Extended Child Safeguarding Practice Review

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1. Introduction

1.1 This Review has been commissioned by the Chair of Sandwell Children's Safeguarding Partnership (SCSP), following a decision by the Rapid Review Group that, in Accordance with Working Together 2018[1], this case met the criteria for a Child Safeguarding Practice Review (CSPR) as abuse or neglect was suspected.

1.2 Upon reflection of the identified themes of the case, the panel concluded there were similar themes to a number of recent local SCR/CSPRs and considered that a deep dive of the actions taken following these reviews, including close scrutiny of their implementation, would provide valuable insight into how successful Sandwell had been in embedding previous learning.

1.3 An extended CSPR was proposed to, and agreed by, the National Panel. This extended CSPR will take into account the guidance in Working Together and the principles of the systems methodology recommended by the Munro review.[2] It will draw on the principles of Child Safeguarding Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

1.4 Of note, the death of VS occurred during the first lockdown of the pandemic creating unique and adverse circumstances for all professionals on both a local and National basis.

2. Summary of Learning Themes

2.1 The following are the main learning themes. Sandwell needs to promote:

- multi-agency partnership working
- end silo working
- increase the use of history
- improve its information exchange between services at key points
- develop its golden thread between strategic vision and frontline practice
- provide enhanced, coordinated services
- develop its Quality Assurance processes
- increase professional curiosity
- foster challenge within and between services
- develop a process for managing change as a result of SCR/CSPR recommendations

3. Context of Child Safeguarding Practice Reviews

3.1 The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at local level with the safeguarding partners. The purpose of the review is to identify improvements to be made to safeguard and promote the welfare of children. Locally, safeguarding partners must identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. Serious child safeguarding cases are those in which:

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[1] HM Government (2018) Working Together to Safeguard Children https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

3.2 This review will:

- recognise the complex circumstances in which professionals work together to safeguard children;
- seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- be transparent about the way data is collected and analysed;
- make use of relevant research and case evidence to inform the findings.
- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted, ensuring that the subject child and/or family cannot be identified.

4. Succinct summary of case

4.1. Mother registered her pregnancy with VS with health professionals in autumn 2019. VS has a sibling born to mother and a previous partner in 2013. Sibling was already known to SCT. Sibling had been made subject to a CP plan in 2018 following an incident and had been placed with maternal grandparents where she reportedly thrived, and her lived experience seemingly improved. Sibling's case was deescalated in 2019 when sibling was made subject to a CIN plan which remained in place at the time of VS's death; sibling had an allocated Social Worker (SW).

4.2 Midwifery informed MASH of the pregnancy via email when mother was 11 weeks pregnant. The information that mother was pregnant was forwarded to sibling's SW but was not followed up as a new referral as it was in an e-mail and not a MARF. Mother was referred to Perinatal Services when she was approximately 17 weeks pregnant. The service was aware sibling was residing with maternal grandparents due to a 'neglect incident'. Mother's engagement with services was often sporadic, with multiple appointments for herself and sibling not being attended. In early 2020, sibling's SW contacted midwifery enquiring about the progress of the pregnancy. When mother was 28 weeks pregnant, two referrals were made to MASH one by the Health Visitor who, having reviewed the case file, was concerned due to the family's extensive history and subsequent high risk to the new born, and the other by sibling's SW's Team Manager. Following receipt of the referrals, a separate SW was tasked with completing a pre-birth assessment. This is not the usual practice within SCT but was due to the SW for the sibling being off work sick, and the need for the assessment to be completed. The assessment was completed 4 weeks later and a strategy meeting held with the police when mother was 34 weeks pregnant. A birth plan was formulated and an ICPC booked for 4 weeks hence, however mother gave birth to VS 37 weeks into the pregnancy, prior to the conference.

4.3 In the later stages of mother's pregnancy and post VS's birth, Covid-19 altered agencies ways of working. The psychiatrist from Perinatal Services completed mother's assessment post VS's birth via video link. Discharge of VS and mother post birth happened quicker than it may have done under normal circumstances. Staff

were discharging all babies at the earliest opportunity due to the risks associated with transmission of coronavirus and were keen to discharge VS who was well. Whilst there was a plan in place, the plan lacked clarity for hospital staff regarding discharge. The hospital contacted the Emergency Duty Team (EDT) to confirm VS could be discharged with mother to maternal grandparents' address. The EDT assumed that maternal grandparents had been assessed as connected carers so there was no reason not to discharge.

4.4 Both mother and father were known to the police. Of note, mother had been subject to domestic violence in a previous relationship and had a caution for child cruelty (wilful neglect) relating to her locking sibling in a room whilst intoxicated. Father was known for drug offences, violence and domestic incidents. There was no known violence between mother and father. It is known that mother and VS visited father each day following VS's discharge.

4.5 On the morning of VS's death an ambulance was called to maternal grandparents' home in response to a child in cardiac arrest. Following a short attempt to resuscitate the subject child, VS was pronounced dead at the scene by ambulance staff. VS presented with vomit in the airways and had a 2mm bruise to the right cheek, 7mm red mark to the chin and yellow fluid around the eyes and nose. Sandwell SUDIC protocol was followed, the Police attended the address and mother was taken into police custody. Concerns were immediately raised by Police and SCT about the home environment in which the subject child and sibling were living – an excessive amount of alcohol was observed at the scene as well as cannabis balls, and the kitchen area was very unkempt. This led to sibling being removed and placed with foster carers as the subject of an Interim Care Order.

4.6 The police have since concluded their enquiries and are taking no further action, and the coroner has completed an inquest.

5. Methodology

5.1 Following agreement to undertake an Extended Child Safeguarding Practice Review, a chair and reviewer, Nicki Walker-Hall, was commissioned.

5.2 An initial set up meeting was held where the proposed key lines of enquiry (KLOEs) and the methodology were discussed agreed.

5.3 Three separate events were proposed in order to examine whether the golden thread from strategic vision to frontline practice was evident. Key practitioners were identified. The Practitioners event was a 2.5-hour event involving 12 practitioners from across the local authority, health, and police, and was facilitated by the lead reviewer. The managers event was a 2-hour event involving 6 managers. A series of questions were provided to strategic managers. The events focussed on the subject's journey through the system and explored the KLOEs to establish how learning from reviews is being used to drive forward improvements to processes, services and practice.

5.4 The reviewer completed a draft report for analysis by the panel. Partner organisations via the Panel were then given an opportunity to agree actions to address blockages and barriers identified before the final report was agreed.

5.5 The panel considered the most appropriate method to share the learning across the workforce in Sandwell.

5.6 It is intended learning from the full report will be made available to the public but only after consideration by the SCSP.

6. Key Lines of Enquiry (KLOE)

6.1 The following KLOEs were agreed:

1. pre-birth procedures/referrals/arrangements/unborn baby network
2. application of thresholds in relation to neglect/injuries
3. progression and escalation of concerns (ICPC)
4. making use of history in relation to domestic violence, and drug and alcohol use
5. involvement of fathers
6. management of unregulated placements
7. assessments
8. information sharing
9. disguised compliance
10. professional curiosity

6.2 A small task group identified the following four additional KLOEs needed to be considered:

11. why the changes suggested through the SCR/CSPRs are not seeming to have had a sufficient impact
12. how Sandwell manages change
13. the process for disseminating learning
14. communication

7. Engagement with family

7.1 The reviewer met with mother and maternal grandmother to gain an understanding of their experiences of the services provided. The reviewer is grateful to them both for sharing their reflections and experiences. The reviewer has offered to meet them both again, to provide an opportunity for the content of the report to be shared.

8. Review team

8.1 The Review Team consisted of members of Sandwell Children's Safeguarding Partnership Review Subgroup, which included senior safeguarding representatives from the following agencies:

- Police
- Clinical Commissioning Group (CCG)
- Sandwell & West Birmingham NHS Trust (SWBNHS)
- Public Health
- Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)
- Sandwell Children's Trust (SCT)
- Sandwell Metropolitan Borough Council (SMBC)
- Sandwell Children's Safeguarding Partnership (SCSP)

8.2 The Review and team were led by Nicki Walker-Hall. Nicki is an experienced independent reviewer from a health background. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology.

9. Timescales

9.1 There is an expectation that all Reviews should be completed within 6 months of initiating it, unless there are good reasons for a longer period being required. In this instance, this timescale was not met. Initiation of the review was impacted by Covid-19.

However, once initiated, the review was completed in line with the agreed methodology within 6 months.

10. Analysis pertaining to the Key Lines of Enquiry

Pre-birth procedures/referrals/arrangements/unborn baby network

10.1 Within Sandwell there are multiple procedures/processes relating to unborn babies. The purpose of all these procedures is to give guidance to those working with pregnant women and create safety for the unborn baby. What is unclear is how all these processes and procedures dovetail to ensure consistent and clear guidance is provided to frontline workers in order to safeguard the unborn. Within the West Midlands, there are nine local areas that collaborate with regards to child safeguarding procedures. Within those procedures there are specific pre-birth procedures which indicate referrals should be made at the earliest opportunity and are clear around the process and timescale. There is clarity on when a pre-birth conference should take place with an expectation this will be as soon as the pre-birth assessment has been completed and at least 10 weeks prior to the due date of delivery.

10.2 In addition, SCT practitioners have Pre-birth guidance which set out the following principles:

- Where there is a risk of harm to an unborn child, that a proportionate response will be offered by the Trust to assess risk, offer support to vulnerable parents and ensure that a robust plan is in place, where necessary before baby arrives.
- That parent(s) are helped to understand what they are required to do to keep baby safe.
- That practitioners and partner agencies work effectively together to share information, minimise risk and ensure good contribution to pre-birth assessments.

10.3 The guidance is clear. Within the guidance there is reference to the SCSP unborn baby protocol on the now redundant LSCB website. Embedding of this protocol was a recommendation of a SCR published in January 2020. This protocol has been superseded by the unborn baby network.

10.4 Sandwell Safeguarding Children Partnership set about developing the Sandwell Unborn Baby Network (SUBN) following a recommendation from a SCR in 2019. The remit of the multi-agency SUBN is as a forum for sharing information about high risk, high vulnerability women and their unborn babies. Fathers are also discussed and information is shared to form part of the pre-birth assessment intervention and plans.

10.5 At the practitioner’s event it became clear that some agencies were unaware of/unclear of SUBN and how to access or refer families. Managers indicated that this case would not have met the criteria as sibling was on a CIN plan and would have met the threshold for statutory intervention, the thinking being that SUBN is for children who don’t meet the level for statutory intervention or if they have been referred in at that threshold but declined support. However, the procedures do not indicate this.

10.6 The development of the SUBN has been slow and it is still not up and running effectively two years after being a recommendation. SUBN development was tasked to SCT and maternity services on behalf of the SCSP and has gone through phases of

development and pause. The delay in its development means Sandwell children are yet to reap the benefits its development was intended to bring. The governance of the SUBN is currently being reviewed by SCT and the SCSP Business Unit as it has been recognised that it needs strengthening. Whilst a referral form has been developed, this has yet to be ratified prior to circulation/promotion. (See section 11.1)

Learning point: The interface between all the policies, procedures and processes is unclear and has not been well articulated. A whole systems approach to safeguarding unborn babies needs to be adopted.

Recommendation: SCSP and its partners to agree Sandwell's strategic approach to safeguarding unborn babies and conduct a mapping exercise of all policies and procedures to ensure frontline workers are receiving a clear and consistent message on how to refer and work with pregnant women where there are concerns for the unborn.

Application of thresholds in relation to neglect/injuries

10.7 There is clear evidence that initial concerns regarding neglect of sibling did result in action being taken. Once sibling's case was de-escalated from CP to CIN there was a less robust response to new concerns.

10.8 When sibling received a burn to her arm there is no evidence that there was consideration to convene a Strategy Meeting to consider the injury and whether this should have led to a joint investigation between the police, SCT and health as would be expected practice. The reviewer has considered sibling's account of the incident and the description of the burn and is not sufficiently assured that the two correlate. This incident provided an opportunity to investigate whether the injury matched the explanation and whether the current arrangements were sufficiently robust. Sibling's safety was given some consideration and grandmother agreed with the SW to keep sibling in her care. This did not happen, mother took sibling from grandmother's to her boyfriend's, as was her right, and there was no immediate consideration as to what action may now be necessary to ensure a) sibling was safe and b) grandmother was in a position to keep her safe. Sibling's living arrangements should have been revisited with mother who, at that time, might have had mental capacity[3] to agree to sibling being accommodated under section 20[4]. Any refusal of section 20 should have led to exploration of whether the threshold had been met to consider more formal arrangements in order to secure sibling's safety.

10.9 This informal arrangement was explored within a CIN meeting regarding sibling and features in sibling's CIN plan three months after the incident. At that time there was a plan to complete a viability assessment for maternal grandparents and a risk assessment for father. Neither of these assessments had been completed prior to VS's birth some six months later. The birth plan acknowledges recent concerns regarding neglect but does not distinguish whether the neglect of sibling was as a result of the care afforded by grandparents or parents.

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[3] Mental Capacity Act (2005) – The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions

[4] Section 20 Children Act (1989) – Sets out the provision of accommodation in various circumstances.

10.10 An Ofsted inspection[5] in 2017, prior to the SCT formation in April 2018, found that in too many cases, risk, while identified, was not subject to timely or appropriate interventions. There was drift and delay in progressing work and, in a large number of cases seen, this had led to children being left for too long in situations of risk without effective action to reduce that risk and to sustain better outcomes. The same issues are apparent in this case.

10.11 Through managerial oversight it was identified that VS's case had not been progressed and an appropriate referral was made however, managerial oversight has not addressed the lack of progression of assessments and the quality of those assessments that had been completed. The reviewer has had sight of all CIN plans for the review period. The plans are often repetitive, with completion by dates for actions extended with no clarity on why the proposed date has been missed, and do not contain a clear focus on the risks/potential risks to the child. Although there is a place for managers' comments this is not being made use of. It would be helpful for partner agencies to be sighted on managers' thinking in order to effectively challenge drift.

Learning point: Where a child is subject to a CIN plan due to neglect, and other isolated incidents occur, such as an injury, these should be managed with the same timely response and rigor as that for children not previously known to SCT, or children subject of a CP plan.

Recommendation: SCSP to seek assurance from SCT that all referrals of concern relating to children open to SCT are investigated with the same rigor as those for children subject of a CPP or referred for the first time.

Learning point: Managers are not making use of existing tools to demonstrate oversight and the progression of cases in CIN.

Recommendation: SCSP to seek assurance from SCT that plans for CIN cases are being progressed, where progress has not been made managers are sighted on this and partner agencies are better placed to challenge.

Progression and escalation of concerns (ICPC)

10.12 SCSP procedures indicate an ICPC should be held as soon as the pre-birth assessment has been completed and at least 10 weeks before the due date of delivery. In this case the pregnancy was known about in the first trimester and there should have been ample time to complete a pre-birth assessment and hold the conference.

10.13 Confusion at the point SCT were informed of the pregnancy led to a delay in the pre-birth assessment taking place. Whilst the pregnancy was known and the SW involved with sibling was made aware of the pregnancy, it has been recognised that midwifery should have sent a MARF to SCT when they first became aware of the pregnancy. However, the issue here was a decision made in the MASH team to pass the information on to the SW for sibling, without requesting the informant submit a MARF, or responding to and progressing by making enquiries. Since this case, there is now a named midwife for safeguarding in post, who is addressing loopholes within midwifery. Now staff would be told to submit concerns for an unborn as a new referral on the appropriate form.

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[5] Ofsted. (2018) Sandwell Metropolitan Borough Council Re-inspection of services for children in need of help and protection, children looked after and care leavers https://files.ofsted.gov.uk/v1/file/2755854

10.14 At the practitioners' event, those present reflected that any agency who knew mother during pregnancy could have submitted a MARF regarding VS, and all had enough information to suggest that further questions could have been asked to ascertain the situation. Attendees stated they felt uncertain about whether there was enough information for a MARF and there was also an assumption that as mother was pregnant and sibling was open to SCT, that actions were already being taken for VS.

10.15 A strategy discussion was held; no health discipline was invited. A decision was made to take the case to ICPC. This triggered an automatic notification to the QAS who arrange the conferences. The ICPC was booked for the 15th working day following strategy discussion, within timescale. However, by that date mother would have been 38 weeks pregnant. The lack of a health representative at the strategy meeting meant an opportunity to request an earlier date for the ICPC was missed. When the date was set, staff were not aware that they could have challenged this decision, based on the fact that all pregnancies are considered full-term from 37 weeks' gestation, and there was significant likelihood that VS would be born prior to this date. VS was born at 37+ weeks prior to the proposed conference date. Since this time an appropriate health representative is now invited to strategy discussions.

10.16 Whilst there were no meetings, there is evidence of communication between the social workers for VS and sibling. Sibling was said to be making good progress with grandparents so there was an assumption that this was a safe place for her and VS; this, and a lack of progression of a formal assessment of grandparents, impacted on decision making. The health visitor also spoke to the social worker in early May and was told that grandparents were a protective factor. Practitioners indicated that there was a clear birth and discharge plan on the system which was discussed between maternity and the social worker. Grandmother indicated that she had not been contacted prior to VS's birth and was unaware of the full content of the plan. Mother and grandmother indicated that they knew father was allowed to attend the birth and had assumed, because of that, he was ok to have contact with VS after discharge. The reviewer has had sight of the plan and it lacks detail of mother's caution for wilful neglect, the reasons why discharge is to maternal grandparents, and clarity on the risks posed by father. There was no written agreement.

Learning point: The slow progression of action in both children's cases impacted adversely. The passing on of information rather than undertaking an enquiry when midwifery shared that mother was pregnant was pivotal. Too many assumptions were made that enquiries were under way and that grandparents were a protective factor. There were many opportunities for professionals to challenge the lack of progress, and get this case back on track, but this did not happen. Lack of progression of grandparents' viability assessment could also have been challenged within CIN meetings. Those professionals not involved with sibling, but involved with mother and her unborn, should have been anticipating a meeting would be held and questioning when this did not happen. Lack of progress of actions within the CIN plan suggests there was a lack of effective managerial oversight and challenge.

Recommendation:

SCSP to seek assurance from its partners that all professionals are being encouraged to challenge and take an active role in progressing cases, challenging slow progress and escalating cases where insufficient progress has been made.

Making use of history in relation to domestic violence, drug and alcohol use and involvement of fathers

10.17 There is evidence that professionals made use of mother's history of mental illness within their practice. Mother was referred to perinatal services in light of her history during her previous pregnancy. In respect to domestic abuse, Midwifery were following guidance regarding routine enquiries concerning domestic abuse; mother answered no to all routine enquiries. Whilst there was no evidence of domestic abuse between the couple it would have been helpful for all professionals to have knowledge of both parents' histories. There was little consideration of history in relation to mother's drug and alcohol use. Whilst mother appeared to share a lot of information with perinatal services this did not include key elements, including her alcohol misuse, as a factor when sibling was removed.

10.18 There is very little information regarding father. This is a national issue that has been noted in many SCR/CSPRs.

10.19 Historically local maternity services focussed almost exclusively on mothers. Whilst in recent years that focus has moved to focus more on fathers, perinatal services are currently working on moving away from a 'mother-centric' approach and are including 'Think Family' in all supervisions.

10.20 The pre-birth assessment provided an opportunity to assess father. The assessment took place late in the pregnancy and is not considered by SCT to be an in-depth assessment, although it was deemed complete. Mother indicated to the reviewer that father was present when she met with VS's SW on the first occasion.

10.21 As part of sibling's CIN plan, a risk assessment of father was required, this remained incomplete at the time of VS's death. The lack of risk assessment meant clarity on the safety of contact between father and VS had not been established and, although it is recorded mother agreed to no contact between VS and father post birth, mother disputes this. In fact, there was little to prevent contact with no written agreement in place. The lack of risk assessment, coupled with evidence of non-compliance previously, should have led to a more robust plan.

10.22 SCT have introduced three generational cultural genograms which will provide practitioners with a useful tool by which they will be able to consider wider family issues. Hidden men training has also been developed and will be available to practitioners.

Learning point: History is not always being drawn on to provide context and background information to new assessments and inform resultant plans. Lack of assessment of father left an omission to the plans with regards to contact between father and VS.
Recommendation: SCSP to seek assurance that its partners are conducting holistic assessments inclusive of all individuals linked to the subject child.

Management of unregulated placements

10.23 When sibling was made subject to a Child Protection Plan and placed with maternal grandparents, thought was given to accommodating sibling under Section 20 of the Children Act 1989. The LA has a duty to accommodate under Section 20 if the person who has been caring for the young person is unable to continue to provide suitable

care and accommodation. It is good practice for the LA to obtain written consent before placing a child under S.20. At that time mother was experiencing acute metal illness and was not deemed to have capacity to consent to S.20. Sibling remained in the care of maternal grandmother from 2019. This was determined as a 'private family arrangement'.

10.24 Whilst a private family arrangement can be made directly between the parent(s) and the relative, friend or connected person, if the child is placed by Children's Services, as in this case, the relevant framework should be applied.

10.25 Where a child is placed with a family friend, family member or other connected person, Regulation 24 of the Care Planning, Placement and Review (England) Regulations 2010 sets out the regulatory framework for the first 24 weeks.

10.26 It is possible to assess the carer as a temporary foster carer so that a child can be placed immediately but the full assessment must be conducted within 16 weeks of the child being placed; this can be extended for a further 8 weeks in specific circumstances. If a child is placed with a connected person who is not approved under Regulation 24, the placement is unregulated and may be unlawful.

10.27 Maternal grandmother was never assessed under Regulation 24 sibling was therefore living in an unregulated placement. Unregulated provision is allowed in law but usually when children (usually over the age of 16) need support to live independently rather than needing full-time care.

10.28 SCT own guidance[6] indicates "The social worker will need to complete a regulation 7 report, which will contain details of the child, circumstances that led to request to place young person in an unregulated placement, which will include the extent that placement searches have taken place, risks involved and safety plan, which included level of monitoring of the placement".

10.29 In February 2020 the government proposed making it illegal to place under-16s in unregulated accommodation; a provision in law that is likely to be implemented later in 2021.

10.30 Latterly the allocated SW in this case requested the placement be regulated, however the SW was told it was a private family arrangement. The reviewer was told this was not unusual however there should be evidence that this has been assessed; this arrangement was not challenged.

10.31 The significance of whether sibling was in a regulated or unregulated placement is that this determines the way the placement is supported and frequency of visits. Grandmother reported that she saw sibling's SW every now and then and no concerns where highlighted.

Learning point: Sibling was thought to be living with grandparents as part of a private family arrangement but was in fact in an unlawful, unregulated placement. SCT have taken the necessary steps to ensure no child in Sandwell is currently in the same situation and have completed specific training around the differences and requirements around regulated, unregulated, private family arrangements and private fostering. All case discussion should include discussion about the legality of arrangements and a prompt is needed for all cases to check the relevant framework if the child is not living with its birth parents.

[6] Sandwell Children's Trust (2018) Guidance Note - Unregulated Placements

Recommendation: SCSP and its partners to develop a 7-minute briefing to be shared with all staff groups regarding how to recognise when a child is a looked after child versus a child living within a family arrangement.

Assessments

10.32 Sandwell SCP procedures state that a pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, preferably before 20 weeks, where:

- a parent or other adult in the household, or regular visitor, has been identified as posing a risk to children
- a sibling in the household is subject of a child protection plan
- a sibling has previously been removed from the household either temporarily or by court order

10.33 The need for a Section 47 enquiry should be considered and, if appropriate, initiated at a strategy meeting/discussion held as soon as possible following receipt of the referral. The expected date of delivery will determine the urgency of the meeting.

10.34 SCT have a pre-birth assessment tool to be used to assess all unborn babies, providing an effective framework for assessing risk.

10.35 As previously discussed, there was a four-month delay in a pre-birth assessment being conducted. This delay reduced the amount of time available to the SW. There is evidence of communication between the SW and health services to inform the assessment, however not all services were contacted directly. The SW sought information regarding engagement with services from the perinatal service. The perinatal service gave a largely positive picture, however if the drug and alcohol service had been contacted directly, they would have indicated that mother was not engaging. Grandmother informed the reviewer she had not been contacted and had therefore not been consulted regarding her ability to support mother or to care for VS. The lack of complete information to inform the assessment likely led to a more positive view of the case.

10.36 In addition to being delayed, not all elements of the assessment had been completed prior to it being signed off which is a concern.

Learning point: No assessment should be considered complete until all elements of the assessment have been completed.
Recommendation: SCSP to gain assurance from SCT that quality holistic assessments, that address all the needs of the individual child, are being completed prior to sign-off.

Information sharing

10.37 Evidence of information sharing between services is limited. There is evidence of a number of conversations between professionals on an adhoc/email basis. The lack of formal referrals, regular CIN meetings, allocation of VS to a separate SW in an alternate team and limited information gathering practices between partners have reduced the level of information sharing usually seen in such cases. Information that was shared was largely verbal in nature with no formal reports between services. The exception to this is the perinatal service letters to the GP.

10.38 Subjects in CIN were not receiving the same level of protection as those in CP. Lack of information sharing led to reduced opportunities for professional challenge. School staff requested new dates for CIN meetings following cancellation but these

were not immediately forthcoming. Whilst there were the required number of CIN meetings to meet statuary requirements, there were fewer meetings during mother's pregnancy with VS than the previous 12 months.

Learning point: The reviewer is unsure whether information sharing practice in this case is representative of practice across Sandwell in general. If this is representative information sharing practice in CIN cases may not be robust.
Recommendation: SCSP and its partners to seek assurance that information sharing in cases where children are subject to CIN is timely, recorded and shared as per agency information recording and sharing policies.

Disguised compliance and Professional curiosity

10.39 Disguised compliance is a regular feature within SCR/CSPRs. To detect disguised compliance, professionals needed to be curious, questioning what they are told and putting it into context of the wider picture. It is almost impossible for a single agency or sole worker to gain clarity on whether they are being deceived or misguided by a parent or grandparent. It is only through a multi-agency approach that allows the professional to test out any concerns that disguised compliance can be fully recognised and responded to. In this case, professionals only held part of the picture. Most services knew sibling lived elsewhere and had a social worker but didn't know that sibling was subject to a CIN plan. Services knew there was an assessment in respect of VS and that sibling was staying with grandparents, however there was a lack of curiosity about why this was.

10.40 Evidence suggestive of disguised compliance on the part of both mother and grandparents was not sufficiently explored and therefore went unchallenged. Self-report by sibling that she was spending nights with her mother, and on occasion mother's partner, provided an opportunity for professionals to gain a greater understanding of the dynamics within the family.

10.41 Sibling's reports were clear evidence that the agreement for sibling to reside with maternal grandparents was being broken on multiple occasions. This suggested either no agreement, non/disguised compliance on the part of grandparents, an inability of grandparents to enforce the agreement, or a lack of understanding regarding the agreement. Either way, greater clarity and more stringent measures to ensure sibling's safety were not considered or taken. Given the evidence it would be wrong to conclude there was disguised compliance.

Learning point: Professionals were insufficiently curious. They did not ask pertinent questions to better inform their thinking and plans in this case.

Examples of Good Practice:

1. SCT representatives felt the level of support and encouragement after the death of VS was excellent. SCT held learning events and staff training and although these were challenging, one staff member felt it had helped her to be a better manager, to learn and be more reflective.
2. The mental health of mother was well cared for during the pregnancy.
3. The summary of involvement from perinatal services to the GP was excellent.

4. CCG have developed Level 3 training for all GPs on safeguarding which includes lessons from reviews.

11. Themed analysis

Why the changes suggested through the SCR/CSPRs are not seeming to have had a sufficient impact.

11.1 The Quality Assurance (QA) process which scrutinises actions following recommendations from SCR/CSPRs has not been robust. Action plans are too task-focussed and are not sufficiently sighted on the intended aim to improve outcomes for children.

11.2 It has been reported that both the recommendations and single agency action plans are monitored on a quarterly basis by the Sandwell Learning and Practice Reviews (SLPR) subgroup, with some updates shared at the SCSP meetings on a case-by-case basis. Agencies provide evidence/updates in relation to the action plans, which are then discussed at the SLPR subgroup – any outstanding actions are addressed by the SLPR representative for the agency.

11.3 When a particular area of work comes under scrutiny via SLPR, this can be signposted to the Quality of Practice and Performance (QPP) for further work e.g. a specific audit. This appears to be the only mechanism for testing whether the action has had a positive outcome.

11.4 For example, the Pre-Birth Network group was developed in 2018 and agreed largely by 2 key agencies; SCT and Health (midwifery). The group went through a change/rebrand under the MASA arrangements in April 2019 to Sandwell Unborn Baby Network (SUBN): this included revision of the Terms of Reference (ToR), Pathway and Procedures in July 2019 which were shared and approved by the then Independent Scrutineer in Dec 19 and accepted by members of QPP in February 2020. The SUBN has continued to meet since that time, and these meetings are currently under review for the effectiveness.

11.5 The SUBN was initially led by Children's Services and then picked up by Sandwell Children's Trust when they were commissioned. There was a delay in its development and progress during this transition.

11.6 The ToR's included governance arrangements indicating a quarterly report relating to prevalence, measurable outcomes, referrals in, outcomes and impact was to be submitted to the QPP board. The SUBN did not gain traction. This has been raised at various forums i.e. SSCB/SCSP meetings and the SCR/Sandwell Learning from Practice Reviews (SLPR) subgroup. A proposed review has currently stalled due to the Pandemic and change within senior management in SCT.

11.7 There has been lack of clarity regarding the referral criteria to the SUBN across the wider partnership including knowledge of its existence beyond the membership. SCT have always taken the lead and chaired this group, however cases discussed are below the threshold for statutory intervention. The development of a referral form to this group is very new and has only just been shared in health, it remains unclear if this has been extended across the partnership. The review of this group is ongoing as the partnership still does not have assurance that the group is fit for purpose.

11.8 At present, it would appear that there is little awareness of the SUBN outside of the 2 leading agencies that introduced the model, whilst there is evidence that this is

mentioned in training, including when and how to make a referral. For the period Oct – Dec 20, no referrals were received for consideration at the SUBN by any agency other than health (midwifery). This questions whether other agencies are aware, accept any ownership, or see themselves as having any responsibilities for referring cases of concern to this group. There is also no evidence of a communication strategy, it may therefore be possible that this model was not communicated beyond the agencies that formed the group.

11.9 A box has now been added to all action plan forms to include 'How do we know we have made an impact?' which needs to be completed in addition to the Progress Update/RAG rating.

11.10 The SCSP has employed an independent scrutineer to consider key areas of work, including the development of the quality assurance cycle, monitoring of actions and responses to reoccurring themes seen in CSPRs. In some instances, further assurance could be given on how the action has led to an improvement in outcomes for children.

11.11 The reviewer has been unable to establish whether the action regarding the development of the SUBN was ever signed off as complete. What is clear is the lack of pace in which recommendations are completed, the lack of challenge from partners to this lack of pace. The reviewer has found insufficient evidence of multi-agency ownership of the issues, evidence of silo working on multi-agency issues, and a lack of partnership working to address the issues.

Learning point: Sandwell partners are not jointly owning and addressing their issues. Whilst it is understandable that task and finish groups complete some of the operational elements of recommendations, the oversight and monitoring of successfully introducing or making changes to enhance and have a positive impact on its children, remains the role of the partnership.

Recommendation: SCSP and its partners to consider how it currently oversees action plans from SCRs/CSPRs and external inspections and ensure the focus moves from the task to the outcome.

How Sandwell manages change

11.12 Change, including systems and processes for multi-agency working, is undertaken via consultation across the partnership, children, young people and families, and led by one of the subgroups. This is usually by way of establishing short-life Task & Finish groups covering specific elements. The final process will be tabled for approval at a meeting of the SCSP before being circulated across the partnership and published.

11.13 Sandwell has not managed to make effective changes following recommendation from a number of SCR/CSPRs or inspections and needs to aim to reach a point where it knows itself well and is not reliant on SCR/CSPRs to identify shortfalls in its systems and processes. Sandwell has had a number of cases that have identified the same issues and, while it is evident some work has begun to address the identified areas for improvement, this work has lacked pace and effect. Ofsted[7] in their most recent inspection made a number of recommendations that were repeats of

[7] Ofsted. (2018) Sandwell Metropolitan Borough Council Re-inspection of services for children in need of help and protection, children looked after and care leavers https://files.ofsted.gov.uk/v1/file/2755854

recommendations made in previous inspections that had not been enacted upon sufficiently to address the issue. This is of concern.

11.14 On a positive note, it is reported that there has been a recognised change in values over recent years which has led to a cultural change on reflection, transparency and support.

11.15 Sandwell currently has no intention to introduce a 'new' change process, however SCSP is executing its responsibilities to review all elements of the safeguarding arrangements for effectiveness - this is its current approach in reviewing the SUBN. It is hoped this will provide assurance that the process works for local children and families and to identify where further improvements may be required.

11.16 The SCSP has recently created a conference style event called 'Safeguarding Today' to improve communication between the SCSP and the children's workforce. This is seen as one of the platforms to be used to share, disseminate, and launch safeguarding messages.

11.17 Within SCT there is an SI Plan which tracks any recommendations made and cross references to each other – this is now being enhanced and extended to track previous recommendations and to be able to tie in repeats.

Learning point: Sandwell has developed an inclusive change management style seeking the opinions of partners and service users before making changes. Whilst this is to be commended, the partnership is yet to be assured that the current process is assisting it to make necessary changes to immediately reduce risks and have a positive impact on children and young people's lives.

Recommendation: SCSP to progress at pace the review of the SUBN and in doing so test the effectiveness of their change process.

The process for disseminating learning

11.18 Learning is disseminated using a range of methods: firstly, via the SCSP membership who are tasked with cascading the full report and 7-minute briefings to their agencies. It is also disseminated via the SLPR subgroup reps and publication/ promotion is discussed at the SLPR subgroup. The reviewer learned that one health discipline on receipt of the 7-minute briefings will edit these to only include the relevant bits for their discipline; these are then circulated on a monthly basis. Within SCT the learning is also disseminated via Trust Communications and through monthly QA Reports. Updates are given during the Core Working Together safeguarding training sessions.

11.19 The dissemination to frontline practitioners is dependent on organisation/agency – some services seem to have greater knowledge than others of learning from reviews, which suggests that the sharing of learning is not consistent across all agencies. This is due for discussion at SLPR in March 2021 with ideas such as recorded webinars with the author upon completion, a publication learning event for practitioners and question and answer sessions being some of the new methods of sharing learning to consider. New 'Learning from Reviews' drop-in sessions will commence from April 2021 which the whole workforce can access.

Learning point: Whilst the new developments are likely to reach a wider audience, the process is not robust and it may be a significant period of time before the learning reaches some frontline practitioners and brings about a change in practice.

Recommendation: A process needs to be introduced to ensure learning is disseminated consistently across and within all organisations to all practitioners.

Communication

11.20 A number of services which serve Sandwell residents also serve residents from neighbouring authorities. Communication when working with multiple agencies in an area where organisations are not coterminous geographically adds an additional layer of complexity to an already complex issue. Communication between services across health disciplines is a national issue. It has long been recognised that the multiple disciplines and multiple recording systems within health add an extra layer of complexity to communicating, both within and between health disciplines and their partners. There is a lack of electronic connectivity between health services which can make it difficult to share information between different teams and organisations. There are some specific examples in this case where important information, which would have been useful to partner agencies, remained in health. Letters from the Perinatal Service were only copied to the GP not the social worker.

11.21 Sandwell Safeguarding Health Partnership has developed a Safeguarding communication pathway within Sandwell Health Economy which is designed to bring clarity. If the pathway is for health only use it is likely fit for purpose however, the author is not clear that it would provide partners with sufficient clarity.

11.22 Communication complexities require careful consideration and clear strategies to manage them. Sandwell has lacked a communications strategy. Currently there is a communications strategy in development; this will be ratified by the SCSP before roll-out across Sandwell and its neighbouring authorities.

11.23 Sandwell does have good cross border working relationships with neighbouring authorities, and 50% of the statutory partner members of the SCSP provide services spanning more than one LA boundary. Within this role is the responsibility for disseminating information to all represented agencies. Cross-border colleagues are also invited to and have access to attend local events, i.e. training, briefings, conferences, audits etc.

Learning point: There has been a lack of strategic vision regarding communication in Sandwell which has left a gap. The current development of a Communications Strategy has the potential to address this. Following its development, all communication pathways need to be aligned to the strategy, and their clarity for all the partners considered.

Recommendation: SCSP and its partners to assure the newly developed Communications Strategy and agencies communication pathways are aligned and driving communication across the partnership.

Appendix i – key to acronyms/ abbreviations

BSMHFT	Birmingham and Solihull Mental Health Foundation Trust
CCG	Clinical Commissioning Group
CIN	Child in Need
CP	Child Protection
CSPR	Child Safeguarding Practice Review
GP	General Practitioner
ICPC	Initial Child Protection Conference
KLOE	Key Lines of Enquiry
LA	Local Authority
LSCB	Local Safeguarding Children’s Board
MARF	Multi-Agency Referral Form
MASA	Multi-Agency Safeguarding Arrangements
QA	Quality Assurance
QPP	Quality Practice and Performance
RAG	Red Amber Green
SCR	Serious Case Review
SCSP	Sandwell Children’s Safeguarding Partnership
SCT	Sandwell Children’s Trust
SI	Serious Incident
SLPR	Sandwell Learning and Practice Reviews
SMBC	Sandwell Metropolitan Borough Council
SSCB	Sandwell Safeguarding Children’s Board
SUBN	Sandwell Unborn Baby Network
SUDIC	Sudden Death in Childhood
SW	Social Worker
SWBNHS	Sandwell & West Birmingham NHS Trust
ToR	Terms of Reference