LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

OVERVIEW REPORT

CHILD: RS

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1. Statutory Framework:

1.1. This Local Child Safeguarding Practice Review (LCSPR) was commenced in 2019 and undertaken in accordance with the guidance contained in Working Together to Safeguard Children 2018 [1] which outlines that reviews should be completed in a way which:

- Reflects the child's perspective and family context
- Is proportionate to the case under review
- Focuses on potential learning
- Establishes and explains the reasons why events occurred
- Invites families to contribute
- Fully involves practitioners

1.2. Working Together 2018 encourages Local Safeguarding Partnerships (LSPs) to use a variety of models for undertaking LCSPRs, including the systems approach. The Significant Incident Learning Process (SILP) is one such model.

2. Significant Incident Learning Process (SILP):

2.1. The SILP methodology reflects on multi-agency work systemically and focuses on why those involved acted in a certain way at that time. The SILP methodology adheres to the principles of:

- Involvement of families
- Active engagement of practitioners and frontline managers
- Systems methodology
- Proportionality
- Learning from good practice

2.2. SILPs are characterised by practitioners, managers and Agency Report Authors coming together for a Learning Event, where the perspectives of all those involved are discussed and valued. The same group considers the draft Overview Report at a Recall Event.

3. Process for this LCSPR:

3.1. In 2019 Sandwell Children's Safeguarding Partnership made the decision to undertake a LCSPR in respect of Child RS. Furthermore, a decision was taken that this would be undertaken using the SILP methodology. The Terms of Reference were prepared, and the Agency Report Authors' Briefing held in September 2019.

3.2. The Scoping Period for the Review covers the period from when Mother's pregnancy with Child One became known to professionals to when Child Two was taken to hospital with serious injuries. Agencies were also asked to provide details of any significant events prior to the Scoping Period.

[1] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Children, HM Government July 2018.

3.3. The SILP Learning Event was held in December 2019 and the Recall Event in January 2020. Events were attended by practitioners, managers and Agency Report Authors from the NHS Foundation Trusts (Midwifery and Health Visiting), Birmingham Clinical Commissioning Group (CCG), GP Practice, Children's Social Care and Police.

4. Introduction to the case under review:

4.1. The LCSPR relates to young parents with two children. The parents were living with the Maternal Grandparents (MGPs) when both children were born and the Maternal Grandfather (MGF) had enduring mental health difficulties. Father had a history of criminality and substance misuse whilst living in London before moving to the West Midlands.

4.2. There were concerns about the care of both children with regards to late immunisations, not being brought to appointments and poor early weight gain. For much of the Scoping Period the family were not in receipt of any additional, targeted, services.

4.3. At the age of a few months, Child Two was taken to hospital with multiple, potentially life-changing, injuries, believed to have been caused non-accidentally. A Police investigation and care proceedings were instigated.

5. Family Engagement in the LCSPR:

5.1. Family members have been informed that the LCSPR is taking place. However, due to the criminal investigation it has not been possible to seek the views of the family. Criminal proceedings concluded with the imprisonment of both parents for causing or allowing serious harm to a child.

6. Pre- Scoping Period:

6.1. Until moving from London to the West Midlands in 2017, Father had lived with his family in London. As a young person he had a history of anti-social behaviour, with complaints to Housing about drug-use, and of criminality, mainly related to acquisitive crime. From 2013 he was under the supervision of the London Youth Offending Service (YOS) and from 2016 the supervision of the London Community Rehabilitation Company (LCRC).

6.2. Mother's Father, the MGF, had enduring mental health difficulties, on occasions requiring him to be detained in hospital under the Mental Health Act, which placed considerable stress on the family, particularly the Maternal Grandmother (MGM). In addition, the MGM had cared for her mother whilst terminally ill and Mother spent some time supporting her Grandfather. As a young child there were some concerns about Mother's sleep and behaviour difficulties. A referral was made to Community Paediatrician, but the appointment was not kept.

7. Scoping Period: Key Episodes:

7.1. Mother's first pregnancy.

7.1.1. In May 2017 Mother did not attend an appointment at the Early Pregnancy Assessment Centre. The GP was informed, and Mother and Father attended an appointment with the GP. Mother's subsequent attendance at ante-natal appointments was inconsistent, though she presented on a number of occasions for unscheduled assessments, so the pregnancy was monitored. Mother disclosed that the pregnancy was not planned. On questioning, no domestic abuse was reported. It is not known what Mother knew about Father's history of offending, but she did not inform Midwifery that he was under the supervision of the London Community Rehabilitation Company (LCRC).

7.1.2. Mother was referred to the Young Parents' Team but did not fit the criteria for the service, as she was not aged 18 years or under. However, it was recognised that she needed additional support and a Maternity Support Worker (MSW) was allocated to provide support, e.g. in accessing benefits, with housing. Mother reported feeling low during the pregnancy due to financial problems and early pains and disclosed a history of panic attacks, although not recent. The Family Nurse Partnership service had been decommissioned in Birmingham at this time.

7.1.3. During June and July 2017 Father was convicted of drug-related offences (Class A & B drugs) and sentenced to an 18-months Community Order with a 3-month Drug Recovery and Rehabilitation Order, to be supervised by the London Community Rehabilitation Company (LCRC). From the beginning of the Order his co-operation was limited and in August he was warned about enforcement action, but no further action was taken regarding this. Father informed the Responsible Officer in October that he was moving to Birmingham, where his partner lived and that she was pregnant. This information was shared at the Integrated Offender Management Meetings in October. The Police have advised there are no minutes of these meetings, but it appears no follow-up action was taken.

7.1.4. LCRC liaised with Birmingham Community Rehabilitation Company (BCRC) regarding transfer of responsibility and, in view of Father's poor co-operation with his Order, BCRC agreed to assume responsibility on a 'caretaking basis'. At the point of transfer Father had outstanding unpaid work hours to be completed. There is no evidence that any local checks, e.g. with Children's Social Care (CSC), were undertaken by Birmingham CRC.

7.1.5. The parents were living with the MGPs during this period and the MGF's mental health deteriorated during October and November. The MGM was fearful as his behaviour became hostile. This necessitated his compulsory admission to hospital under the Mental Health Act and a period of stay in the Psychiatric Intensive Care Unit (PICU). It is recorded that a carer's assessment should be offered to the MGM, but there is no evidence this was completed. The GP received a notification of his discharge, but this did not contain any information about the difficulties with his behaviour in the home prior to admission.

7.1.6. Midwifery, i.e. the Midwives and Maternity Support Worker, were not aware of the family background, i.e. MGF's mental health needs, Father's criminal background and drug rehabilitation order.

7.1.7. The notification of pregnancy was not sent by Midwifery to Birmingham Health Visiting service and hence the ante-natal visit by the Health Visiting Service, usually between 28 and 36 weeks of pregnancy, was not undertaken.

7.2. Birth of first child: Early 2018

7.2.1. Child One's birth was an assisted ventouse (vacuum) delivery and Father was present. Post birth, Child One required 48 hours in the Neonatal Unit. There were no concerns about Mother's care of the baby, and she appeared to have good family support. There is no evidence in the medical notes of the baby having a haematoma whilst in hospital. Child One was discharged at 10 days.

7.2.2. When the Birmingham Health Visitor One (Bank) undertook the new birth visit at 13 days post birth, there were concerns about Child One's weight gain. Mother reported giving the baby small amounts of the feed as the Midwives had been concerned about the baby being overfed. The Health Visitor advised increasing the feeds and observed the baby taking the increased feed. There were also concerns about possible jaundice. It was noted that the baby had a Mongolian blue spot and a haematoma on the head, believed to be caused at birth. Details of the haematoma, i.e. location, size, were not noted in the records. There is no record of who was living in the household, including of Father and MGF.

7.2.3. Birmingham Health Visitor One advised Mother to take Child One to the GP or the Urgent Care Centre. There was no liaison with the GP by the Health Visitor and family remained on Universal Health Visiting Service. Mother did not follow Health Visitor's advice; she did not attend the GP or Walk-In Centre.

7.2.4. The Health Visitor contacted the Community Midwife who undertook a home visit and discussed the child's static weight gain with the Paediatric Registrar who advised on a feeding regime. Child One's weight then increased. The Maternity Support Worker undertook one post-birth visit.

7.2.5. A few days after Child One's birth, following a discussion by Community Mental Health Team with the MGM, the MGF's order was revoked and he returned home. It was noted that the home conditions were crowded and that the daughter, her partner and their newly born baby were living in the household. The discharge letter to the GP noted there were '*no acute risks*'. There was liaison between GP and CMHT, but not with the Health Visitor. In Sandwell, GPs and Health Visitors share the electronic client information system, SystemOne, but in Birmingham this is not the case, with Health Visitors using a different system, Rio.

7.2.6. Within the appropriate timescale, Birmingham Health Visitor Two undertook the planned 6 – 8 weeks assessment of the baby, who was alert, well presented and gaining weight. There was continued evidence of the haematoma on the head, but no details recorded. Child One had not been registered with a GP. Mother was advised to register with the GP and bring Child One to the clinic in 4 weeks to check

weight. Mother did not do so and there was no follow up. Child One was registered with the GP Practice early in May.

7.2.7. In June 2018 BCRC was contacted by LCRC. There appeared to be some confusion as to whether BCRC has taken over responsibility and it was clarified they had not done so due to Father's lack of engagement. Father's Orders terminated in July 2018. He had failed to engage with the CRC in London and Birmingham and enforcement action had not been taken. There was no evidence of any contact with Birmingham Police or further offending during this time.

7.3. Visit to GP: Summer 2018

7.3.1. Child One's 6 – 8 weeks assessment by the GP was undertaken late at 29 weeks. The baby's development was satisfactory and noted to be happy, responsive and well nourished. Mother reported that Child One had had two recent falls from the sofa; there had been a week's delay in seeking medical attention. The GP examined the child undressed and found no evidence of any injuries. The GP referred the family to the Birmingham Health Visiting service by email for assessment of safety in view of the falls. There was no further contact between the GP and Health Visitor.

7.3.2. At this time Mother was 11 weeks pregnant (late booking) and the GP referred her to Midwifery. There was a similar pattern regarding Mother's ante-natal care with non-attendance at booked appointments but unscheduled presentations. There was some concern about the unborn baby's growth and two appointments for scans were not attended. Further appointments were sent when appointments were not kept.

7.3.3. In response to the GP referral, Birmingham Health Visitor Three visited 4 weeks later. Health Visitor Three observed that Child One was appropriately dressed, babbling and responding to Mother. The falls were discussed with Mother and Maternal Grandmother (MGM). Child One was reported to have been in MGM's care when the falls occurred. They were receptive to safety advice. Advice was also given regarding safe sleeping (e.g. sleeping on sofa not advisable) and Child One's cot was seen. Reassurance was given about weaning as Mother was concerned about Child One choking. Mother reported being supported by family and her partner, who was not seen.

7.3.4. Mother was 17 weeks pregnant and the Health Visitor agreed to undertake the ante-natal contact at the same time as Child One's 9 – 12 months developmental assessment. The family remained on Universal Health Visiting Service. As planned, Child One's assessment was completed by Health Visitor Four in November, but the proposed ante-natal contact was not undertaken.

7.3.5. During the second pregnancy, Mother informed Midwifery about the MGF's mental health difficulties. Toward the end of the pregnancy it was noted that Mother was stressed about the birth of a second child and showed signs of depression. Midwifery contacted the Young Parents' Team and the Maternity Support Worker undertook one home visit. Mother stated that she stayed at home with Child One as this was '*safest';* it would be a '*big step'* to take Child One out. The Maternity Support Worker encouraged Mother to take Child One out more, e.g. to stay and play sessions. There was no liaison with Health Visitor and no additional support was offered to the family.

7.4. Birth of Child Two: Early 2019

7.4.1. No concerns were noted by Midwifery at the time of Child Two's birth. Mother was viewed as an 'experienced mum'. She was supported at the birth by MGM and Aunt, not by Father.

7.4.2. At this time, the family were in the process of moving to Sandwell. After some difficulty gaining access, the Community Midwife visited at the new address. The flat was very cold, and Mother explained that they could not afford the heating. Father was not seen as he was in the bedroom. Sleeping arrangements were not observed. There were then further difficulties for the Midwives in seeing Mother and baby as the family moved back to Birmingham due to a drainage problem in the new flat.

7.4.3. Two weeks after Child Two's birth, Birmingham Health Visitor Five completed the new birth visit at the MGP's home. There were no concerns regarding the baby. Father and Child Two were asleep on a mattress in another room. There was no discussion about safe sleeping.

7.4.4. At the time of Child Two's birth MGF's mental health deteriorated and his behaviour became aggressive. He was again sectioned under the Mental Health Act and admitted to the Psychiatric Intensive Care Unit. There was no liaison between the Community Mental Health Team and the community health services.

7.5. New-to-area visit by Health Visitor:

7.5.1. In spring 2019 health visiting responsibility in respect of Child Two transferred from Birmingham to Sandwell. No information was provided in respect of Child One.

7.5.2. Sandwell Health Visitor One undertook the new-to-area home visit when Child Two was 10 weeks old. There were some difficulties in setting up this visit with Mother, requiring tenacity on the part of the Health Visitor, which adhered to the No Access procedure. Both Mother and the baby's health checks with the GP were overdue. Mother was interacting well with the children, but there was concern about Child Two's weight loss and safe sleeping. Child Two, who was almost two months old, had only gained 1 kg since birth and had fallen to 0.4th centile. Child One's cot had not been brought from Birmingham and Child Two appeared to be sleeping on a baby bean bag on top of a Moses basket. Advice was given regarding safe sleeping arrangements.

7.5.3. Generally, there was concern about the family moving between Birmingham and Sandwell and lack of equipment. Father was seen briefly bringing in the family's possessions from Birmingham.

7.5.4. Following the visit, in line with the Management of Faltering Growth in Early Childhood Policy[2], the Health Visitor contacted the Paediatrician who advised a review by the GP and weekly weighing of Child Two. Health Visitor and GP to monitor and if there were further concerns to refer to the Paediatrician. Sandwell Health Visitor One contacted Mother's GP surgery, Child Two was not registered but an appointment was arranged for the next day. There was no direct contact between

[2] The Management of Faltering Growth in Early Childhood. Sandwell and West Birmingham Hospitals NHS Trust. December 2015.

the Health Visitor and GP and the Receptionist did not pass on any information shared by the Health Visitor.

7.5.5. The Health Visitor also discussed the concerns with the Named Nurse for Safeguarding. There was concern that there were no weights recorded for Child Two, now two months old, since the age of 2 weeks, making it difficult to plot the centile chart. It was agreed further information would be sought from Birmingham Health Visitors, including whether there had been concerns regarding Child Two's early weight gain. This was not actioned. The level of service was escalated to Universal Plus Health Visiting [3].

7.5.6. The next day Child Two was seen by the GP regarding the weight loss. Child Two's weight had fallen from 25th centile at birth to 0.4th centile. Mother appeared relaxed and had increased the frequency of feeds. It was recorded Child Two looked '*thin'*. There were no further comments regarding the baby's presentation. The GP recommended that Child Two should be reviewed in 10 – 14 days; it is not clear how this would be achieved. Mother gave Child Two's address as the MGP's address in Birmingham, so the GP practice was unaware that the family had moved to Sandwell. There was no further liaison between the GP and Health Visitor and a plan for managing Child Two's weight was not put in place.

7.5.7. Sandwell Health Visitor Two made several attempts to visit the family to follow up on the concerns regarding Child Two's weight, which may have been difficult due to the family moving between Sandwell and Birmingham. Mother suggested a visit at the weekend or that she attend the clinic. Health Visitor also advised Mother that a referral to Children's Social Care would be necessary if she could not see the baby. A home visit was eventually achieved two weeks later. The Health Visitor had access to the GP records so was aware Child Two had been seen by the GP.

7.5.8. Child Two had gained weight, but remained on the 0.4 centile, and had an appointment to start immunisations. There was concern about the care of the feeding bottles, which were noted to be dirty, being washed in cold water and inappropriately stored and advice was given. The baby was sleeping in the Moses basket, which was seen by the Health Visitor and it was reported by Mother that Child One was sleeping in the cot, but this was not seen. It was late morning and Father was reported to be asleep in the bedroom. Child Two was still not registered with a GP.

7.5.9. Sandwell Health Visitor Two decided that, as the situation was improving, a referral to MASH would not have been accepted as a visit had been achieved, Child Two had gained weight and Mother had agreed to come to the baby clinic. No advice was sought from the Trust's Named Nurse for Safeguarding.

7.5.10. Later in the spring, Mother took Child Two, aged three and a half months, to the clinic to see Sandwell Health Visitor Two. Child Two was undressed, had maintained weight and started immunisations. Weight remained on 0.4 centile. Mother reported that Child Two had developed bruising following the immunisations nine days earlier. The Health Visitor noted 'small faded greyish bruise' on Child Two's

[3] Universal Plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting. Health Visitor Factsheet, https://assets.publishing.service.gov.uk.

left chest. Mother said there had been bruising to the left elbow, but nothing was observed. The baby also had a scratch on the left cheek; the suggestions was this was self-inflicted. No further injuries were noted. The bruising to Child Two was not discussed with the Named Nurse for Safeguarding and no further action was taken regarding this. This was the last contact with the Health Visiting service.

7.5.11. Arrangements were made for Mother to bring Child Two to the Baby Clinic in two weeks, but the baby was not brought.

7.5.12. Shortly afterwards in June 2019, Child Two was taken to the Emergency Department by parents and medical investigations identified extensive, potentially life-changing, non-accidental injuries, which were likely to have occurred over a two-week period. A criminal investigation and care proceedings were instigated.

7.5.13. Police found the family home to be extremely untidy, with dirty feeding bottles and nappies. There was a basket for Child Two to sleep in but no cot for Child One.

8. Analysis:

8.1. Effectiveness of multi-agency working:

8.1.1. Information presented to the review indicates that this was a vulnerable family. Mother was a young woman living with her parents when she became pregnant and Father was still living in London. There were additional difficulties for the family. The MGF had longstanding mental health difficulties, on occasions his behaviour became aggressive and difficult to manage, which necessitated admission to psychiatric unit under the Mental Health Act. Father had a history of criminality and was subject to community orders to the LCRC, including a drug rehabilitation order. However, none of the agencies had a full picture of the family circumstances and the inherent stresses and potential risks.

8.1.2. The CMHT liaised with the GP regarding the MGF's mental health difficulties, e.g. discharge letters were sent. However, these letters could be sent some time after discharge and provided only basic information and no details of the MGF's behaviour, e.g. aggression at home. No information was shared with the Midwives or Health Visitors, which meant they were not able to discuss the impact of the MGF's mental health with the family and identify if they had any concerns about their safety. Nor were they aware, as practitioners who were visiting the household, of the implications for their own safety when the MGF became acutely unwell.

8.1.3. There is no evidence of a 'Think Family[4]' approach by the CMHT nor of consideration of the impact of MGF's condition on the wider family, particularly on a Mother with a young baby (babies). There was no multi-agency consideration of any potential risks. This is particularly evident when the MGF's order was revoked around the time of Child Two's birth and he returned to the family home where there were then two very young children. There was no discussion with the GP or Health Visitor to discuss whether this was the right time for his return home nor were Discharge Planning Meetings held.

[4]At a glance 9: Think child, think parent, think family. Social Care Institute for Excellence, May 2012. https://www.scie.org.uk/publications/ataglance/ataglance09.asp

8.1.4. There should be an expectation that the CMHT will gain as full an understanding as possible of the other practitioners working with the adult and their family, inform them of significant developments and involve them in the assessment of risk, in order to safeguard any children and adults in the household. Additionally, it would give practitioners the opportunity to consider the implications for their own safety. Discharge Planning Meeting/Discussions should be held including all community practitioners involved with a family to share information, consider potential risks and identify the support needs of the family. **(Learning Point)**

8.1.5. The lack of a Think Family approach in this case has been acknowledged in the Agency Report of the Mental Health NHS Foundation Trust and this is an area of practice for development that had previously been identified by the Trust. A local Think Family Practice Review has been recommended and accepted. **(Birmingham Safeguarding Partnership)**

8.1.6. When Father's supervision transferred to Birmingham CRC, no checks were undertaken with local agencies. There appeared to be no understanding of the history regarding Father's substance misuse, which could well have implications for his parenting capacity and risk to the children. Again, the Health Visitor and Midwives were not aware of this. Given Father's history of criminality and substance misuse it would have been appropriate for BCRC to make a referral to the local Multi-Agency Safeguarding Hub (MASH). This may not have led to an assessment by CSC, but early help may have been considered and the information would have been shared with the Health Visiting Service, so that Birmingham Health Visitors would have been informed about the family circumstances.

8.1.7. There are two examples of proactive contact between the GP and Health Visitor. Firstly, when the GP saw Child One for the late 6 – 8 weeks review, was told about the baby's recent falls and requested, via email, a visit by the Health Visitor to discuss safety. Secondly, when the Health Visitor was concerned about Child Two's weight gain and made an urgent appointment for the baby to be reviewed by the GP.

8.1.8. However, there was no direct communication between the Health Visitor and GP on either occasion neither was there a follow-up discussion about whether any further action was required. The GP recommended that Child Two's weight should be reviewed after 10 to 14 days, without identifying how this would be achieved. There was no agreed action plan, which meant that when Child Two was not brought to the clinic in June this was not immediately followed up. This highlights the importance of a proper hand-over between clinicians when there are concerns about a child and significant information needs to be shared and action agreed.

8.1.9. Bi-monthly Multi-Disciplinary Team Meetings (MDTs) are held at the GP Surgery with Birmingham Health Visitors to discuss families of concern. This is a positive development, however, there are challenges as the GP Practice liaises with eight Health Visiting Teams. Concerns about this family were not raised at these meetings. Similarly, Midwifery hold monthly MDTs in Sandwell with Health Visitors, Housing and Children's Centres, but again concerns were not raised about the family. This indicates that the family's level of vulnerability had not been recognised. **(Learning Point and Recommendation)**

8.1.10. Analyses of Serious Case Reviews have identified the importance of direct contact between practitioners, e.g. telephone or face to face discussion[5]. Evidence showed that '*direct communication provided a more immediate and effective way to share concerns'*. Simply sharing information is not enough, there needs to be a discussion about the significance of the information shared in the context of what is known about the family, including whether this indicates an increased level of risk, an agreement about the action to be taken and how this will be reviewed**.** In addition, practitioners retain responsibility and ownership for the outcome, they cannot simply '*pass the baton'* to another practitioner.[6] **(Learning Point)**

8.1.11. It has been raised during the review that there was limited liaison between Midwives and Health Visitors at the transfer of responsibility and it has been noted that Midwives do not routinely record in the child's red book, e.g. plot weights. Due to time constraints, direct communication may not be possible in all cases, but Midwives routinely recording in the red book would be extremely helpful for continuity of care and direct contact should be encouraged where there are concerns about a baby's care and progress which need to be pursued by the Health Visitor. The red book is an important form of communication for parents and practitioners, all of whom can use the book to record information about the child. Therefore, keeping this record up to date should be a priority for all practitioners. **(Learning Point)**

8.1.12. The hand-over of responsibility between the Birmingham Health Visitor and Sandwell Health Visitor was not robust. The Birmingham Health Visitor did ensure that there was a telephone conversation between the practitioners, but this related only to Child Two and not Child One, so in effect there was no transfer of responsibility for Child One. Not only did this mean that Child One was not followed up, but also the Sandwell Health Visitor was not able to compare the development of Child Two with Child One and identify that the feeding difficulties, poor weight gain, delay in GP registration and in starting immunisations was a pattern.

8.1.13. In summary, the effectiveness of multi-agency working was undermined by the lack of information sharing between agencies and direct communication, i.e. telephone or face-to-face, between practitioners, which meant that agencies did not have a full picture of the family circumstances nor of potential risks to the young children.

8.2. Assessment of need and level of service provided.

8.2.1. There was a lack of an assessment of need by any of the agencies involved with the family and for most of the review's Scoping Period the children's vulnerability was not recognised. The family fundamentally received basic universal services, e.g. Universal Health Visiting, and no additional services were offered, e.g. Early Help. However, this was a complex family and the history indicates that there were a number of occasions when additional services would have been beneficial and increased the focus on the needs of and risks to the children. There was a pattern of non-engagement by parents with agencies, which led to a delay in both children

[5] Analysing chid deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003 – 2005. Brandon et al. DCSF, 2008.
[6] Pathways to harm, pathways to protection: A Triennial analysis of serious case reviews 2011 to 2014. DFE 2016.

being registered with the GP, receiving their immunisations and having their developmental checks. There was concern when both babies were young about their slow weight gain, Child Two had fallen from 25th centile to the 0.4 centile in their first two months.

8.2.2. In addition, after the parents obtained a tenancy in Sandwell, it appears that there were some problems with the property, and they were unsettled, moving between their flat and the MGP's home. This raised concerns about safe sleeping. Mother appears to have been viewed as an 'experienced mum', but this failed to recognise that the move to independent accommodation took away the daily support the family had received from the MGM in caring for Child One, as well as the protection offered. Hence, this was a significant change of circumstances for a young mother with a second baby and two children under eighteen months.

8.2.3. There was some recognition of Mother's age and vulnerability by Midwifery when she booked for her first pregnancy and she was referred to the Young Parents Team. As Mother was not aged 18 years or under, she did not meet the criteria for the service, however, additional support with benefits and housing was offered by the Maternity Support Worker. There was no liaison between Maternity Services and other health professionals despite Midwifery Services at times being concerned about Mother's mental health.

8.2.4. The level of Health Visiting service was not escalated until the family moved to Sandwell after the birth of the second child. In discussions at the Learning and Recall Events it was agreed that escalation should have happened much earlier, whilst the family were living in Birmingham, potentially from the first visit when there had already been concerns about Child One's weight gain and Mother was experiencing some difficulties with feeding. In addition, this was a young mother. The impact of the family remaining on Universal Health Visiting for much of the Scoping Period was that there was less monitoring and follow-up when one of the children was not brought to a clinic appointment. Importantly, it also meant that there was less opportunity for the Health Visitor to develop a relationship with Mother and gain a greater understanding of the family circumstances and the Father's role within this. Mother talked about her partner being supportive, but he was only fleetingly seen by the Health Visitors and no observations were made of his care of the children. Following the new-to-area visit by the Sandwell Health Visitor, the family were escalated to Universal Plus Health Visiting, leading to an increased level of contact for a short period.

8.2.5. There is no evidence that consideration was given to referring the family for early help services[7], either in Birmingham or Sandwell. Whilst reporting that she received good support from her partner and family, Mother appeared to be socially isolated and was anxious about going out of the home with Child One. Close to the birth of Child Two she told the Maternity Support Worker that she felt safer indoors. Evidence would suggest that there were times when family support/engagement with a

[7] **Early Help** means taking action to support a child, young person or their family early in the life of a problem, as soon as it emerges. It can be required at any stage in a child's life from pre-birth to adulthood and applies to any problem or need that the family cannot deal with or meet on their own. It also applies to all children and young people, with any form of need.
http://www.lscpbirmingham.org.uk/early-help

Children's Centre or with Homestart would have been helpful to the family, e.g. when there were early concerns about Child One's weight gain. **(Learning Point)**

8.2.6. Sandwell Health Visitor Two had difficulty contacting Mother to arrange a review of Child Two's weight and advised Mother that if contact was not established a referral to Children's Social Care would be necessary. A home visit was achieved and on examination Child Two's weight had increased so the concerns lessened. This was Sandwell Health Visitor Two's first contact with the family, she was not aware of the background history regarding concerns about Child One's early weight gain, late immunisations and developmental checks. The Health Visitor reported at the Learning Event that she was wanting to establish a relationship with Mother and promote her engagement and was concerned a referral to CSC would undermine this.

8.2.7. Sandwell Health Visitor Two decided that a referral to MASH would not be accepted as a visit to review the baby's weight had been achieved and Mother had agreed to come to the baby clinic. No advice was sought from the Trust's Named Nurses for Safeguarding. This highlights the danger of a practitioner 'second guessing' the response of MASH to a referral, particularly when there are safeguarding concerns. A discussion with MASH would have been helpful in considering the family's level of need and whether any additional support was required. **(Learning Points)**

8.2.8. On the next contact when Mother attended the baby clinic, she reported the bruising to Child Two. There appeared to be a lack of professional concern and curiosity regarding the cause of the bruising to a non-ambulant child and of adherence to best practice and NICE guidelines[8]. Advice was not sought from the Named Nurse for Safeguarding. It may be that Mother's apparent openness about the bruising, albeit with an unusual explanation, again lessened the Health Visitor's concern. However, an alternative explanation for Mother's openness may have been that this was a 'cry for help'.

8.2.9. SCIE's analysis of Serious Case Reviews identified several instances in which a professional's identification of bruising to non-mobile babies did not result in a referral. The analysis highlights possible reasons including:

- Lack of understanding of child protection procedures.
- Lack of professional curiosity and 'respectful scepticism'.
- Second opinions not sought from more experienced clinician.
- Fear of getting it wrong and damaging the relationship with the parents.[9]

8.2.10. Similarly, The Department of Education's Research Brief[10] acknowledged the importance of practitioners building strong relationships with families but noted that they also need to retain '*respectful uncertainty*' towards families and maintain '*an open and questioning mindset*'.

[8] Child maltreatment: when to suspect maltreatment in under 18s, NICE Clinical Guideline, Oct. 2017.
[9] Safeguarding Children. Not making a referral after bruising to non-mobile babies. Social Care Institute for Excellence Briefing, Updated April 2016.
[10] Building on the learning from serious case reviews: a two-year analysis of child protection database notifications, 2007 – 2009. DFE, September 2010.

8.2.11. Bruising in non-mobile babies should always trigger discussion with the agency's Safeguarding Lead and consideration of a referral to MASH. This highlights the impact of the 'churn' of health staff, combined with the family moving between health trusts, at significant times, e.g. the birth of the second child.

8.2.12. There are questions about why additional help was not offered to this family. One answer is that practitioners were not aware of the complexities of the family situation. Universal services were offered to the family by the GP, Midwives, Health Visitor, none of whom knew about Father's background and history, including criminality and substance misuse, and only the GP and CMHT had information regarding the MGF's mental health difficulties. Also, the constant change of Health Visitors meant that the only practitioner who was visiting the family home regularly was not able to develop a relationship with the family and gain a fuller picture of the family circumstances and any developing patterns.

8.2.13. The other possibility is that practitioners were desensitised in some way to the family's difficulties. In an area where there is a large number of young parents with accommodation difficulties, whose children's immunisations and developmental assessments are delayed, and where practitioners are dealing with these problems 'day-in-day-out', it can be difficult to distinguish one family's difficulties from another. The danger of '*cultural normalisation and professional desensitisation'* was recognised in the Triennial Analysis 2001 – 2014.[11] To offer all these families an additional service would place stress on a service that was already struggling to cope with the demands, and this becomes a way of practitioners coping with the high demands. However, it can result in vulnerable children not receiving an adequate assessment of their needs. This was discussed with practitioners who held mixed views, but considered it is a response that they should be alert to. **(Learning Point)**

8.2.14. The challenges for practitioners in identifying the children who are most at risk in their area has been recognised in The Child Safeguarding Practice Review Panel's First Annual Report[12], which highlights that '*The inherent tension in child protection practice is how best to identify those children most at risk without pulling into the child protection system thousands of family who would never seriously harm their children'*. 46% of the 538 children who died or were seriously harmed were not known to Children's Social Care and the Panel questioned whether they should have been. This is a key question that has been considered in this review and there were points when a discussion with, referral to, CSC would have been appropriate.

8.2.15. Research has indicated that there can be a view amongst practitioners that families, particularly where grandparents are actively involved, from BAME communities prefer to manage without outside help and do not require additional services. This may have been a factor in the reason that a referral for additional

[11] Pathways to harm, pathways to protection: A Triennial analysis of serious case reviews 2011 to 2014. DFE 2016.

[12] First Annual Report 2018 to 2019, The Child Safeguarding Practice Review Panel. OGL, 2019.

support through Early Help was not considered and the carer's assessment of the Maternal Grandmother by the CMHT was proposed but was not undertaken.[13]

8.2.16. In summary, the information presented to the review has evidenced that this was a family which undoubtedly required additional services, potentially from soon after the birth of Child One, when there were difficulties with feeding and weight gain. A referral for early help services would have led to a Team Around the Child being established and the opportunity for a more in-depth assessment and understanding of the family circumstances and the risks and vulnerabilities. In addition, the increased concerns regarding the care of Child Two should have prompted a discussion with a Safeguarding Lead and referral to MASH/CSC.

8.3. Invisible men in household:

8.3.1. For some years, national guidance and research has highlighted concern about practitioners' focussing on mothers, the invisibility of males in the household and the need for practitioners to be alert to the need to engage with fathers and male partners. There were two males in this family about whom very little was known by practitioners.

8.3.2. It is known that at times during the Scoping Period the MGF's mental health deteriorated, including at significant times, i.e. around the time of the birth of both children. However, there is no evidence by the CMHT of assessment of the risk to others in the household, notably the very young children. The Maternity Support Worker, Midwives and Health Visitors who were visiting the household were not aware of his acute mental health difficulties and the stress that this created for the family. In fact, Birmingham Health Visitors referred to Maternal Grandmother in the records, but there was no reference to Maternal Grandfather. Additionally, practitioners were not aware of any potential risks to themselves.

8.3.3. Despite not working, Father never attended health appointments with Mother and the children. He was rarely seen in the family home and on two occasions was reported by Mother to be sleeping in the late morning. It was recorded several times that Mother viewed Father as '*supportive'*. This appears to have been accepted without question and there were no observations of his behaviour towards, and care of, the children. Health Visitors were not aware of his history of criminality and substance misuse. At the Learning Event, Health Visitors noted that it was unusual for fathers to engage with them and therefore there was acceptance of fathers not attending/being present for appointments. It is also important to consider Father's perspective; given his history he may not have been comfortable dealing with professionals. This focus on mothers and acceptance of fathers not engaging with health practitioners requires a shift in culture and practice and services need consider ways to promote engagement with fathers.

8.3.4. At the Learning Event, it was suggested that the fact that there had not been a consistent Health Visitor for the first 16 months of Child One's life was a factor in not knowing more about the Father, as they had not developed any understanding of

[13]Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. Memon, Taylor and de Visser. BMJ Open. 2016; 6(11): Published online 2016 Nov 16

how the family was living day to day. In discussion with the Agency Report Author, Sandwell Health Visitor One had expressed the view that, given this was a first visit, and it had been difficult gaining access, it would have felt '*intrusive'* to have questioned the role of Father too closely.

8.3.5. The Biennial analysis of SCRs highlighted the lack of information about, and lack of engagement with, men in child health and welfare.[14] The themes were:

- The failure to take men into account in an assessment
- Rigid or fixed thinking about men as 'all good or all bad'
- The threat posed by men to workers **(Learning Point and Recommendation)**

8.3.6. These findings were reinforced by Ofsted's thematic report of serious case reviews[15] which found that in reviews concerning babies this was a recurrent theme and '*again and again the reviews found that fathers had been marginalised' and described as 'ignored or invisible'*. There had been insufficient focus on the father of the baby, the father's own needs and his role within the family. The First Annual Report of The Child Safeguarding Practice Review Panel notes that '*Such a lack of professional curiosity in fathers and partners not only potentially leaves women and children vulnerable, it can also leave fathers feeling alienated and forgotten and their role in bringing up the children dismissed'*.[16]

8.3.7. In summary these messages very much mirror the findings of this LCSPR. There was a lack of information sharing between agencies in respect of both males in the household and their roles in the family were not understood. Significantly, there was a lack of proactive engagement with Father and he was invisible to practitioners. This is an area of practice that requires development. **(Learning Point)**

8.4. Policies and Procedures:

Having policies and procedures in place alone does not safeguard children and young people. However, they do provide a framework for practitioners to work within and promote effective multi-agency working. A number of local policies and procedures were relevant for this review including: Was Not Brought, Faltering Growth, Safe Sleeping, Bruising to non-mobile babies and Transfer Protocols.

8.4.1. **Was not brought:** There is evidence of appointments routinely not being kept, e.g. ante-natal, immunisations and health checks. Policies were adhered to in terms of follow-up appointments being sent, but it does not appear that the pattern of consistent failure to attend appointments was recognised and acted upon, notably when this same pattern was repeated with Child Two.

It should be noted that it is only once children are registered with a GP that appointments for immunisations and developmental checks are sent to

[14] Understanding Serious Case Review and their impact: A Biennial Analysis of Serious Case Reviews, 2005 – 2007. Brandon et al, DCSF 2009

[15] Ages of concern; learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serous case reviews from 1 April 2007 to 31 March 2011. October 2011.

[16] Annual Report 2018 to 2019: Pattern in practice, key messages, and 2020 work programme. The Child Safeguarding Practice Review Panel. 2019.

parents. This means that if children are not registered, they can 'fall through the system'.

In discussion with practitioners several examples have been provided where GP surgeries have put in place systems to promote the registration of babies, e.g. Sandwell GPs sending the registration form with the appointment for the Mother's post-natal check, Birmingham GPs sending a reminder by text message to parents. In addition, Sandwell Health Visiting service has instituted a system whereby on a quarterly basis they track expected dates of birth and check whether any additional family members have been registered at the GP Surgeries.

8.4.2. **Faltering Growth:** The Health Visitor followed the local policy by contacting the Community Paediatrician and Named Nurse for Safeguarding and arranging for Child Two to be seen urgently by the GP. However, there was a lack of direct contact between the GP and Health Visitor which would have led to a more co-ordinated and effective response. There was no agreed plan of action put in place. There was a discussion at the Recall Event as to whether the seriousness of Child Two's weight loss should have led to a referral to the Community Paediatrician, rather than just a discussion.[17]

8.4.3. **Safe Sleeping:** At various time it appears that the Health Visitors had concerns about safe sleeping in the household and gave appropriate advice, e.g. not to sleep on the sofa with a young baby. However, it was agreed at the Recall Event that a more robust approach was required to confirm that this advice had been heeded and it was noted that cots and bedding are available through local charities. It is concerning that when the Police visited the family home, in the course of the criminal investigation some months after the family had moved to independent accommodation, there was no cot for Child One.

The SWBH NHS Trust has advised that Midwifes do not routinely check sleeping areas but Health Visitors do, which would appear to be contrary to the Safe Sleeping Policy as below:

> '*At the ante-natal assessment by the Midwife, FNP nurse or Health Visitor, Primary/New Birth Visit conducted by the Health Visitor (10 – 14 days following birth) and the New to Area Visit conducted by the Health Visitor there should be a documented discussion about safer sleeping, taking into account any cultural practices relating to sleeping arrangements. Health Visitors, FNP Nurses and Midwives should request to see where the baby will be sleeping both in the daytime and at night.*

[17] The Management of Faltering Growth in Early Childhood. Sandwell and West Birmingham Hospitals NHS Trust. December 2015.

Health Visitors, FNP Nurses and Midwives should discuss each point and encourage discussion with the parent/carer about sleeping arrangements and safer sleeping for babies.' [18]

Sandwell audit Health Visitors' practice in respect of safe sleeping advice and it has been agreed that the audit tool will be shared with Birmingham Health Visiting Service. **(Learning Point and Recommendation)**

8.4.4. **Bruising to non-mobile (non-ambulant) babies:** Mother reported to the Health Visitor that Child Two had developed bruising following the immunisations. The Health Visitor observed a '*small faded greyish bruise'* on Child Two's chest and scratches to the face. Advice was not sought from the Trust's Named Nurse for Safeguarding regarding this and no further action was taken. There has a be a question as to whether this might have been 'a cry for help' from Mother, given that this was close in timing to Child Two's presentation at hospital with serious non-accidental injuries. Mother was also keen to attend the clinic rather than the Health Visit come to the family home. Why was this?

It is understood that there was a lack of local guidance in respect of bruising to non-ambulant children and the West Midlands regional Child Protection guidance has been updated to include this.[19] However, the significance of bruising to babies who are not independently mobile has been recognised for some time. The 2009 NICE Clinical Guideline[20]highlighted the importance of considering the developmental stage of the child, '*if a child is unable to move independently, bruising is unlikely to be accidental unless there is good history of an accident'*. This was reinforced in the NICE Clinical Guideline, Child maltreatment: when to suspect maltreatment[21] The guidelines highlight the importance of a practitioner seeking advice from their Safeguarding Lead.

The new West Midlands guidance should be widely disseminated and embedded into practice across agencies. **(Learning Point and Recommendation)**

8.4.5. **Transfer Policies:** During the Scoping Period there were three key points when responsibility transferred between agencies. These included from Midwifery to Health Visiting, from Birmingham to Sandwell Health Visiting service and from London to Birmingham Community Rehabilitation Company. Evidence presented would suggest that these processes were not effective.

There was a lack of communication between the Midwives and Health Visitors and it has been noted that Midwives do not routinely record in the child's red book. Sandwell and West Birmingham Hospitals NHS Trust's audit practice in

[18] Policy for Safe Sleeping in Children. Sandwell and West Birmingham Hospitals NHS Trust, June 2017. To be reviewed 2020.
[19] Regional Child Protection Procedures for West Midlands: Injuries in Babies & Children under 2 years of age.
[20] When to suspect child maltreatment. Clinical Guideline, NICE, July 2009.
[21] Child maltreatment: when to suspect maltreatment in under 18s, NICE Clinical Guideline, Oct. 2017.

respect of the completion of the child's red book and have agreed to share the audit tool with Birmingham's Health Visiting service.

When responsibility transferred between health visiting services information was only provided in respect of Child Two and not Child One. SWBH NHS Trust's New to Area Best Practice Guidance highlights that it is the responsibility of the receiving Health Visitor to '*ensure sibling notes are also received and reference cards are updated with sibling information'*. [22]

The transfer of responsibility for the supervision of Father's community orders between the CRCs was not effective. Birmingham CRC accepted responsibility on a '*caretaking basis'*, which meant that London CRC retained overall responsibility. However, Father failed to engage, no breaching action was taken, and the orders finished with an almost total lack of engagement without any consequences for him.

It is important to recognise the significance of times of change for families as they may be moving away from existing, important, support systems. Ineffective transfer practice, including the lack of information sharing, increases a family's vulnerability and potential risks are not highlighted.

8.5. Context practitioners were working in:

8.5.1. Evidence presented to this Practice Review has highlighted the staffing difficulties and the adverse impact of these on service provision in two areas. Firstly, health visiting in Birmingham and, secondly, the London Community Rehabilitation Company. The high workloads, turnover of staff and use of bank/agency workers undoubtedly impacted on the quality of service provided to the family. This is reflected in Inspection Reports.

8.5.2. The impact of the churn of Health Visitors meant that one Health Visitor did not have the opportunity to build a relationship with Mother and the one-off visits did not enable the Health Visitors to fully identify any concerns, e.g. neglect. Concerns tended to be viewed as isolated incidents, rather than as a developing pattern, which may have been a factor in the family's level of support not being escalated to Universal Health Visiting Plus.

8.5.3. Birmingham has an establishment of 227 Health Visitors. At the time of the review there were 140 in post, i.e. over 30% vacancy rate. The Care Quality Commission's unannounced inspection in June 2019 found:

> *'The service did not have enough health visiting staff with the right qualifications, skills, training and experience to keep children, young people*

[22] Health Visiting Service New to Area Visit Best Practice. Sandwell and West Birmingham Hospitals NHS Trust, June 2017. To be reviewed February 2020.

and families safe from avoidable harm and to provide the right care and treatment.'[23]

8.5.4. The CQC issued the Birmingham Trust with a Section 31 notice - an '*urgent notice of the decision to impose conditions on their registration as a service provider in respect of a regulated activity'*. The Trust has an action plan in place, which includes building competencies, undertaking audits and 'dip samples' and providing a duty system of Named Nurses to provide safeguarding advice. **(Learning Point)**

8.5.5. London CRC were similarly experiencing staff shortages and frequent changes of workers. Though threatened, enforcement action was not taken in response to father's almost total lack of engagement with his orders. There was a lack of professional curiosity regarding father's move to Birmingham to live with his partner who was known to be pregnant and whether there were any safeguarding concerns. There is no evidence of a risk assessment being undertaken. The changes in the Responsible Officers, combined with the transfer to Birmingham, meant that there was a lack of ownership and no one officer took responsibility for managing the Father's orders.

8.5.6. In 2017 Her Majesty's Inspection of Probation's report regarding LCRC highlighted that the quality of public protection work was not of an acceptable standard overall and there were continuing concerns about LCRC's practice in relation to safeguarding. The report noted that evidence suggested '*the LCRC was not treating child safeguarding work as a priority'*. There had also been concerns about practice regarding enforcement action, although this was an improving picture.

8.5.7. In response, the service has worked to stabilise the workforce, developing a central process to manage enforcement action and during 2017/2018 staff have undertaken safeguarding training. A follow-up Inspection of LCRC, published in August 2019, found there had been '*considerable efforts'* to improve the quality of work over the past year.[24] **(Learning)**

8.5.8. The Triennial Analysis of SCRs 2011 - 2014 [25] highlighted the impact of resource constraints on the quality of service provision, as has been evidenced in this LCSPR. The analysis suggests that this can result in a lower level of service being provided. '*In particular, agencies often adopt short-term pragmatic solutions, rather than consider the ongoing needs of families.'* This concern was identified again in The Triennial Review 2014 – 2017 which noted '*Workload and budgetary pressure stand out as factors that threaten professional practice and through that imperil children's safety and welfare'*.[26]

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[23] Birmingham Community Healthcare NHS Foundation Trust: Quality Report, Published September 2019, Care Quality Commission.
[24] An Inspection of London Community Rehabilitation Company. Her Majesty's Inspectorate of Probation, August 2019.
[25] Triennial Analysis of Serious Case Reviews (2011 – 2014). Practice briefing for LSCBs. Research in Practice, June 2016.
[26] Complexity and challenge: a triennial analysis of SCRs 2014-2017. Final Report. Department of Education, March 2020.

8.5.9. In summary, it would appear, that with such chronic staffing difficulties and churn in the Birmingham Health Visiting service and the LCRC, the systems created a start again approach to families as each practitioner was coming to the situation anew. Practitioners were much less likely to identify patterns in the care of the children and the need for increased, targeted, intervention at an early stage. Additionally, this undermined effective multi-agency communication and working.

9. Examples of good practice:

1. Mother's age and vulnerabilities were recognised by the Midwives during the first pregnancy and arrangements were made for additional support to be offered by the Maternity Support Worker.

2. Following a visit to the surgery, the GP was concerned about Child One's safety and supervision and requested a follow-up visit by the Health Visitor.

3. The Sandwell Health Visitor was tenacious in arranging the new-to-area visit and immediately escalated the family to Universal Plus Health Visiting service.

4. Following the new-to-area visit, the Sandwell Health Visitor initiated the Faltering Growth Policy and ensured that Child Two was seen urgently by the GP, despite not being registered at the Practice.

5. The Sandwell Health Visitor was determined in arranging the follow-up contact with Mother to monitor Child Two's weight gain.

10. Key Learning:

1. Bruising on non-mobile/non-ambulant babies, no matter how minor, should always be treated seriously and advice sought from a Named Nurse/Safeguarding Lead/MASH. Practitioners should consider whether a Mother, by pointing out unexplained bruising, may be asking for help. **(Recommendation)**

2. Safeguarding children and young people should be the priority for all agencies and practitioners providing services to adults, i.e. CMHTs, GPs, CRCs. There should be an embedded **Think Family** approach. At times of significant change practitioners should ask themselves, 'Who else lives in this household?', 'What other practitioners do I need to inform about any developments?'

3. The importance of practitioners not focussing solely on mothers, but engaging with fathers and gaining an understanding of, and valuing, their role in the family. This requires a shift in culture and practice and services need consider ways to promote this.

4. The importance of assessment and early identification of the level of need, vulnerability and risk and of consideration of the appropriate services, including the provision of early help, e.g. Children's Centres, Family Support Workers.

Practitioners require training and skills to undertake this task, as well as reflective supervision.

5. Practitioners should consider the impact of cultural normalisation and professional desensitisation on their practice, which can result in families not receiving the additional services they require.

6. Practitioners should guard against 'second guessing' the response of MASH/CSC to concern about the care and safety of a child and deciding not to make a referral.

7. Practitioners should demonstrate professional curiosity, 'respectful scepticism' and constructive challenge and not accept what a family tells them at face value.

8. Information sharing alone does not safeguard children. It is a dynamic process, requiring checking back as to the understanding of information shared, agreement as to its significance, e.g. does it indicate an increased risk, the actions to be taken and how these will be reviewed. Information sharing does not absolve practitioners of responsibility for a child and family, they retain 'ownership' until it is known that concerns have been resolved or action is in place to manage these.

9. Direct communication, e.g. by phone or face to face, provides the best opportunity for practitioners to share information, analyse risks and agree a way forward.

10. The importance of practitioners being aware that moving between areas, and away from existing, support systems can increase a family's vulnerability. Hence, careful transfer of responsibility between practitioners is essential.

11. The importance of the role of the GP and of early registration of a new baby with a GP Practice, as this is the trigger for sending appointments for developmental checks and immunisations. **(Recommendation)**

12. The importance of health practitioners, notably Midwives and Health Visitors, routinely recording information, particularly any concerns, in the baby's red book, e.g. weight gain, so progress can be tracked.

13. All key practitioners, i.e. Midwives, Health Visitor, Early Help workers, should have an understanding of the importance of Safe Sleeping and the real dangers of co-sleeping, sleeping on sofas, etc., and know what action to take if there are concerns. **(Recommendation)**

14. The value of Multi-Disciplinary Meetings (MDTs) held in GP Practices, involving Midwives and Health Visitors, where early concerns about the care and safety of children can be shared and a co-ordinated approach taken. **(Recommendation)**

15. The value of community health services, i.e. GPs, Health Visitors, using red flags/alerts in electronic medical records to indicate concerns regarding a child or family. (In Sandwell - the safeguarding node.)

16. Severe staff shortages and churn inevitably undermine practitioners' ability to provide a consistent and responsive service and can create a 'start again approach', so that emerging patterns of concern are not identified.

11. Conclusion:

11.1. This Local Child Safeguarding Practice Review (LCSPR) has considered the services offered to a family where there were concerns about the care of the children and the youngest child sustained serious, potentially life-changing, non-accidental physical injuries. It has been identified that for most of the Scoping Period no additional services were offered or provided to the family.

11.2. The information presented to the LCSPR has evidenced that this was a vulnerable, young, family which undoubtedly required additional services, potentially from soon after the birth of Child One, when there were difficulties with feeding and weight gain and a delay in registration with the GP. A referral for early help services would have led to a Team Around the Child being established and the opportunity for a more in-depth assessment and understanding of the family circumstances. This would have helped to ensure the family were receiving the right services at the right time. Cultural normalisation and professional desensitisation may have been a factor in this.

11.3. Similar concerns were raised regarding the care of Child Two, indicating the pattern was being repeated, but again additional services were not offered to the family. A referral to MASH was not made when there were serious concerns about Child Two's weight gain and difficulties engaging with the family, nor was advice sought or a referral made when there was bruising to Child Two, a non-mobile child. The review has highlighted the dangers of 'second guessing' the response to a referral.

11.4. There were two males in the family about whom very little was known by practitioners, namely the Father and Maternal Grandfather. Father had a significant history of criminality and substance misuse, but there was no consideration by the Community Rehabilitation Company of how this would impact on his parenting capacity or communication with the community services working with the family. The Maternal Grandfather had long-term mental health difficulties, but the Community Mental Health Team did not 'Think Family' and consider the potential stress and risk this presented for the family. For some years, national guidance and research has highlighted concern about the invisibility of males in households and the importance of practitioners not focussing solely on mothers and being alert to the need to engage with fathers and male partners. This requires a shift in culture and practice.

11.5. The effectiveness of multi-agency working was undermined by the lack of timely information sharing between agencies and of direct communication, i.e. telephone or face to face, between practitioners. This was compounded by the move of Father from London and of the family between local authorities in the West Midlands. This

meant that the agencies did not have a full understanding of the family's circumstances, of the strengths, risks and vulnerabilities.

11.6. It would appear, that with such chronic staffing difficulties and churn in the Birmingham Health Visiting service and the London Community Rehabilitation Company, the systems created a 'start again approach' to families, as each practitioner was coming to the situation anew. This was apparent when concerns about the children were increasing at a time when the new Health Visitor was aiming to establish a relationship with Mother. With such staff churn, practitioners were much less likely to identify risks and patterns in the care of the children and therefore the need for increased, targeted intervention at an early stage.

11.7. The LCSPR has identified many lessons for individual agencies and multi-agency working which will be disseminated by Sandwell Safeguarding Children Partnership and by local agencies.

12. Recommendations:

Below are recommendations for Sandwell Children's Safeguarding Partnership. Agencies involved in the review have also produced single agency action plans. The implementation of all these recommendations will be monitored quarterly by SCSP.

1. SCSP should ensure that the learning from this LCSPR is disseminated widely and incorporated into updates, and/or the development of policies and procedures.

2. SCSP should ensure that the Overview Report is presented to Birmingham Safeguarding Children Partnership and that the Partnership identifies and takes forward the actions required for their partnership.

3. SCSP should share the findings of this LSCPR with London Safeguarding Partnership (LSP) with the recommendation that they identify and take forward any actions required for their partnership.

4. SCSP to seek assurance from the Sandwell Health Forum that the safe sleeping policy for SWBNHS is shared with all relevant staff including Midwives, Health Visitors, Early Help services and Children's Social Care. SCSP to be assured by the Sandwell Health Forum that regular MDT meetings are being actively promoted, e.g. in GP practices, to include prompting registration of new births.

5. SCSP should ensure that, when finalised, the West Midlands guidance in respect of bruising to non-mobile/non-ambulant babies is widely disseminated and embedded in practice across all agencies.

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APPENDIX A

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