharge letter; the Consultant Paediatrician wanted to rule out developmental hip dysplasia as JS was breech presentation until 35 weeks' gestation and also family history. The FN pointed out that JS kept their left leg bent when lying down. The FN repeated the 4 month Ages and Stages Questionnaire developmental assessment and although there was some improvement JS remained delayed in fine motor skills and problem solving. The FN thought this could possibly be due to environmental factors. Mother and father stated they were happy with JS's development and were unwilling for medical follow up as yet. FN gave advice re: swaddling, play and feeding. Parents were informed that JS's weight remained under the lowest growth line, they were not concerned. The FN planned to review JS's weight at the next visit and refer to the GP again if it continued to remain under 0.4th centile. Mother and father reported they were supported by their family; step mother was childminding whilst JS's parents were working. JS had also missed an appointment with a Consultant Paediatrician.

3.2.59 Later in November 2016, father's GP referred JS, aged 20 weeks, to hospital via ambulance. JS had been accompanying their father to a routine appointment when father and PGM 2 asked father's GP to look at JS as they were unwell. They stated they could not get JS an appointment with their own GP. PGM 2 and father stated JS had a cold the day before and was lethargic, with shortness of breath. The GP noted JS was pale, sweaty, unresponsive and moribund; JS's oxygen saturation was very

low at 78%[12]. The ED resuscitation department was pre-alerted as JS was having difficulty in breathing.

3.2.60 On admission, JS was mottled, making poor respiratory efforts, and was being assisted to breathe. JS was drowsy a provisional diagnosis of either bronchiolitis[13], or sepsis[14] was made. JS was intubated[15] and moved to the Intensive Care Unit where they were reviewed by a Paediatric Consultant. Intravenous fluids and antibiotics were commenced.

3.2.61 JS was transferred to Royal Stoke University Hospital PICU with a 2-day history of cough and cold, lethargy and increased work of breathing. JS arrived intubated andhad tests looking for evidence of infection which proved negative.

3.2.62 Discussions were had as to whether JS might have a rib fracture – no fracture was confirmed. Hospital staff indicated to mother and father that if they did not attend for follow up, a MARF would completed in view of their concerns regarding JS's late presentation.

3.2.63 JS was discharged on IV antibiotics, being administered by a community nurse. The FN contacted the ward for an update, and was informed of the concerns regarding late presentation; JS had a follow-up appointment with the Consultant Paediatrician in January 2017.

3.2.64 The following day the FN discussed the case in supervision. The ward had expressed concerns as to why mother and father had not sought advice sooner. The FN was concerned regarding JS's weight plateauing, not achieving developmental milestones and failing to be taken to hospital appointments. There were also outstanding immunisations and concerns regarding home conditions. Mother had returned to work. Mother was defensive when advice was offered. FN was to discuss these concerns with mother and father and the need to put JS first, also to consider referral to CSC.

3.2.65 The next week the FN went to the home address and found no one home. Mother responded to a text by requesting a rescheduling of the home visit. A further call was picked up by father who reported mother was working late; he was waiting for her to finish work. Father reported JS was now well and was aware of the hip scan due mid-December.

3.2.66 JS's GP received a discharge letter which gave a diagnosis of a viral upper respiratory tract infection. A week later mother did not attend for an appointment with her GP.

3.2.67 A fortnight later the FN made text contact with mother explaining she would like to visit and wishing to confirm a planned home visit the following day. No reply was received.

3.2.68 JS attended the GP having been feverish overnight and with a cough. JS was diagnosed with a chest infection and commenced on antibiotics. The following day mother and MGM took JS back to the GP and reported that JS was "wheezing

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[12] Normal oxygen saturation ranges from 95 to 100 percent. Values under 90 percent are considered low.

[13] Bronchiolitis is inflammation of the bronchioles, the smallest air passages of the lungs.

[14] Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs

[15] Intubated - a tube inserted into the trachea for ventilation

yesterday" so they gave JS "1 puff of MGF 2's inhaler". They felt JS was much better so were questioning as to whether JS could possibly be asthmatic. On examination JS appeared alert, smiling, their temperature was normal, their chest was clear, with no added sounds.

3.2.69 The following week the FN sent a telephone message to mother explaining that she would like to arrange to see her and JS (aged 6 months). Mother replied "Hi FN I do not feel the need to have a nurse anymore (they are) developing just fine and (their) weight is no concern to us, as for (them) being weighed I will take (them) to the local clinic in order for it all to be sorted, thankyou kindly for all your help. Mother x".

3.2.70 The FN informed her supervisor who contacted mother but her mobile was answered by father. The FN supervisor offered the couple the opportunity to continue with FNP and have a change of nurse, or if they still wanted to leave the programme they were told they would be transferred to the health visiting service.

3.2.71 In January 2017, a 999 call was passed from the 111 service for JS. JS's father had become concerned as JS seemed to be increasingly drowsy that morning and was refusing food. JS had not slept the night before. It was noted that JS had a history of a chest infection 2 months previously and was still on long-term antibiotics following renal infection. JS appeared well but had intermittent diarrhoea. Parents stated that JS was not interacting as normal however the ambulance crew noted that JS appeared orientated to surroundings and interacting well with mother and father. JS was discussed with paediatrics and admitted with a history of poor feeding and lethargy for 2 days. Following admission JS was reviewed and noted to be pale and lethargic. Nothing obvious was found, JS was taking feeds and not vomiting.

3.2.72 The following morning JS was reviewed; on examination there were no concerns, JS was a well-baby, with unusual prolonged sleepy episodes. All observations were within normal parameters, JS was feeding well, and a urine sample was obtained and sent for toxicology. JS was discharged home later that day at 15.05.

3.2.73 At 17.50 the ward doctor received a call from toxicology laboratory which showed JS's urine was positive for morphine; the rest of the screen was negative. A discussion was had about further testing to identify how much morphine has been detected. The ward spoke to the Emergency Social Worker who discussed the case with the Police.

3.2.74 At 23.45 JS was returned to the ward by two social workers from the Emergency Duty Team (EDT), no police were in attendance. Mother and father had been arrested and were in custody and likely to be in overnight. JS looked awake and alert, and was dressed well. JS was noted to have a 2cm scratch on their left cheek, not scabbed. It looked new and in view of this JS was stripped while EDT was still present. JS was also noted to have x2 pinprick marks on their right hand and 1 pinprick mark on their left heel. A red circular mark was seen around their right wrist and red blotches were seen on the inside of their right wrist plus 1 small spot. JS was happy, smiling and interacting well; they had a feed on admission. JS was noted to become unsettled and had a high-pitched cry but settled off to sleep. On changing JS's nappy it was noted the area was red but the skin was not broken.

4 ANALYSIS OF THE KEY LINES OF ENQUIRY

4.1 Introduction

4.1.1 This chapter contains the analysis of the key lines of enquiry, the learning of this serious case review.

4.2 Was support offered to the family appropriate and adequate?

4.2.1 Mother and father's age and inexperience as parents are significant factors in this review and reinforce the locally recognised need for this age group to receive co-ordinated enhanced provision throughout pregnancy and in the early years of their child's life.

4.2.2 The focus of professionals during mother's pregnancy with JS was largely on mother, however not as a child in her own right who had safeguarding needs. Mother was involved with and supported by health services tailored for teenagers. The midwife completed a Young Person's Needs Assessment and Action Plan. This assessment identified mother was 16, father was nearly 19, this was an unplanned pregnancy, there were housing issues, previous anxiety and depression and poor relationships with both mother and father's parents.

4.2.3 The combination of issues identified and mother's age means that professionals should have been guided to make use of the West Midlands Pre-birth protocol[16]. This protocol is clear that whilst not all under 18s require referral to Children's Social Care, there are occasions when the young person may themselves have needs which require assessment under Child in Need or Child Protection procedures. In this situation both prospective parents should be assessed for protective and vulnerability factors and any ongoing issues that may impact upon the young parent(s) considered within a family assessment using a Think Family approach; there is no evidence professionals referred to this protocol. This protocol was not followed, no referral or multi-agency assessment was made meaning support was limited to that being offered by health professionals.

4.2.4 Mother was however referred to and enrolled on the Family Nurse Programme thus receiving intensive support from the FN both during pregnancy and post-delivery.

4.2.5 A family assessment would have provided the professionals with greater information on mother's past. As mother was still a child the School Nurse (SN) for vulnerable young people should have been contacted. The SN would have had access to mother's school nursing records thus providing greater knowledge of her history and could have remained involved ensuring mothers safeguarding needs received increased consideration.

4.2.6 Mother disclosed issues in her relationship with her biological father, with MGM and, at the beginning of the pregnancy, with PGF and PGM 2. Whilst this was recorded, professionals saw a family who were stepping in to assist mother at times of need. It appears that this picture inhibited the professionals from considering these relationship issues as a significant factor and one that would benefit from a multi-agency approach.

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[16] http://westmidlands.procedures.org.uk/assets/clients/6/Sandwell%20Downloads/Pre-birth%20protocol.pdf

4.2.7 In addition, mother was moving between families and family members, "sofa-surfing" throughout her pregnancy. The close geographical proximity of the addresses and the fact that family members lived in acceptable environments and were perceived to be functioning families, coupled with no necessity to change GPs, midwife, etc, seemingly masked the fact that mother was both vulnerable and living a somewhat transient and chaotic existence, two risk factors identified in Sandwell LSCB's pre-birth protocol that suggest a multi-agency approach was required. It would have been important to include housing in meetings.

4.2.8 After JS was born, mother and father engaged with the FN whilst they were living with their extended family; the FN was delivering the FNP as expected. The FNP was a rigid programme with tight criteria. The FN always asked mother who was supporting her and she always replied father and varying members of his extended family and at times, MGM. What was not fully established was the extent of the support parents required to deliver JS's care, or whether mother and father contributed to or had the skills to look after a home. No discussion was had with the adults with whom the couple were living about the couple's abilities and capacity to care for JS independently. Whilst living with PGF and PGM 2, mother and father would not have had responsibility for some of the basics required when living independently.

4.2.9 Following JS's birth the focus remained on mother from a parenting perspective. Indicators that JS was at risk of harm, and mother and father were not putting JS's needs first, did not receive priority attention.

4.2.10 Mother was invited in the third trimester of her pregnancy to be involved with the young parents' service, which would have offered her additional support and services through Connexions and welfare rights. Mother was unable to attend an appointment, due to a growth scan. Mother then opted out of the service citing being seen more frequently by antenatal services because of concerns around JS's growth. As a result, mother and father missed out on the assistance these services could have offered and there is no evidence that this was discussed or alternate arrangements considered.

4.2.11 There are additional support services available to young parents and their children within Sandwell, these are largely accessed via Early Help and require professionals to complete an early help assessment. This allows for a team around the family (TAF) meeting to be held, a Lead Professional identified and a plan developed. The professionals involved at this point did not recognise that this was a family who would have benefitted from such services and therefore no further assessment was completed nor a referral for Early Help; the FN would likely have been the Lead Professional.

4.2.12 There was an accumulating picture of neglect. The parents' abilities to care for JS independently were masked during the period they were living with PGF and PGM 2. There were some early signs that the parents lacked the capacity to manage JS's basic care, and increasing evidence that they might not be providing the stimulation, guidance and boundaries JS needed without the continuous support of their extended family.

4.2.13 As issues arose these were not responded to effectively. Issues of non-compliance were not seen as indicators of risk that required additional support and services. When concerns arose regarding JS failing to thrive, a condition that had led to

referral to children's social care and the use of child protection procedures with mother's youngest half sibling; the same response was not considered necessary. The practitioners involved did not explore with mother how she felt about, and the impact of, children's social care involvement with MGM and her siblings; no contact was made with any of the professionals involved. Instead mother, father and JS were seen as a totally separate unit.

4.2.14 There is evidence that JS's mother and father were not sufficiently recognising or prioritising JS's needs. When challenged about JS's growth and development, mother indicated that she and father did not have the concerns professionals had and therefore did not feel the need to respond as requested. JS's growth and developmental needs were not being monitored by the appropriate professionals as parents were failing to present JS at appointments. This meant that JS missed out on the additional services available in Sandwell e.g. dietician, community paediatrician, children's centre activities. JS missed investigations which may yet prove to be detrimental to their long-term health.

4.2.15 In addition, JS's parents seemingly became less accepting of the advice and support on offer, to the point of rejecting that advice and services in the weeks prior to the critical incident. Sandwell has a thresholds document in place and using that as a tool could have provided greater clarity on the accumulating concerns and support needs.

4.2.16 Latterly this case was being managed with only two agencies involved; health and, in a limited way, housing. The two agencies were working in silos. Opportunities arose for the two agencies to information share but these were not used.

The FN was placed in a difficult position, believing the case didn't meet the criteria for MARF because her service was involved and mother was disengaging with her because she was the conduit for all of health and was following up on non-compliance issues. The FN also believed informing housing of potential breaches in tenancy (e.g. animals in the house), would likely have had a negative impact on the family unit. It is important for professionals not to take responsibility for the actions of their clients. Ultimately clients are responsible for their actions and professionals are there to advice and support. Latterly disengagement with FNP meant the only community-based health service involved was the GP who was unaware of this fact.

4.3 Was the family's transition to independent living appropriately managed?

4.3.1 Although the community health professionals involved with the couple were largely aware of their living circumstances on a day-by-day basis, insufficient thought was afforded to the couple's longer-term living arrangements. An initial discussion was had between mother and the FN and advice given re: supported accommodation, however when this was rejected, and an initial approach to housing was not followed through by the couple; there was no further discussion. Indeed, after mother moved in with PGF and PGM 2 the only recording made about the couple's plans, was by the midwife three months prior to the birth of JS. At this time mother indicated they would "possibly be staying with father and his family once baby born"; there was no recording of any discussion post JS's birth.

4.3.2 Professionals were not proactive in their approach to obtaining long-term accommodation for the family and did not manage the process of the family moving

to independent living. Mother, independent of the professionals involved, who proactively telephoned SMBC 'contact centre' when JS was six weeks old and was advised to complete a Housing Options Triage form. Mother indicated that father's family were no longer able to accommodate them as the house was overcrowded by three people. Mother returned the forms two weeks later.

4.3.3 Whilst housing swiftly completed checks with the family, there was no communication with any other professional to ensure the information provided was correct, or to consider whether this was the best option for JS and their parents. The application was fast-tracked and the case was passed to a senior officer requesting that consideration be given to awarding Band 3 priority to mother and father's rehousing request to prevent a crisis presentation. Whilst this was commendable, the speed of the change in living circumstance and lack of communication between agencies left health professionals playing catch-up as within a week the couple had been allocated a house. Two days after allocation a standard sign-up pack was completed for the tenancy to commence the following week. As part of the sign up a 'Getting to Know You' form was completed; the new tenant detail form indicated father was not working, this is contrary to what health professionals understood, and had health problems. No referral was made to Welfare Rights.

4.3.4 Because mother was under 18 she could not legally be a tenant, so the house was allocated in father's name only. There is no record of either mother or JS being present at the time of interview.

4.3.5 It appears that the focus was on letting the property rather than considering the wider needs of the family. The vulnerabilities that JS, mother, father presented as a family unit, particularly when determining future contacts and support requirements, were not recognised. Whilst the form used at the time did not require the 'whole' family's needs to be considered, there was an expectation that officers would be able to recognise vulnerabilities presented by families and put in place appropriate support. It is not clear from the paperwork available whether the 'floating support' service, that would have been appropriate in this case, was offered to or declined by father.

4.3.6 As a result of internal learning from this case, a review of the Post Tenancy Sustainability Assessment form has been undertaken. The assessment now requires the circumstances of housing and the needs of the whole household are considered rather than solely the main tenant, when determining the schedule of future contacts. In addition, Neighbourhoods will be undertaking a full review of the tenancy management processes to assess how issues/vulnerabilities presented by individuals/families are identify and respond to.

4.3.7 Since the time of this case the Best Start Programme has been introduced in Sandwell. This programme builds on the best aspects if the FNP but with increased flexibility; it has broader criteria but because caseloads are higher the allocated nurse is unable to have the same extended role thus encouraging greater multi-agency working. At the start of professional involvement this family would have met the criteria for universal plus offer. The best start team brings together all the services that make up and deliver the universal plus offer and consists of community paediatric services, Early Years SENCOs, allied health professionals, housing and welfare advice services, child and adolescent mental health services, sexual health,

alcohol and substance misuse services, community operating groups (COGs), Troubled Families Programme, Domestic Abuse Services.

4.4 Was help from additional sources considered appropriately? Was there a Lead Professional involved as this was a vulnerable couple?

4.4.1 This is a case that would have benefited from having a Lead Professional whose role it would have been to support the child and family, act as an advocate on their behalf and coordinate the delivery of support services. However, none of the professional recognised the need. Recognising when a family's needs could be better met by other services, and the point at which it is appropriate to make referrals to other agencies and services for support, is a skill. It can be difficult to assess when to make such decisions, particularly when professionals are working closely with the family or there is fluctuation in the presentation of a child or family.

4.4.2 In this case help from additional sources was not considered appropriately. The first opportunity to respond to indicators of risk and seek help from additional sources came at the beginning of mother's pregnancy but this was not considered necessary. Mother presented as more mature than her years. On first contact with midwifery mother was identified as young and homeless. The midwife involved perceived that mother and father were largely accepting of advice, support and services throughout mother's pregnancy with JS. Mother and father always indicated they were each other's support and, after the wider family's initial response, that they had good support from both their families. Indeed, the FN and midwife both felt the parents were easy to engage with and that they had established a good rapport and good communication with mother. However, if examined more closely there was evidence of, at best, resistance or ambivalence and at worst disguised compliance[17]:

1. Mother missed two appointments with the GP for blood tests related to monitoring of the pregnancy
2. Mother took discharge against medical advice
3. Mother attended two appointments without growth records
4. Mother rejected supporting accommodation

4.4.3 It is noteworthy that at no time did mother or father initiate contact with any of the practitioners involved, with all contact being at agreed appointments or via emergency care.

4.4.4 All the issues listed were seen in isolation and practitioners rationalised why mother took many of the actions she did:

1. the midwife believed mother disliked having blood taken so avoided blood tests.
2. because mother's records were on Badgernet it was not seen as significant that mother didn't bring JS's growth record.
3. mother was entitled to make a decision on where she would live and there was an alternate viable option for father to apply for housing in his own right.

[17] Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately diffuse professional intervention. (NSPCC)

4.4.5 The exception is mother's discharge against medical advice, for which there is no rationale.

4.4.6 Recognising and putting together all these concerns to assist professionals in their decision making is crucial.

4.4.7 When the couple and JS moved into their own accommodation when JS was 12 weeks old, there was a marked escalation in concerning behaviours. Although these did not go unnoticed, by the practitioners involved, and were discussed in supervision, they did not cause sufficient concern to prompt discussing the concerns with partner agencies, making use of multi-agency assessment tools or making any onward referrals for further support. Within the practitioner event those present indicated they did not feel that this case would have met the threshold for a MARF. The reason given was that, because FNP was an intensive programme and the couple were engaged in the programme, no additional service would be needed. This raises the question as to whether there is an over-reliance on FNP(a finding within a recent SCR in a neighbouring authority), or whether professionals do not understand and/or value the skills and knowledge of partner agencies.

4.4.8 What also became clear were the difficulties all professionals were experiencing in making contact with housing at this time and currently. A change to the telephony system meant it was and is a long process to get through to a housing officer. Professionals were also aware that it was difficult to get accommodation for a young person as there was a lack of spaces. These two factors influenced the actions of the professionals involved. The imminent introduction of the Homeless Reduction Act in 2018[18], meaning every person should have a personal action plan, may well address some of the current issues.

4.4.9 Sandwell SCB has a home conditions assessment tool that could have been used by practitioners attending the accommodation, to assess JS's living conditions. Some practitioners indicated they had never used this tool and had not been trained to do so; this has now been addressed. Practitioners indicated that this factor coupled with the fluctuating presenting picture meant they never reached a decision to use the tool. There is no agreed neglect tool being used across Sandwell currently.

4.4.10 Health practitioners did not contact housing to discuss their concerns.

4.4.11 The first check completed by housing 10 days into the tenancy was an over-the-telephone contact which did not afford an opportunity to observe the home conditions, however the follow-up visit was. The recordings of this visit were lost; it transpired they had not been scanned onto the IT system and were not in the house file as per system. The housing officer in attendance at the practitioner event could not recall anything specific relating to the conditions JS was living in.

4.4.12 The housing officer, from memory, recollected doing the visit in two stages as father, the tenant, wasn't present at the property on the first occasion. The housing officer could not recollect whether JS was present. The officer reflected he should not have been in the property with mother alone as she was under 18. The officer was confident that he would have inspected each of the rooms and doesn't believe that he had any concerns at the time of the visit. The officer indicated that tenants are always given notice of the visits so would have an opportunity to tidy up prior to a

[18] Homeless Reduction Act 2018 will come in force in April 2018

visit; in short housing officers likely see the tenants and houses 'at their best'. The housing officer made an opportunistic brief visit to gain father's signature.

4.4.13 In addition to the Post Tenancy Visit form, the process requires officers to complete a 'tenant visit form' at each visit. This document records details of occupancy (including children), requires the officer to document whether any children have been present/seen during the visit, as well as noting if there are sufficient beds within the home and the condition of the property. The officer concerned did not complete this form as he was unaware of the form and the need to complete this form during a visit. The learning from this has been actioned within the organisation.

4.4.14 In this case none of the practitioners involved considered there were sufficient concerns to initiate the use of safeguarding/child protection processes until after the critical incident. This issue appears to have its origins in the past with practitioners citing past experience of the high thresholds and response by Children's Social Care to previous referrals as a barrier.

4.4.15 A recent Ofsted monitoring visit indicated that *"There are timely and effective processes in place to ensure prompt and thorough screening of new contacts, including those that concern domestic abuse in the SPOC. Experienced and knowledgeable managers provide clear case direction and they make appropriate decisions. As a result, the application of locally agreed, thresholds of need, are appropriate in this part of the service. Cases are promptly and appropriately referred to early help services by managers in the SPOC'*.

4.4.16 Following the critical incident and clear evidence JS had been given morphine hospital staff made a timely and appropriate referral to Children's Social Care.

4.5 Was there appropriate safeguarding supervision of front-line practitioners? Was supervision carried out within timescales and monitored appropriately?

4.5.1 None of the practitioners involved with JS and their parents had sufficient level of concern to discuss JS in dedicated safeguarding children supervision. The midwife maintained the case met none of the criteria that would mean safeguarding children supervision was required. The FN and midwife discussed the case once in a multi-disciplinary team meeting in early pregnancy, but believed there was nothing known to them about the case that would've made them consider revisiting this case in that forum again during the pregnancy.

4.5.2 The FN discussed the case, within timescales, in clinical supervision on two occasions after JS was born, and with her supervisor on a further occasion. This supervision has a safeguarding element within it. There is scope for three-way supervision with the named nurse for safeguarding; however this was not requested by either the FN or her supervisor. In supervision the issues that presented immediately prior to the meeting were discussed but without placing those issues in the full context of what was known or knowable of the family.

4.5.3 On the first occasion the supervisor made helpful suggestions of what options lay open to the FN however, didn't check that the FN had the knowledge and skills to carry out those suggestions, nor did the supervisor revisit whether the FN had followed through on the suggestions.

4.5.4 Staff within the acute hospital setting did not seek supervision on the two occasions when there were clear, and sufficient, concerns to warrant doing so: e.g. mother's self-discharge and the delayed presentation of JS in a collapsed state. Had they done so it is possible referrals to Children's Social Care would have been discussed and advised.

4.5.5 The GP who responded to JS's collapse did not seek any advice, support or supervision. Neither JS's GP or any of the GP practice staff sought advice or support when mother did not attend, or JS was not brought to appointments. In addition, the GP was informed when mother and father did not take JS to the hospital for arranged appointments and tests but did not follow this up with the parents.

4.5.6 The second occasion the FN had supervision, this followed JS's admission to hospital in a collapsed state. Both the FN and the supervisor had direct contact with the hospital during JS's admission which was good practice. The FN supervisor had been informed by the acute hospital staff of the staff concerns. Within the supervision session the ward's concern as to why mother and father had not accessed help for JS were discussed in addition to the FN's concerns regarding JS' plateauing weight, not achieving developmental milestones, failure to be taken to hospital appointments, outstanding immunisations and the home conditions. It was acknowledged mother could be defensive when offered advice. The resultant plan was for the FN to discuss the concerns with mother and father, and the need for them to put JS first. The FN was directed to consider referral to Children's Social Care. The rationale for not completing a Home Conditions Assessment was not explored.

4.5.7 Practitioners at the learning event remained convinced that these issues would not have led to action or assessment by Children's Social Care, which is of concern, even if this is just a perception.

4.5.8 The format of the supervision does not appear to be assisting either the practitioner or supervisor to formulate a clear plan which holds safeguarding the child at its heart. The supervisor indicated the supervisee should consider making a MARF however, the case had already met the threshold[19] for referral at this point. The reviewer considers the supervisor should have given a clear directive to complete and submit a MARF and sought additional advice and support from the Trust's named professionals.

4.5.9 The FNP worked with a group of individuals who were recognised as being difficult to engage in services, so as a service they often employed tactics, such as a change in worker, to try and re-engage families in the programme. Whilst this was commendable they needed to maintain focus on the child especially as concerns were accumulating.

4.5.10 The FN was unable to follow through the plan to discuss the concerns with mother and father as they declined contact. The FN contacted the supervisor indicating that mother appeared to be disengaging. This information was considered in terms of there being a relationship issue between the FN and mother, rather than in the context of the accumulating safeguarding concerns and as further evidence of neglect.

[19] Sandwell Multi-Agency Thresholds Document

4.5.11 Whilst choice of worker should be a consideration, where there has previously been a seemingly good relationship any breakdown in that relationship should be considered in context of the work the practitioner has been doing. Where parents have been challenged and/or are unaccepting of the advice, the impact on the child must be the prime concern.

4.5.12 Mother was offered a different worker but this information should have added to the existing concerns thus prompting a referral to Children's Social Care.

4.5.13 The lack of safeguarding supervision for midwives was identified by the CQC in an inspection. The reviewer was informed this issue has now been addressed, however in this case the community midwife stated she had no concerns of her own that would have prompted her to seek supervision. The midwife had not been made aware that mother had taken her own discharge, and therefore did not seek supervision.

4.6 Was there sufficient challenge by practitioners if the parents did not comply with advice and instructions?

4.6.1 The FN did on occasions challenge the parents when they did not comply with advice and instruction. Mother was the more vocal of the couple and practitioners describe her offering what seemed like plausible explanations for the actions she took. For instance, the FN challenged mother about making feeds up with tap water in the hospital setting. Mother was convincing when she indicated staff had told her this was ok. This mode of operating can make it difficult for practitioners to assess whether a parent is likely to comply with advice.

4.6.2 Other than the FN there is little evidence that parents were challenged. Maternity staff did not sufficiently challenge mother over her decision to take self-discharge, leaving her and her unborn at risk without using processes and procedures, both internal and multi-agency, designed to protect.

4.6.3 Paediatric staff challenged mother and father over the late presentation of JS to hospital; however they did not complete a MARF. Instead they indicated that if the parents did not bring JS for follow-up they would then complete a MARF; this was not robust decision making.

4.6.4 Latterly the challenge for non-attendance and non-compliance issues was left to the FN with all health professionals abdicating their individual responsibility to do this. The FN felt it was her continual challenge of mother that was leading to mother's disengagement from the FNP. Whilst sharing information around attendance and compliance issues is commended, abdicating responsibility for challenging this is not.

4.6.5 As well as a lack of challenge there was also a lack of focus on the impact of the parents' non-compliance on JS, leaving JS's recognised needs unaddressed.

4.7 What policies and procedures do agencies use when clients request cessation of involvement of a service being provided to ensure a child is safeguarded?

4.7.1 Each service has its own policies and procedures indicating what to do when clients fail to bring their children to appointments and disengage with services.

4.7.2 In this case mother and father requested cessation of involvement from FNP only. The FNP Core Service Specification guides FNs and their supervisors on the actions to

take and states that the FN "will persist in their efforts to re-engage clients who indicate that they no longer wish to receive the programme, either directly or by repeated missed visits". Within this specification it is left to the supervisor's discretion; in conjunction with the FN to decide how long to continue attempts to engage clients.

4.7.3 However, the same document states: "If a client with significant risk or safeguarding factors is not receiving programme visits for any reason, local safeguarding processes should be implemented."

4.8 Prescribing of medication

4.8.1 The prescribing of medication to adults and the administration or accidental ingestion of medications is more often associated with parents who have an addiction to illegal substances. The circumstances in this case are therefore somewhat unusual.

4.8.2 JS was not living with PGF and therefore the safe storage advice that is given directly to patients would not necessarily have been known to mother and father unless they had actively read the instructions on the bottle.

4.8.3 PGF had a recognised condition for which he was receiving a number of medications. Tramadol (a strong painkiller) had been prescribed from March 2012 and Morphine Sulphate (an oral form of morphine that is not a controlled substance) from October 2013.

4.8.4 There would be no need for PGF to present himself to be seen unless a new health concerns presented itself. During 2016 PGF only had one face-to-face appointment with a GP and 3 consultations with a staff nurse, none of the primary concerns were in relation to pain management. All prescriptions were printed off by different staff on repeat prescription and the only time he received a quantity of two bottles was in October 2016. This corresponds to the date on the bottle found at mother and father's address. Attendees at the practitioner event indicated a new ordering process is being piloted in Sandwell which may address the issue and a system of random audits introduced.

4.8.5 PGF indicated after the event that he had requested a second bottle to leave at the couple's address for if he needed it when visiting.

4.8.6 There are two known occasions when JS received medication which was not prescribed for them. On the first occasion JS was given 1 puff of Ventolin. This behaviour was not challenged by the attending GP and other professionals were unaware. The second occasion is the critical incident leading to this review.

4.9 Discharge from hospital prior to full information being received

4.9.1 The decision to discharge a patient from hospital lies with the allocated Consultant Paediatrician supported by the registrar. It is not unusual for patients to be discharged prior to all results being received; indeed it would not be appropriate for a patient to remain in hospital if their condition did not require it. In this case JS was deemed a well child on discharge from hospital.

4.9.2 Whilst testing urine for toxicology is not a routine test, it may be requested if the clinician has not been able to establish a diagnosis. Following discussion with

hospital staff it appears the requesting of the test was almost an afterthought ‘we might as well’. Hospital staff had not been anticipating a positive result. The actions taken after the results indicated JS had morphine in their system were swift and decisive.

5 LEARNING

- There was a lack of recognition by health professionals that this case required a multi-agency approach. The FNP service acted as a repository for everyone's concerns; the FN did receive information of failures to attend appointments and admissions and discharges to hospital. The allocated FN followed up the concerns raised by secondary and tertiary care staff with mother and father, when they permitted, but with little evidence that this affected a positive reaction by the parents. In short, the FN was placed in a position of taking full responsibility for everyone's concerns without support from multi-agency partners.
- Agencies involved with the couple and JS did not recognise they had a crucial role in supporting the move from home to independent living.
- The professionals involved in this case did not give sufficient consideration as to whether their service was best placed to address the presenting issue, nor did they follow guidance and make use of tools which might have helped them in their assessments and decision making. The routine use of recognised tools, e.g. significant events charts, chronologies, home condition assessments, would have assisted however there was no neglect tool for professionals to use. Perceptions around the threshold for MARF, expectations on individual practitioners from the FNP service, and concerns regarding the potential negative impact on the family unit if practitioners shared information gleaned during home visits, all inhibited practitioners from reaching out to partner agencies for help. The lack of a neglect tool and training on the use of the available tools contributed to the lack of exploration as to whether the threshold for onward referral for early help or child protection had been met.
- There is a lack of recognition of what constitutes a safeguarding concern and when there is the need to access support and supervision from safeguarding health professionals. As a result, support and supervision is not being sought by professionals at appropriate points. Supervisors, whilst in an advisory capacity, need to make greater use of the SSCB threshold document within supervision.
- There was insufficient challenge by all practitioners when parents did not comply with advice and instructions.
- The issue does not appear to be one where the policies and procedures did not provide sufficient guidance, but one of professionals not recognising the safeguarding factors and implementing the SSCB procedures.
- The extent that families take each other's prescribed medication is not known, however it is not a new phenomenon. It is vital that opportunities that present, for professionals to directly challenge any administration of a medication that has not been prescribed for a child, are taken. Safety advice is given by GPs at the time of prescribing and by pharmacists at the time prescriptions are collected it. This is a learning point for health professionals.
- The actions of the acute hospital in discharging JS were in line with expected practice. Learning point: Consideration needs to be given to whether all children who attend with excessive drowsiness without an immediately identifiable cause should have their urines sent for toxicology.

6 CONCLUSIONS

6.1.1 From the information available to the review professionals involved in JS's care could not have expected JS would be physically harmed by mother or father. JS was 6 months old at the time of the significant incident.

6.1.2 Professionals' initial view of mother was someone who was confident, competent and keen to engage with services; she appeared mature for her years. Mother was able to mask her anxieties to the extent professionals were unable to detect them. Although JS's pregnancy was unplanned and the wider family were not initially overjoyed, mother expressed excitement at the prospect of becoming a parent and father's family, after their initial response, provided the couple with shelter and support throughout the pregnancy and the first six weeks of JS's life.

6.1.3 Mother's presentation, and the wider family's support of the couple, blurred the professionals' view of the issues from the start. Mother was never assessed as she really was; a vulnerable 16, going on 17-year-old, a child in her own right. Mother required safeguarding; she was homeless, having had difficulties in childhood, issues in her relationships with her family and she would have benefited from a multi-agency approach, including housing, throughout the entire period under review.

6.1.4 Pregnancy and the period of time mother lived with father's family offered opportunities for mother and father's parenting skills to be assessed and developed, and practical support offered. The FN did some of this work. Presenting issues were addressed as they arose; however, this was done on a single agency basis and not as part of a wider multi-agency plan. There was a lack of joined-up thinking. A Team Around the Family approach, with an identified Lead Professional, would have enhanced the work undertaken by the FN.

6.1.5 As well as a change in permanent home, JS had 5 admissions to hospital with the associated changes in environment and upheaval. Although mother and father were constants in JS's life, multiple people were also involved in providing care, both family and professionals. Aged three months, JS moved from an environment where their parents were supported in their parenting into a flat with mother and father. Following their parents move to independent living, there was some evidence of neglect and JS was not receiving the care and monitoring professionals felt JS required.

6.1.6 Whilst there was nothing to suggest an incident of this nature was likely, historical information and recognition of the accumulating indicators of neglect could have acted as warning signs that the couple, for whatever reason, were not coping and there was a lack of focus on the outcomes for JS. These indicators included:

1. failure to attend appointments
2. failure to accept advice
3. administration of a prescribed medication
4. disengagement with services
5. failure to thrive
6. developmental delay
7. late presentation when JS was unwell
8. dirty finger nails and grubby blankets
9. flat observed to be unkempt with dirty bottles and a cat litter tray was full.

6.1.7 There were a number of occasions that referrals for additional support or for neglect could have, and should have, been made. At the practitioner event, attendees talked about knowing when to respond to low level neglect which is how the neglect in this case was viewed, however when all the factors are brought together the picture is significant.

6.1.8 A lack of recognition that the issues had reached a threshold where JS needed safeguarding via a multi-agency response, coupled with a lack of training on the use of assessment tools and fear that relationships with the parents might be affected by communicating with partner agencies, acted as barriers. These barriers account for the lack of response to the indicators of neglect. The current supervision did not provide sufficient support and scrutiny to enable staff to overcome these barriers and so JS's vulnerability increased as professional input decreased.

6.1.9 Assessing fluctuating environmental situations whilst managing parents' defensive responses and challenging compliance issues will always be a challenge to professionals. Defensive responses and issue of compliance should always increase professionals' concerns and curiosity, when there are already safeguarding issues, rather than act as a barrier to referral.

7 RECOMMENDATIONS

Recommendation 1

SSCB should be assured that the pre-birth protocol is embedded and used in all appropriate cases to ensure that young mothers and babies are able to access all relevant services.

Recommendation 2

The SSCB should be assured that the Threshold document is fully understood and practitioners have confidence in it.

Recommendation 3

The SSCB and partners should agree and roll out a tool to assist professionals in the identification and grading of neglect to ensure that appropriate referrals are made and action taken.

Recommendation 4

SSCB should be assured by health partners i) that they have in place robust provisions for supervision and ii) that they have in place robust 'Did not attend' (DNA) policies.

Recommendation 5

The SSCB should seek assurance from Housing Services (Neighbourhoods) that their officers are trained in safeguarding and think safeguarding in its widest sense, to include neglect and this includes the use of the Post Tenancy Sustainability Assessment form. The SSCB should also seek assurance from Neighbourhoods that their review of the tenancy management processes now gives their staff guidance and a process on how issues/vulnerabilities presented by individuals/families are identified and responded to.

Recommendation 6

The SSCB should enquire with the Director for Public Health about the launch of a prevention campaign aimed at parents/carers of safe handling and storage of drugs. This should include the dangers of taking them whilst they have care for children.

Glossary of Terms & Abbreviations

A&E	Accident and Emergency
CP	Child Protection
CSC	Children's Social Care
ED	Emergency Department
FN	Family Nurse
FNP	Family Nurse Partnership
GP	General Practitioner
HV	Health Visitor
IUGR	Intra Uterine Growth Retardation
IV	Intra-Venous
MARF	Multi-Agency Referral Form
MW	Midwife
LA	Local Authority
PICU	Paediatric Intensive Care Unit
SBR	Serum Bilirubin
SN	School Nurse
SPOC	Single Point of Contact
USS	Ultra-sound Scan

Appendix 1: Panel members

The review panel consisted of the following members:

Agency	Role
	Lead Reviewer
Sandwell and West Birmingham Clinical Commissioning Group	Designated Doctor Safeguarding /Sandwell Safeguarding Children Board Serious Case Review Subcommittee Chair
Sandwell Safeguarding Children Board	Child Death Coordinator/ Serious Case Review Coordinator
Sandwell and West Birmingham Clinical Commissioning Group	Designated Nurse for Child Death
West Midlands Police	Detective Inspector
Sandwell Metropolitan Borough Council	Senior Commissioning Manager
Sandwell Public Health	Early Year Programme Manager – 0-19
Sandwell and West Birmingham Hospital Trust	Safeguarding Children Lead Nurse

Appendix 2: Terms of Reference

Sandwell Safeguarding Children Board Terms of Reference in respect of JS

The period of Review for this Serious Case is from the point prior to pregnancy October 2015 known to January 2017, the date of the incident. Reference should however be made briefly about the extent of agency involvement prior to this period (if relevant and appropriate).
Agencies that identified significant background history (where relevant) on family members predating the review period and subsequently should submit a brief summary account of that history. An example is a summary of JS's mother's educational history.
All agencies should review all records held electronically, on paper or in patient held records.
At this point, in-depth chronologies only are being requested and should be completed using the template provided by Sandwell Safeguarding Children Board.

Genogram

A genogram is supplied with paperwork, however, all agencies should submit a genogram if there is additional information.

Chronologies

The following agencies should submit chronologies on the template provided by Sandwell Safeguarding Children Board:

- Children's Social Care
- SWBH NHS Trust
- West Midlands Police
- Probation
- BCPFT
- Sandwell and West Birmingham CCG
- WMAS
- Education
- Sandwell Housing

It is important that any learning or good practice is identified in the comments section of the chronology.

The Terms of Reference are as described in Working Together

- Keep under consideration if further information becomes available as work is undertaken that indicates other agencies should carry out individual management reviews.
- To establish a factual chronology of the action taken by each agency.
- Assess whether decisions and actions taken in the case comply with safeguarding procedures.
- To determine whether appropriate services were provided in relation to the decisions and actions taken in the case.

- To recommend appropriate interagency action and learning from the case in the light of the findings.
- To assess whether action is needed in any agency.
- To examine interagency working and service provision for children.
- To establish whether interagency and single agency policies and procedures supported the management of the case.
- Consideration how and what contributions can be sought from family members.
- To establish lessons for practice and clear recommendations and an action plan from the overview report.

Key Lines of Enquiry and Scope of the Review

When completing a chronology could practitioners please consider:

1. **Was support offered to the family appropriate and adequate?** Practitioners should review how support was assessed and evaluated.

2. **Was the family's transition to independent living appropriately managed?** What assessment took place initially to make this decision and how was it managed?

3. **Was help from additional sources considered appropriately?** Was there a Lead professional involved as this was a vulnerable couple?

4. **Was there appropriate safeguarding supervision of front-line practitioners?** Was any supervision carried out within timescales and monitored appropriately?

5. **Was there sufficient challenge by practitioners if the parents did not comply with advice and instructions?** Practitioners should comment on any evidence that this happened and recommendations made as a consequence.

6. **What policy and procedures do agencies use when clients request cessation of involvement of a service being provided to ensure a child is safeguarded?** If appropriate, practitioners should attach copies of policies and procedures relating to comments.

Lines of enquiry for individual agency reports

All agencies should consider whether their policies, procedures, management and supervision resources adequately supported professionals working this case and aided appropriate decision making and professional judgement.

In addition to the requirements of Working Together to Safeguard Children the overview report writer will:

- Comment on whether the IMRs have addressed these Terms of Reference and all relevant issues.
- Analyse the inter-agency working assessments and provision of services.
- Determine whether actions taken, decisions made were in accordance with current safeguarding policies, procedures and practice.
- Comment on professional judgement and decision making based on evidence.

- Consider what different decisions if any may have led to a different conclusion.
- Identify whether more could have been done, the lessons learnt and make findings and recommendations.
- Provide an executive summary.
- Interview any relevant family members if appropriate
- Involve agency decision makers in an interim and final analysis of the decision making in this case based on the available information and case material presented
- Present the findings to the Sandwell Safeguarding Board and Partner agencies as a learning event if so invited.

Sandwell Safeguarding Children Board will follow Working Together 2015 which states:

> *'The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.' Working Together 2015, Page 79*

Appendix 3: Practitioner Event Attendees

The following practitioners were involved in the group meetings with the lead reviewer and other panel members:

AGENCY	ROLE
Sandwell Metropolitan Borough Council – Neighbourhoods	Neighbourhood Service Manager
Sandwell Metropolitan Borough Council – Neighbourhoods	Neighbourhood Service Manager
SW PPU	Detective Inspector
Sandwell Metropolitan Borough Council – Neighbourhoods	Neighbourhood Assistant
Sandwell Metropolitan Borough Council – Neighbourhoods	Neighbourhood Assistant
Sandwell Metropolitan Borough Council – Neighbourhoods	Neighbourhood Assistant
Sandwell and West Birmingham Hospital Trust	Health Visitor
Sandwell and West Birmingham NHS Trust	Specialist Midwife Team Manager
Sandwell Hospital	Ward Manager
Local Health Centre	**GP**
Local GP Practice	**GP**
Sandwell and Birmingham Clinical Commissioning Group	Pharmacist
Sandwell and West Birmingham NHS Trust	Midwife Team Manager