Serious Case Review

OVERVIEW REPORT

Re Child H

Born July 2011

Significant injury: Late December2011

Independent Chair – Prity Patel

Independent Overview Report Author – Ron Lock

September2012

Content

Introduction

1.1 This Serious Case Review relates to the circumstances which led an infant, aged 5 months (who will be referred to as Child H in this report) to receive significant injuries which were thought to be the result of abuse. The medical report considered that Child H had "been subject to an escalating pattern of non-accidental injury" and the range of injuries were thought to have occurred sometime within the preceding ten days. Both the father and the mother were arrested on suspicion of causing grievous bodily harm and Child H was placed in Local Authority care following the need for surgery to deal with his injuries.Ultimately the Crown Prosecution Service (CPS) considered that there was insufficient evidence to support a criminal prosecution of either parent in respect of the injuries to their child.

1.2 As a pregnant teenager, the mother lived in a supported housing project (mother and baby unit) and she was discharged back to live there with Child H following his birth. The father who was a little older than the mother, lived elsewhere. Following disagreements between the parents over the care of Child H, the father became the main carer for their baby by the time Child H was approximately 6 weeks old,using the support of a member of the extended family to help care for his baby. This arrangement was supported by Children's Social Care (CSC) and the Police at the time.

1.3 Prior to the eventual significant injuries to Child H, whilst his father was the primary carer, he was taken to hospital on several occasions because of medical concerns, firstly about breathing issues, then regarding vomiting blood and on a further occasion because of a bruise behind the ear. Whilst some concerns were raised because explanations did not always fully match the presentation of Child H, these were not considered to relate clearly to child protection concerns. During the time that the father was the main carer for Child H, a Core Assessment had considered him to be a competent father and that should Child H be returned to his mother, that child protection procedures would be put in place.

1.4 Because the serious nature of Child H's eventual injuries were very likely to be the result of abusive care and have an impact on his long term development, and additionally because there were a number of agencies involved in providing services to the parents and their child, the Wiltshire Local Safeguarding Children Board (LSCB) decided that this case met the criteria for a Serious Case Review (SCR) to be undertaken.

1.5 The criteria, established in relevant government guidance, states that an LSCB should consider whether to conduct a SCR whenever "a child sustains a potentially life threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children."[1]

1.6 The purposes of this Serious Case Review reflects the relevant government guidance to: -

[1] Paragraph 8.11, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working to better safeguard and promote the welfare of children.[2]

1.7 In order to undertake the SCR,each agency that had some direct involvement with the childand his family was required to undertake an Individual Management Review (IMR) to look openly and critically at its practice in relation to their involvement with the family. In undertaking this, each agency was also required to produce a chronology of its contact with the family. The managers/officers conducting the IMRs did not at the time immediately line-manage the practitioners involved and were not directly concerned with the services provided for the Child H or his family.

1.8 Senior representatives from relevant organisations in Wiltshire were brought together to form a SCR Panel in order to review and analyse the material from the IMRs. An independent safeguarding consultant with a professional background as a child care lawyer, Prity Patel, was commissioned to be the chair of the SCR, and Ron Lock, an independent safeguarding consultant with extensive professional experience in safeguarding children and young people, was commissioned to detail the analysis and findings from this SCR and complete the Overview Report.

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[2] Paragraph 8.5, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

Terms of Reference

2.1 Time Period

2.1.1 The time covered by this SCR includes the period of time from when the antenatal services provided to the mother up until Child H being placed in foster care following his injuries.

2.2 Agencies required to provide Individual Management Reviews

Wiltshire Council - Children's Social Care
Wiltshire Council - Schools and Learning
General Medical Practice
Sirona Care and Community Child Health
Royal United Hospital Bath NHS Trust
University Hospitals Bristol NHSF Trust
Wiltshire Police
Great Western Hospitals Foundation NHS Trust – Midwifery services
Great Western Hospitals Foundation NHS Trust – Children and Young People's Community Health Services
Greensquare Group/Spitz Support Service
4Children
Wiltshire Probation Trust
Wiltshire Council - Integrated Youth Services
Wiltshire Council - Housing Options and Homes 4 Wiltshire

Additionally the South West Ambulance Trust were contacted for information although there was no significant involvement to require an IMR to be undertaken.

2.3 The Serious Case Review Panel

2.3.1 The SCR Panel included the following: -

- The Designated Nurse, Safeguarding Children - (NHS BaNES/Wiltshire)
- Head of Service, Community Safeguarding - Wiltshire Children's Social Care
-Detective Inspector, Public Protection Unit - Wiltshire Police
- Designated Doctor, Safeguarding Children - Sirona Care and Community Child Health
- Head of Strategic Housing
- Head of Service - Early Years and Childcare, Wiltshire Council
- Assistant Chief Executive - Wiltshire Probation Trust
- Virtual School Head Teacher – Wiltshire Council
- LSCB Development Manager

Business and Administrative Support: -

- LSCB Business Manager
- LSCB Administrative Assistant

2.3.2 All the Panel meetings were chaired by Prity Patel, an independent safeguarding consultant, and the independent overview report author was in attendance at all of the panel meetings.

2.4 Independence

2.4.1 All authors of the IMRs were independent of the services delivered to the family and the details of their independence were clarified in each of the IMRs.

2.4.2 The chairperson of the SCR Panel was independent of all professional agencies in Wiltshire and her background is as a child care lawyer, and as an independent consultant. Her previous work has included involvement in SCRs either as the chair or overview author but had not done so previously in Wiltshire.

2.4.3 The overview report writer was independent of all professional agencies in Wiltshire and had been the author of a previous SCR in Wiltshire. His background as an independent safeguarding consultant has included involvement in numerous SCRs either as author or chair.

2.5 Terms of Reference for the SCR to consider

Specific Issues: -

A1: Consider what relevant information was known to agencies about the background of the two young parents and whether this should have indicated that they would be likely to require additional support in caring for their first baby

A2: Was the level of both ante and post natal care provided appropriate and sufficient to meet the needs of the parents and their new baby, were any risk factors noted?

A3: What was the effectiveness of the interagency response to Child H's admission to hospital in October 2011and injuries sustained in November 2011?

A4: Is there a thorough understanding of thresholds and safeguarding responsibilities both intra and inter agency?

General Safeguarding Issues

B1: Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?

B2: Did the agency have in place policies and procedures for safeguarding children and acting on concerns about their welfare?

B3: What were the key relevant points/ opportunities for assessing risk and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in a timely, informed and professional way?

B4: Did action accord with the assessments of risk and decisions made? Were appropriate services offered/ provided, or relevant enquiries made, in the light of assessments?

B5: Where relevant, were appropriate child protection or care plans in place, and child protection and/ or looked after reviewing processes complied with?

B6: When, and in what was the Child's lived experience, their wishes and feelings ascertained and considered? Was this information recorded?

B7 Were more senior managers, or other agencies and professionals, involved at points where they should have been?

B8: Was the work in this case consistent with agency, LSCB and South West Child Protection policy and procedures for safeguarding children, and wider professional standards?

B9: Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

B10: Were there any issues in communication, information sharing or service delivery between those working office hours and those providing out of hours services?

B11: Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Were there staffing or resource issues?

B12: Was there sufficient management accountability for decision making?

2.6 Methodology/SCR process

2.6.1 There were five SCR Panel meetings overall from April – August 2012, although there was an additional briefing meeting for the IMR authors as well as a workshop to provide support and advice once IMR authors had begun their work.

2.6.2 The completed IMRs were presented to the SCR Panel by their respective authors over two meeting days on the 7th and 15th June 2012 and the deadline for completion of the final drafts was 29th June 2012.

2.6.3 The first draft of the Overview Report was considered at the Panel meeting on the 6th July 2012 and the second draft on the 6th August 2012, by which time a draft Executive Summary and the Health Overview Report had been produced and were reviewed. Each panel member had taken responsibility to provide the final quality assurance of particular IMR reports and these were reviewed alongside the quality assurance by the Panel of the action plans. The final presentation to the LSCB of the Overview Report and Action Plans took place on the 7th September 2012. Following discussion at the LSCB meeting, the Overview Report was further revised for completion by the 21st September 2012.

2.7 Parallel processes

2.7.1 During the SCR process, Police investigations were continuing in terms of endeavouring to identify who had caused the injuries to Child H, and evidence was provided to the CPS in respect of these investigations. By the end of the SCR process,the SCR Panel was informed

that the CPS had decided not to pursue criminal proceedings in respect of either parent. Whilst the SCR Panel were kept up to date with any progress in respect of criminal investigations, these did not have any impact on the work of the SCR Panel or compromise the process.

2.7.2 Whilst care proceedings were being undertaken in respect of the child, these did not have any impact in respect of the SCR process.

2.8 Involvement of the family in the process

2.8.1 Family members were informed of the SCR and given literature explaining the process and were also formally invited to attend. The LSCB Development manager met with the parents separately to explain the process and to encourage them to contribute. Additionally a member of the extended family, who had periods of time caring for Child H, was invited to contribute to the process. Although separate meetings were arranged on neutral premises for the parents and the aunt, it was only the mother who attended her meeting. Her contributions to the SCR have been included within the content of the report.

2.9 Individual Management Reviews

2.9.1 All of the Health IMRs have been reviewed by the Health Overview Report author and are included in her report and so this section will not include any analysis of these. The Health Overview Report author has made additional recommendations for each health IMR and these will be forwarded to the respective health organisations for their consideration for further action. Therefore their own IMR recommendations will remain as those which will be subject to Action Plans and to the scrutiny of their management and the LSCB regarding their completion.

<u>Wiltshire Council (Children's Social Care)</u>

2.9.2 This IMR is well structured in terms of the factual aspects of the case and is explicit within the analysis of some of the failings of practice that occurred in this case. This was especially so in respect of poor quality assessments which did not identify key risk factors, and a failure to prioritise the needs of Child H by social workers. No reasons are given why there is no genogram as part of the IMR whereas the family relationships are quite complicated with the involvement of some extended family in the care of Child H, which would have benefited from the development of a genogram.

2.9.3 There is some acknowledgement within the report of some organisational issues which may have impacted on the operational practice within the case which gives some understanding of why practice did not reach the required standards at certain times. Whilst the lessons learned are contained within the body of the report rather than being explicitly stated, the recommendations do reflect what needs to change in the future.

<u>Wiltshire Council – (Schools and Learning)</u>

2.9.4 This IMR reflects the education history of both parents and gave some very useful background information about their upbringing and childhoods. There was less of a

requirement to analyse the professional practice within the schools and education welfare services because it predated the time frame covered by this SCR. Some useful recommendations were nevertheless made to improve recording processes and how to track vulnerable children.

Wiltshire Police

2.9.5 This IMR provides detailed information about Police involvement with this family and gives useful analysis of the Police interventions. The Police had full information about the father's history of criminal convictions for assault and did share this with Children's Social Care (CSC) although the IMR does identify how there were gaps in respect of multi-agency information sharing which did not support efficient decision making within the Strategy Meetings held. A separate Genogram was supplied separately by the Police to support the work of the SCR Panel but is not included in the IMR

2.9.6 The recommendations relate specifically to the learning identified within the IMR and importantly relate to information sharing processes, additionally proposing a move to co-located premises with CSC. Although there is a Police IMR recommendation to improve Strategy Meetings, this is also a recommendation for this Overview Report.

Greensquare Group/Spitz Support Service

2.9.7 This IMR reflects the work of the mother and baby unit who provided the supported accommodation for the mother when she was pregnant and then again for her and the baby following Child H's birth. The report does not contain a genogram and may well reflect the service's lack of knowledge about the extended family. The report does appropriately highlight how practice could have been improved on occasions, and in particular of the need for greater risk assessment processes. Some areas of new practice are helpfully highlighted

2.9.8 In many respects the recommendations reflect a need to review basic safeguarding practice and improve these when necessary. It is apparent that the experiences of the mother and baby unit in respect of this case have generated some useful learning opportunities for the service.

4Children

2.9.9 This IMR reflects the involvement of the local Children's Centre in the provision of some support services to the family. This involvement was not a consistent one although outreach workers were involved with the family at some key events. Some gaps are identified in taking action at appropriate times whereas some positives were identified in the purposeful information sharing by staff and the keenness to involve other agencies. Again there is no Genogram included in the IMR.

2.9.10 The recommendations appropriately reflect the IMR's learning in the case which primarily focus on the work of outreach workers and of improving internal recording practice, (importantly in capturing the child's voice) and in terms of the interface with external agencies.

Wiltshire Probation Trust

2.9.11 Probation's involvement was prior to the time period for the SCR although their work with the father gives some useful background information in terms of the father's offences and his response to Probation supervision. Whilst the IMR identifies some very good practice in their work with the father as a young man, there is a question raised about the inappropriate use of the Multi Agency Public Protection Arrangements (MAPPA) although this would not have made any realistic difference to later events in the case. Recommendations are appropriately made although the impact these will have on the service is less clear.

Integrated Youth Services

2.9.12 This IMR reflects the mother's involvement with Connexions, the Host Family scheme and on one occasion with the Teenage Pregnancy Coordinator. Despite this only amounting to limited direct involvement, some useful analysis is nevertheless provided in terms of professionals only focussing on the "here and now" rather than considering the broader context of the family. The Youth Offending Service did not have any contact with the father due to the low level disposals in terms of the offences.

2.9.13 Some useful recommendations have been made to try to address some of the key areas of early help which could have been improved in this case i.e. the use of the Common Assessment Framework and in terms of the Team around the Child processes.

Wiltshire Council - Housing Options and Homes 4 Wiltshire

2.9.14 This IMR reflects some good detailed analysis of contact and meetings with the parents although they did not provide housing services directly to the family. Despite the limited involvement, some learning has emerged and an innovative recommendation about wanting to shadow other agencies is made in order to attempt to improve shared understanding of the practice of colleagues.

Health Overview Report

2.9.15 This report is a thorough piece of work in bringing together the analysis across the health agencies and raises some additional areas of analysis based on the broad knowledge of health practice by the author and on further examination of some of the health records. To some extent this has extended what was known at the outset of the SCR and added to information not otherwise included in the Overview Report.

2.9.16 Key areas of analysis reflect that health professionals did not appear to have a clear understanding of multi-agency thresholds for intervention and that there was generally an over optimistic view of the parenting abilities which remained throughout the work with the family, and with the father particularly. In fact it is identified that there was insufficient assessments undertaken. The Health report also comments on the inconsistencies of the Strategy Meetings from the health perspective – this is taken further by recommendations within this Overview Report.

2.9.17 Apart from new recommendations made to each of the Health agencies, this report makes separate recommendations which generally relate to the broader dissemination of the learning from the case and how these need to feed into commissioning and contractual arrangements as well as future health governance structures.

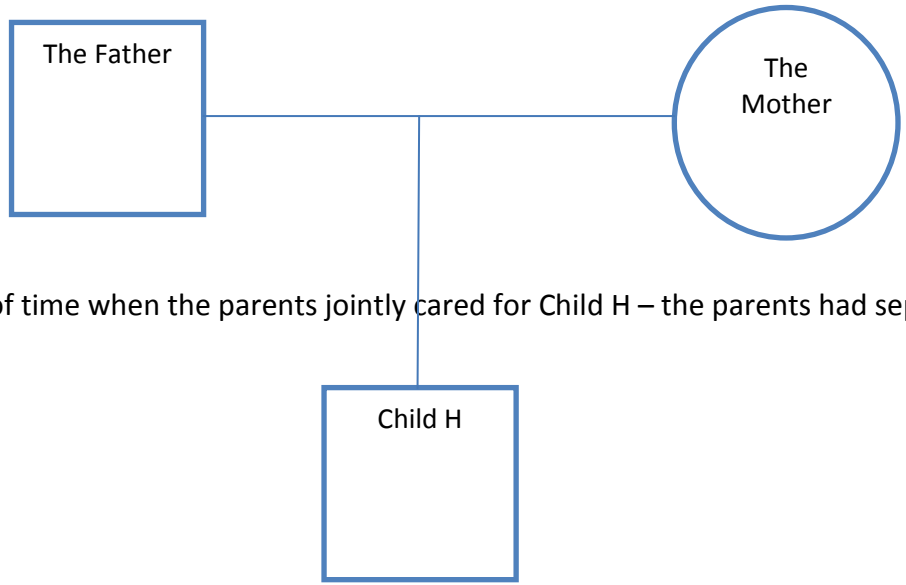
Genograms

2.9.18 There is a lack of genograms being provided by the majority of the IMRs which tends to reflect the lack of detailed knowledge held by agencies about the extended families of the parents. Nevertheless the IMR authors should still have provided a genogram even if very limited information is known. For future reference the LSCB's SCR sub group will need to reinforce to agencies in future SCRs of the importance and value of always including a genogram of the agency's understanding of family relationships in respective IMRs.

Genogram

A paternal aunt provided much support to the father in the care of Child H

Maternal aunts did provide support to the mother



There was no period of time when the parents jointly cared for Child H – the parents had separate accommodation

3. The Facts

Background Information

3.1 Re The mother: As a child, the mother attended school locally and went on to local college where she attained a qualification in Child Care. There were no concerns identified about her development, behaviours or social relationships

3.2 When the mother became pregnant with Child H, she was living with a member of her external family but moved out once it became known that she was pregnant. The mother gave details of what happened at this time in her contribution to this SCR.

3.3 Re The father: The father's school life was curtailedafter experiencing fixed term exclusions before again being permanently excluded in his secondary school.

3.4 As a young adult, the father had criminal convictions for violent offences for which he was sentenced to prison from **late 2009**. He was released on license for 3 months after serving less than a year in prison.Overall the father's compliance with the condition of his license period was good, and when this ceased in the **summer of 2010,** his offender manager assessed him as presenting a medium risk of re-offending. At this time the father said that he had significantly reduced his alcohol intake and that following the help received whilst under license, he had learned how to manage his anger and stay in control of it most of the time.

Period of Review – December 2010 – January 2012

3.5 In **early 2011**, the mother undertook her antenatal booking at 10 weeks pregnant. The father's name and address were noted as the mother's partner. As this was a teenage pregnancy, the need for a Common Assessment Framework (CAF) was cited. From the booking in appointment, a letter was sent to the GP, health visitor and local Children's Centre to inform them of the pregnancy. A Pre-CAF report was sent to the Supporting Young Parents project worker.

3.6 The mother made contact with the duty social worker for Children's Social Care (CSC) to request help with accommodation whilst she was temporarily staying with friends. She was later seen by a housing options advisor, with the mother saying she was homeless. Arrangements were made for an Initial Assessment to be completed, which was undertaken by a social worker from CSC.

3.7 The mother moved into a Supported Housing project (the mother and baby unit)which provided accommodation for women aged between 16 and 24 years who are pregnant or who have one young child. With accommodation successfully arranged, the case was closed by CSC.

3.8 An appointment was set up for the midwife to meet with the mother to undertake a Common Assessment Framework (CAF), although the mother did not attend. It was recorded by midwifery services in April 2011that as the mother had moved to the supported housing that a CAF was no longer needed as the mother"was directly involved" with CSC.

The records noted the name of the social worker who had recently completed the Initial Assessment.

3.9 Soon after this, the father was arrested after being found in possession of a controlled drug for which he was later give a caution.

3.10 Child H was born on the in the summer of 2011. Because of his low birth weight, Child H was placed in the Neonatal Intensive Care Unit (NICU) where he was visited by both parents. The mother remained on the post natal ward at this time. The Children's Centre received the Pre CAF assessment form on the following day.

3.11 The mother was discharged home to the mother and baby unit whilst Child H remained in the NICU. Child H was noted as irritable and "jittery" over a period of time, although it was not recorded that this was discussed with the mother prior to the baby's discharge from hospital. Although the health visitor was contacted to enquire about the mother's circumstances, she had not by this time met her.

3.12 The Children's Centre outreach worker carried out a Pre-CAF assessment with the mother ten days after the birth,who said she was enjoying her new life as a mum and was visiting the NICU daily. The father was also visiting daily.

3.13 Child H was discharged from hospital and a home visit to the mother and baby unit by the NICU outreach worker noted that the parents were confident of making up feeds and bathing the baby. The father was there on this occasion although he was not allowed to reside in the accommodation. Further contact noted that the mother and the baby had settled well and that the father was very supportive.

3.14 The Police were contacted late at night to say that the father had taken Child H, (when he was just over two weeks old) from a party that the mother had been attending, apparently without the mother's knowledge. A number of enquiries were made by the Police through the night and the father was located the following day. He maintained that he had taken Child H becausethe motherand others had been drinking at the party and he did not feel it was appropriate that Child H was there. He said he informed those at the party of his intentions. There were no concerns about the care of Child H whilst in the care of the father who confirmed that he would be returning the baby later that day.

3.15 The Police simultaneously made a referral to CSC regarding the incident and included information that the father may be involved in drugs. CSC staff spoke with the support worker at the mother and baby unit who spoke very positively ofthe mother's parenting.

3.16 The NICU outreach worker visited later that day with knowledge of the recent incident, and saw the mother and the father with Child H who was reported as doing well and that he was gaining weight appropriately. It was noted that the mother was quiet, appeared upset and had a bruise on her right cheek. Following the visit, the outreach worker contacted the social worker to gain further information about the recent incident. The health visitor also visited on the next day to undertake a new-birth visit and she reported seeing both parents, and that they appeared to be caring for the baby together. A tense atmosphere was

recorded. The manager of the mother and baby unit reported that the father had so far been an attentive caring partner and father.

3.17 At a home visit a week later by the Children's Centre outreach worker, the mother said that she and the father were no longer together but that they were on good terms over access to Child H. The NICU outreach worker visited soon after and reported that Child H was thriving.

3.18 After a telephone call from the father to the health out of hours service, he expressed concern that Child H (who was approximately 4 weeks old at this time) was inconsolable, crying and had vomited – he was advised to take the baby to the local hospital which he did that evening. Child H was admitted to the ward for observation and both parents were seen by the doctor, although they said they were not together as a couple. The father later told the staff nurse that he was concerned over the level of care that the mother was giving to Child H, notably the baby's hygiene and the cleanliness of bottles. He also said that the mother was drinking and using drugs. Child H was discharged as being well on the following day to the father with instruction for him to inform the mother and that he had the discharge summary document. The children's ward nurse telephoned the health visitor to inform her of the discharge and the health visitor expressed concerns over the discharge into the care of the father, who did not have Parental Responsibility at that time, and referred to the recent incident when it had been claimed that he had "abducted" the child, of which the ward had not been previously aware.

3.19 Two days later he health visitor completed a pre-CAF assessment checklist and described how the father had developed a positive relationship with Child H and that the mother had struggled with sole care and needed support. The health visitor had visited the mother and baby unit and seen mother and baby and was concerned about hygiene in the bedroom. The checklist referred to CSC involvement and that no CAF would be completed until "child protection status clarified" but that the health visitor would not be able to provide the additional services needed for the baby. It was understood that Child H was now in the care of the father and a member of the extended family, but there were no details of the address.

3.20 On the same day as the health visitor contact, Child H was readmitted via the father and kept in overnight at the regional hospital.Whilst the reasons for this were unclear in the records, it appeared to be a request had been made for the father to return Child H to the hospital, once the hospital had become aware of the recent incident when it had been said that the father had taken the baby from the mother's care without her permission. The mother seemed to be unaware of her child's current whereabouts. The health visitor raised concerns with CSC as did the regional hospital. The consultant community paediatrician later made a referral to CSC saying that the care arrangements for Child H were chaotic. The paediatrician was concerned that the father was difficult to contact and was concerned whether he was feeding Child H properly. The father had however told the paediatrician that the motherwas unfit because of drinking and drugs (cannabis), which she later denied. There were concerns by the paediatrician about the level of conflict between the parents at this time.

3.21 Strategy Meetings/Discharge Planning Meetings were held, the first between CSC and the Police and then in the hospital with paediatric input. In the hospital meeting, both parents were in attendance. A decision was reached for Child H to be discharged to the mother, with which the father was in agreement. It was also decided that an Initial Assessment would be undertaken followed by a further Strategy Discussion. The Police gave information to CSC about the father's previous offences, which they recorded as an offence relating to violence and as a caution for a drugs offence. The Initial Assessment was completed by the following day and concluded that the mother was going out too often, drinking and leaving Child H with other carers and that the father was sometimes taking care of the baby without the mother's knowledge and being un-contactable. It was decided that a Core Assessment should be undertaken.

3.22 Two days later, the Police were asked to provide a welfare check in respect of Child H after a relative of the father had reported the mother to be out drinking, with concerns regarding who the child was left with. Child H was found at a local address safe and well and asleep with sufficient milk and clothing, being cared for by an 18 year old.

3.23 There were concerns noted in a conversation between the Children's Centre outreach worker and the mother and baby unit regarding the mother's drinking, and that she had recently returned home intoxicated. The Core Assessment began at the end of August 2011 and a few days later, the health visitor expressed concerns to the social worker about the mother failing to engage with services and that she may be drinking heavily. The father was described as a positive influence.

3.24 Whilst Child H was in the care of the father, he called the ambulance service because the baby was said to be blue, although on attendance it was found that this was not because of breathing difficulties but because the baby was hungry and had worked himself into a state as a result. The paramedic helped the father to make a bottle and to then feed and wind the baby (who was now approximately 6 weeks old). The ambulance service contacted the Police and CSC to inform them of the visit – the father was described as "clueless" to the Police. The father was due to take Child H back to his mother later on the next day. There was a discussion between the Police and Emergency Duty Service of Children's Social Care (EDS) – Child H and the father were later seen by the Police with no child protection concerns noted.

3.25 Although there was a pre-arranged visit for the social worker to see the mother she was not at home and had apparently been staying with various friends since a recent fire at the mother and baby unit which had made it impractical to reside in her room at that time – she was unable to be located or contacted by phone. The father continued to express his concern for the mother's ability to care for their baby. The social worker advised the father that if he had doubts about the mother's care of Child H when she picks him up from contact, then he would be entitled not to return him**.** On the following day the social worker advised the father to seek legal advice.

3.26 Less than a week after the visit by the ambulance service, Child H was seen at the Minor Injuries Unit (MIU) out of hours service in the early hours of the morning with breathing difficulty, with the father saying that the baby had "squeaky breathing" since the recent fire

at the mother and baby unit. No child protection concerns were noted – there was nothing recorded about the cause of the breathing difficulty.

3.27 On the dame day,a Strategy Discussion was held at the instigation of the Police between the Police Child Protection Investigation Unit and the manager of the CSC referral team, when it was acknowledged that Child H was now with the father who was said to have Parental Responsibility, and that Child H would be at risk of significant harm if returned to his mother. It was agreed that if the mother attempted to remove Child H or if she approached the Police in getting the child back, that she would be advised it would be a legal matter and that she would have to pursue the matter through the courts. The Police records noted that there would be an Initial Child Protection Conference (ICPC) called by CSC.

3.28 Mrs B was advised the next day of the stance taken by CSC and the Police of supporting the father, but she denied to the social worker that she drank when she was looking after Child H. She was advised to see Child H at the father's home under supervision and that the father would be seeking a Residence Order. The social worker recorded that the mother appeared not to take the concerns sufficiently seriously.

3.29 Later that day, Child H was again taken to the regional hospital with breathing difficulties after first being referred there by the GP following the attendance at the MIU the previous day. However the father did not arrive at the hospital at the expected time and needed to be contacted - he said was delayed by transport difficulties. Child H was detained overnight and discharged back into the care of the father on the following day.

3.30 It wasduring mid- September 2011that the father registered Child H with his own GP (Child H had previously been registered with his mother at a different surgery). The health visitor contacted the new surgery to explain that the father had become the main carer because of concerns about the mother's care. The father's surgery held information in respect of his previous excessive drinking and his prison sentence for a violent assault.

3.31 Shortly after, the father visited the Housing Options service and spoke with an advisor. He told the advisor that the social worker had awarded him sole custody of his son until a court order. The housing advisor tried unsuccessfully to contact the social worker to clarify the situation.

3.32 There was a change of health visitor in late September '11 and the new health visitor saw Child H and the father at a relative's home a few days later– The father's own home was in a flat with a relative although he was said to rarely stay there. Child H was said to be clean and appropriately dressed and reaching his milestones. The father and child were soon after seen by the social worker, when the father was viewed as competent and managing well. He was said to be staying with this relative at the moment. The mother was separately seen by the social worker – she had weekly contact with Child H, supervised by the relative in her home, but had not attended recently. The mother claimed that the father had been out drinking whilst Child H was in the care of the relative.

3.33 At aged 3 months, Child H was admitted to hospital with a history of vomiting blood – the explanation given by the father was thought unusual by the paediatrician. On examination,

it was considered that the bleeding may have been caused by an ulcerated area at the back of the throat, but otherwise unexplained. The community paediatrician noted "not definite NAI[3] but unexplained" and contact was made with CSC to inform them of the admission. However, the medical view was ultimately that there was no child protection concern associated with Child H's condition and he was discharged back to the father and CSC were informed of this decision and a discharge summary was sent to the GP a week later.

3.34 The baby was readmitted a day after his discharge for continued concerns over vomiting blood and was discharged again two days later. Child H was referred to the Ear Nose and Throat specialist at the regional children's hospital as a result. The paediatric consultant told the CSC assistant team manager that there was no concern at this stage and that there were no signs of non-accidental injury. Child H was discharged back to his father. During his time in hospital, the mother had been told she could visit but that she would need to be accompanied by a social worker. When Child H attended the ENT appointment just over a week later, no abnormalities were found. Child H was seen at the GP surgery at this time for routine immunisations-there was no record of any discussion about the recent hospital admission or which parent was present at the consultation. Information about Child H's attendance at the ENT appointment was not sent to the GP for a further 3 ½ weeks.

3.35 The Core Assessment was completed by early November 2011 which concluded that the father was providing good care of Child H and that should he be returned to the care of the mother, then child protection procedures would immediately be put in place. The assessment also concluded that the father had no offences which would be concerning in relation to caring for a child. The case was closed by CSC although the father wanted support regarding financial assistance and although given advice, was unhappy about the lack of social work support continuing.

3.36 Soon after the case being closed by CSC,the outreach worker from the Children's Centre was told by a colleague who had former contact with the father,to be aware when visiting him alone.

3.37 The father attended the local MIU on the early afternoon in lateNovember 2011with a head injury to Child H which was said to have been caused by the father slipping in the bath with Child H on his chest, and Child H knocking his head on the side of the bath. The father had sought advice from the health visitor before taking the baby to the MIU. Child H was referred to the regional hospital although by 8.10 pm, as he had not arrived, the EDS was contacted who then located the father by phone at 9.45pm, who said he was now on his way to the hospital – he said that he had transport difficulties.

3.38 On arrival at the hospital at 11.50 p.m., it was noted that Child H had bruising around the side of his head and ear. It was noted that the explanation for the history was not consistent in some of the detail about what actually happened in the bath to cause the injury. Also, because of the unusual shape and location of the bruise, as well as the delayed presentation, the consultant community paediatrician completed a child protection medical report and in a discussion on the ward on the following day with the EDS social worker,it was

[3] Non Accidental Injury

agreed for them to discuss with the Police for further investigation. The social worker then discussed the situation with the Police and it was then agreed via a Strategy Discussion over the telephone, that Child H would be discharged back to the father but on the expectation that he would be going to his relative's home. According to the Police records of this discussion, the paediatrician was said to have remained a little concerned in that the unusual shape of the bruise did not quite fit with the explanation, but did not however consider that the Police should be interviewing the father about this incident.Subsequently the Police decision two days after the bruising had initially been reported was that there was no further action for them as the injury was "as a result of an accident".

3.39 The health visitor again spoke with the father over the phone two days later and he explained how Child H had recently been kept in overnight following the head injury. The health visitor arranged to visit in a month's time.

3.40 At this time the health visitor provided information to the council housing service via letter confirming that the father was the main carer for Child H due to safeguarding concerns regarding the child's mother, and that the father was applying for Residence Order and had full support from CSC. The information included that currently the father was living in a shared flat which was overcrowded.On the same day, the housing officer spoke with the CSC duty officer who confirmed that Child H resided permanently with the father.

3.41 The health visitor told the social worker that she was clear that she did not have any concerns about the father's parenting and thought he acted appropriately over the recent incident (bruise to the head/ear) and had contacted her at the time.

3.42 Following the recent hospital admission,a pre-arranged welfare visit was made to the relative's address by a social worker (not the same social worker who had completed the recent Core Assessment). The father was not present at the meeting and did not arrive as planned during the 45 minutes that the social worker was there. Child H was also not present in the home. The relative reported that the mother's attitude had changed and that contact was now going well. Feeding of the baby was discussed, with the agreement for the social worker to contact the health visitor about this, which happened the next day. Following this contact, the case was closed by CSC.

3.43 On the same day, the GP received detailed information in a report from the paediatrician about Child H's recent hospital admission and of the concerns about the bruising. On the same day Child H was seen in the surgery for routine immunisations – this was two hours after the paediatric report had been received. It was not recorded that there was any discussion about the recent injury to Child H and again it was not recorded which parent attended with the child. (It was presumed to be the father as this was the GP surgery that he and Child H were registered with).

3.44 As part of the process of planning a joint home visit between the health visitor and the Children's Centre outreach worker, the outreach worker told how she had recently been told not to visit the father alone due to concerns that he had a violent history,and was known for his drug use. The health visitor advised the outreach worker to contact CSC with this information.

3.45 When the outreach worker contacted CSC in mid-December 2011,she was told that the case had been closed and that this information would not be taken "due to data protection". This was apparently due to the information being viewed by the social worker as hearsay. This decision was challenged by the outreach worker and later by her manager although this did not change the outcome. CSC did not have a record of this conversation. The outreach worker informed the health visitor of the contact with CSC and that they were aware of the father's history but that the case was closed. The health visitor had not been previously informed of the case closure.

3.46 Child H did not attend for his outpatient appointment at the hospital the next day - a letter was sent as notification of the non-attendance to CSC and to the (previous) health visitor.

3.47 Three days later, the health visitor and Children's Centre outreach worker undertook a joint home visit and saw the father and Child H. The baby was asleep on his front and the fatherwas reminded that he had previously been told that this was inappropriate. Re the recent missed hospital appointment, the father claimed that he had been given incorrect information about this. He said that he enjoyed being a dad and that he continued to be supported by his extended family. Child H was recorded as being sick and appeared to have a rattley cough, finding it difficult to breathe. The father was advised to call the GP and make an appointment and told that both workers were worried about Child H. It was decided that the outreach worker would speak with CSC, with Housing and with the Benefits section, as the father claimed that he had no money. There was also a plan to complete a CAF at the next contact which was to be at the Children's Centre. The father did not later attend the surgery with Child H as advised.

3.48 On the same day, the outreach worker spoke with the community police officer to request a check be undertaken in respect of the father as she was concerned that he may have an offending history and that he would gain a Residence Orderin respect of Child H.

3.49 Just prior to Christmas 2011, the mother took Child H to the MIU as she was concerned about bruising on him when she was having contact. On initial examination, it was noted that Child H had various bruising his head and body. At some stage the father joined the mother when Child H was being examined. Following admission to the ward at the hospital, because of his medical condition he was then transferred to the regional children's hospital and admitted into intensive care.

3.50 The matter was referred to CSC and the Police on the same day as the admission because of the severity of the injuries and because they were thought likely to be the result of abuse. Arrangements were put in place for neither parent to have contact with Child H on the ward unless supervised by CSC – they were both told of the concerns about the cause of the injuries. A Strategy Discussion was also held on the next day.

3.51 The child protection medical report described a severe traumatic injury to one part of Child H's body and that other injuries, including a number of fractures, reflected that Child H had been subject to an escalating pattern of non-accidental injury. Both parents were arrested and both denied harming Child H. They were released on bail with the condition of no contact with Child H unless directed by CSC. Arrangements were made for the mother to

sign an agreement for Child H to be retained in the care of the local authority (Section 20, Children Act 1989)

3.52 Child H underwent a full skeletal x-ray and MRI which identified a range or injuries and fractures, all thought to be the result of abusive care. It was estimated that all the injuries would have occurred over the preceding 10 days. A further Strategy meeting was held at the Bristol Hospital at the end of December 2011.

3.53 Child H was subsequently discharged from the hospital and was placed in foster care. Three months later, Child H was made subject to an Interim Care Order.

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4. The Child's Lived Experience

4.1 It was apparent that Child H had a difficult and traumatic first five months of his life which began with his premature birth and initial stay in the intensive care unit at the hospital. From the age of one month, attendances at hospital became a regular feature for Child H in that he was admitted overnight in hospitals on a further six occasions before his final admission with the serious injuries.

4.2 Despite the good work undertaken by hospital staff, hospital admissions would inevitably have generated some levels of insecurity for Child H. This needed to be linked with the insecurity of his home life reflected by the apparent chaotic lifestyle of his parents. It was significant to note that overall Child H was seen by 27 different doctors and 12 paediatricians.

4.3 Child H had numerous "homes" in his first five months with either his mother or his father as his main carer, and at times with babysitters overnight or in the care of two particular relatives. In this way there was less opportunity for one consistent carer to develop a close attachment to Child H and for them to get to understand his developing needs and personality, or for Child H to feel security in any consistency of emotional and practical care.

4.4 Furthermore, Child H was often unwell, and needed to be checked on one occasion by the GP after having been sleeping next to a room that caught on fire. It was also apparent that his feeding at times was inconsistent with a particular occasion when the father called the ambulance because of the amount of distress that Child H was suffering – the fact that the reasons for his distress was because he was hungry was initial evidence of some of the inattentive care he experienced.

Analysis

NB: Whilst it was clear from the medical assessment of Child H's injuries, that these could not have been accidentally caused, the following analysis of professional interventions with the family does not imply that one or other parent, or any other person, was responsible for causing the injuries to their child.

5. The extent of background information known to agencies about the young parents and whether this should have indicated that they would likely require additional support in caring for their first baby.

5.1 For the link to be made about whether the background information about the parents was indicative of whether they were likely to require additional support to care for their first baby, firstly such knowledge needed to be available or sought by relevant practitioners, and then for use to be made of any such information in making a judgement about future parenting.

5.2 The background information in respect of the father should have raised serious questions about his ability to care for a baby without some form of support or guidance. This would have been especially important as he became the main carer for Child H for much of the five months before he was seriously injured. It was not apparent that the father had any previous experience of caring for a child before he became the main carer for Child H, or that he had previously experienced any parenting modelling behaviours.

5.3 The agencies which knew much of the background information were Wiltshire Schools and Learning via his education records, his GP, and then the Youth Offending Service and Probation regarding their involvement with the father in relation to his offences for assault. However, none of these agencies were involved at a time when he and the mother were expecting their child or at any time following Child H's birth, so were not in a position to make any links with future parenting. In fact Probation identified the father as "medium risk" of harm to members of the public and as a "low risk" to children. The latter reflected that at that time the father had no contact with children and that he was not likely to do so in the immediate future. In fact his period of supervision by Probation ended almost a year before Child H was born. The GP surgery was however the only professional service which knew the background and was providing services to the father during the period of the mother's pregnancy and then following Child H's birth.

5.4 When the mother booked for her antenatal care, the father was identified and basic information of name and address was sought and obtained, but no information was sought about his background or about the strength of their relationship or how long they had been together. Because of the amount of information that needs to be collected by the midwife at this time, there may not have been time to approach this area of questioning about social history. Whilst information in respect of domestic abuse was given to the mother, it was not apparent that questions were asked about this as required by local procedures in respect of unborn babies. The mother may have talked of her partner's background if asked about domestic abuse and it was apparent that she knew some information about his history as she had mentioned to the social worker at the time of the Initial Assessment regarding her homelessness that he had been in prison and had used drugs. In fact in her contribution to this SCR, the mother said that she did not know of any of the father's criminal history of violence at that time, but just that he had previously used drugs.The ante natal process did not unfortunately elicit any information from the mother about her partner. She had however attended a domestic abuse workshop whilst resident in the mother and baby unit. Staff at the mother and baby unit considered that the mother"had a clear understanding

about domestic abuse and what was acceptable and what was not." Staff also reported that the father was caring and supportive and that there was no conflict in the parental relationship in this early stage.

5.5 The fact that the father presented as attentive and supportive throughout much of the pregnancy meant that concerns were not identified, although he was aggressive and rude to ward staff when frustrated at a delay in discharging the baby home following the birth. However, this would not necessarily have been enough to trigger further enquiries about his background. It was apparent that questions were asked about the father's alcohol and drug use but no concerns were raised by the information he or the mother gave in response.

5.6 Therefore the father became a parent without any involved professional during the ante natal stage knowing of his offences for violence and for a background of some substance misuse. Potentially more robust questioning and probing by maternity services professionals and by the health visitor could have highlighted some of this background, but his overall presentation during this time suggested that he would be a reasonably competent and caring father.He was also described as "charming" by staff at the mother and baby unit.

5.7 Nevertheless when the father registered Child H with his GP soon after he became his main carer, then here was an opportunity to make the link with his background and the impact this could potentially have on his parenting ability. The GP Practice however did not make the links and it was not apparent that the information in the father's records of his violent background were accessed and reviewed when he presented as a carer of a young child on his own. The father had himself told the GP that there was CSC involvement and yet this still did apparently prompt a review of his records or if this was done, then it would have been concerning that no link was made about his background and his likely need for support as a lone parent.

5.8 Of course the Police had access to the father's offending history, but they did not become involved with the family until just two days after Child H was first discharged from hospital, when there was the incident of the father allegedly taking the baby from the mother's care without her knowledge. The Police accessed the father's history from the Police database whilst they tried to locate him and once Child H had been found, a referral was made to the Child Protection Referral Unit which was then shared with CSC. It was not apparent however that all the background information was in fact shared along with the referral to CSC, with reference only being made at this time to potential drug use by the father. As part of CSC's involvement at this time, the concerns about drug use did not seem to raise concerns about his parenting abilities, in that no questions were asked of him about this.It was apparent that the EDS saw their role at this time as simply ensuring that the crisis was over, and they were reassured that the baby had been returned to his mother's care, and on enquiry, her abilities were described as "brilliant" by the mother and baby unit staff.

5.9 It was two weeks later when a further referral was received following Child H having admissions to hospital and concerns about the chaotic relationship of the parents. On this occasion the Police shared the convictions regarding violence and some intelligence in respect of the father. This new information to CSC should have led to more detailed enquiries about his background, as it was very relevant to his continued and future parenting

ability, particularly in the circumstances of the couple's chaotic lifestyles at that time, and that Child H was only one month old and therefore extremely vulnerable. The opportunity to uncover and consider the background in more detail lay in the completion of the Initial Assessment and Core Assessment which was to follow. This is dealt with later.

5.10 Little was known of the mother's family history by professionals although there was nothing specific in her background to raise concerns about her future parenting. However, the lack of parental support to the mother and the fact that the mother was a teenagerat the time of her pregnancy, were nevertheless risk factors in themselves which warranted further exploration which should have alerted the midwife to be more enquiring. Generally however, the mother presented fairly positively in the ante natal stage and appropriately attended appointments. The midwife expected that there would be a CAF undertaken as this was viewed locally as good practice in respect of a teenage pregnancy, and that ultimately this would raise important information about relevant background information. However, the midwife missed an opportunity on this early occasion to fully explore the mother's background and to begin to make some assessment of her future parenting skills. Unfortunately, for a range of reasons, a CAF was not eventually completed and so no understanding of the mother's social history was gained at any sufficient level to help assess her future needs as a potentially vulnerable teenage mother.

6. The appropriateness of ante natal and post natal care – was it sufficient to meet the needs of the parents and their new baby, were any risk factors noted?

6.1 The first supportive initiative for the mother as a pregnant teenager was for her homeless status to be addressed, and the housing advisor, in line with the protocol at that time, arranged a joint CSC assessment of the mother's needs. Supported lodging (the mother and baby unit) was then appropriately found for the mother. Whether the Initial Assessment by CSC at this time should have broadened its areas of assessment, was a separate issue, and there were clearly some communication difficulties between the Housing Options service and CSC in terms of who was taking the lead in the work with the mother and then in relation to links with the mother and baby unit. Nevertheless, in terms of the overall outcome for the mother, this seemed an effective set of interventions to resolve the accommodation problems within a reasonable period of time.

6.2 Therefore, for much of the ante natal period, the mother was resident in the mother and baby unit and this meant that resources for personal support were available. In fact a support plan was completed when she entered the project which included attendance at workshops as well as one to one support and some group activities with the other young mothers/mothers to be. It appeared as though the mother did not make use of all of the opportunities, but those that were mainly provided were in respect of her life skills and Benefits. This was primarily because she entered the project very early in her pregnancy. Overall however, the mother did not consistently engage with the project, not attending activities if she did not have to.

6.3 The mother came under the care of the teenage pregnancy team although at the time of her booking and subsequent delivery, a teenage pregnancy policy was being developed, and was eventually completed in September 2011, shortly after Child H's birth. The new policy

would have generated the expectation for longer booking-in and subsequent appointments, and so in this way the mother did not receive the enhanced midwifery response which was deemed appropriate soon after.

6.4 However, the mother's teenage status meant that her circumstances were formally reported to the specialist support midwife; vulnerable groups/safeguarding (SSMVGS) and it was identified that the local Children's Centre would be informed and that a CAF would be later completed. Additionally, information about the pregnancy was sent to the GP and to the health visitor, and the Connexions service also became aware. In this way therefore it appeared as though a reasonable package of support was to be available to the mother as a potentially vulnerable young mother to be.

6.5 Interim arrangements were in place prior to the Teenage Pregnancy Policy coming into use which meant that a Pre CAF was completed and sent to the young parent's project worker and also communicated to the Connexions worker. The purpose of a Pre CAF is to help practitioners to decide whether a full needs assessment via the CAF is needed, although in these circumstances it was being shared with other professionals, which according to the relevant IMR was to "ensure that a CAF started". In fact it appeared as though a form with just the name and address was sent, presumably as a marker to start the process. There was an opportunity here for a Team Around the Child approach to be taken as early as February 2011 when the Pre CAF was initially shared among the professionals.

6.6 These arrangements appeared overly complicated, and in fact did not lead to the completion of a CAF. There appeared to be an expectation locally that a full CAF would be completed for a pregnant teenager, although it was not a procedural requirement. In fact from the booking-in appointment, there appeared to be some reliance on the later completion of a CAF as a way of collecting and checking out background information, rather than undertaking all this at the booking-in appointment. It was appropriate that referrals were made to CSC for help for the mother in respect of her accommodation needs but it was because of CSC's involvement that at the 22 week ante natal appointment, the midwife noted that a CAF was not needed because CSC were now involved. Conversely, the health visitor recorded that a CAF was not needed because of the mother's age – clearly in her eyes the CAF related to the mother rather than the unborn child. If there had been sufficient concerns about the unborn child, then there was the potential to request a pre-birth risk assessment, although it was apparent that the health practitioners and the mother and baby unit did not consider that the threshold had been reached for such a request. A CAF, even undertaken in respect of the mother as a young person could still have addressed the support needs required for both her and Child Has a new baby.

6.7 The assumption by the midwife about CSC's continued involvement and therefore no need for a CAFwas inappropriate and should have been checked out by the midwife contacting the social worker directly. In fact CSC involvement had been solely focussed on the accommodation problems and once solved, closed the case. It was shortly before the decision not to proceed with a CAF, that CSC had ceased their involvement. This was poor and ineffective inter agency working and therefore an opportunity was lost to have had greater exploration of the mother's needs as a young person in her own right as well as in

respect of her unborn child. Whilst this might have been accomplished via a CAF, the Initial Assessment by CSC in February 2011 did not include any analysis of any need for future parenting support although it recommended further contact with the Children's Centre and the midwife. The assessment did however refer to the child's father in that the mother said he had been in prison and had used drugs, but there was no follow up on this information in terms of what it might mean regarding future care of the baby.

6.8 The current policy for teenage pregnancies[4] identifies the "completion of a CAF to identify fully the needs of the young parent", but lists this as a "Best Practice Point" rather than a formal requirement. It would therefore still be conceivable that a midwife or health visitor can decide against a CAF if it is believed that an assessment of higher threshold is being undertaken or that there is CSC involvement. The key issue here is that confirmation of other interventions should be sought and recorded before any such decision is made. The IMR in respect of midwifery services is however confident that a CAF would be completed regardless of CSC involvement and that the process is now consistently embedded in practice by midwives. The Children's Centre recognised the confusion over the use of the CAF in this case but additionally commented that the CAF pathway process is still not being followed, with referrals being received in various formats frommidwives.

6.9 In other respects, the ante natal care given by practitioners was appropriate and the mother attended the majority of her appointments, often with the father present. Generally no concerns emerged about her commitment to the baby and regarding her parenting abilities.In her contribution to this SCR, the mother spoke of how she was very confident at that time, and felt supported by the mother and baby unit staff, and how she had expressed this to the midwife.

6.10 The mother had delivered her baby early which added an additional risk factor to the circumstances and subsequently the mother received a high level of initial post natal support. This linked with Child H being detained in the NICU and the mother being seen by the midwife in the Day Assessment Unit (DAU) on five occasions, although none of these were when the mother had care of the baby. The midwife then did a home visit at 13 days post natal, following discharge from hospital the day before. The NICU outreach team also provided a service following discharge as per a protocol for the early discharge of low birth weight infants and this meant that Child H and the mother were seen on three occasions at the mother and baby unit.

6.11 In effect, for the first month following Child H's birth, post natal support to the family was quite extensive, firstly from within the NICU which provided high quality medical and nursing care, but then, following discharge, from the NICU outreach service, the midwife, the Children's Centre outreach worker, the staff from the mother and baby unit and the health visitor. Communication between the relevant professionals was therefore important in order to coordinate the different services which were available, but also to share information about the limited background information known about the family. However whilst there was evidence of information sharing, there was much less evidence of

[4] Teenage Pregnancy Policy – Great Western Hospitals NHS Foundation Trust and Wiltshire Community Health Services, Maternity Services – Approved 9.9.11.

anycoordination of services – the lack of a CAF had undoubtedly made this process more difficult.

6.12 It was not apparent that information was shared by the midwifery service to the NICU, who were not aware that the mother was residing in a supported housing project. Additionally NICU staff did raise any concern about Child H's presentation as "jittery" in the post natal period. Whilst this could have potentially reflected that Child H was experiencing withdrawal from medication/drugs taken by the mother, the concern should have been shared with relevant professionals and made known to the mother. The lack of information from midwifery services did not help the NICU to decide how to deal with this issue, although contact could have been made with the midwife to ask if there had been concerns about such matters in the ante natal period. It was unclear from the midwifery notes whether the aspects of baby-care training were to be covered by the NICU, although this was the expectation. In fact NICU did undertake this role, and noted that both parents cooperated with this. However this should have been formally checked out to avoid any false assumptions being made.

6.13 One of the important aspects of post natal care is the effectiveness of the liaison between the midwife and the health visitor to ensure an efficient handover. On this occasion the baby was discharged into the care of the health visitor following the final visit by the midwife on the day after hospital discharge. This was done via letter to the GP and health visitor but there was no verbal handover and no understanding by the midwife of what the visiting patterns of the health visitor and the NICU outreach staff would be. The Teenage Pregnancy Policy which was not approved until after Child H's birth, identifies the need for the midwife to have "verbal and written liaison with the health visitor" and so this was presumably seen as good practice even before the policy was developed. A discharge planning meeting would have been helpful in these circumstances in order to identify and share any possible risk factors, but primarily to coordinate the post natal support to the family and to be clear, with the mother in supported housing, how the father was to be involved in the care of the baby. However it is not apparent that there is any particular criteria for arranging a discharge planning meeting – perhaps the need to always give this active consideration should be contained within the Teenage Pregnancy Policy. The Policy currently refers to the importance of multi-agency involvement and the need to ensure that all health professionals are updated regarding safeguarding, but makes no comment about the value of discharge planning meetings.

6.14 It is important to note that during the ante natal and early post natal stages that the father was well engaged in the processes. The lack of involvement of fathers has been identified as a failing in many Serious Case Reviews nationally, but in this case there was good evidence of his involvement. To some extent this was due to the father's keenness to be involved, but he was clearly included in advice and support given to the mother. However, information regarding his involvement and contribution to sessions with the midwife was not always recorded, which then detracted from what could be learned about his parenting abilities and the part he would play in the direct care of the baby. Although the health visitor recorded a tense atmosphere at her birth visit to both parents, she should have

explored this with them, a longside discussion about the alleged incident at the party when the father took the baby off for the night, which had taken place the previous day.

7. <u>Assessment Activity:</u>- What were the key relevant points/opportunities for assessing risk and decision making in this case? Do assessments appear to have been reached in a timely fashion and did actions accord with the assessments and decisions made?In particular what was the response to Child H's hospital admissions in October and the injuries in November 2011?

7.1 Apart from the ante natal stages when opportunities were missed to undertake detailed assessments of parental social history and any impact on parenting, once Child H was born the first opportunity to assess any level of risk within this young family occurred less than a week after Child H had been discharged from hospital following his birth. This was the occasion when the father took Child H away from the party that the mother was attending and the Police were called to locate him. Generally this incident was handled well by the Police, and CSC were informed but did not consider that their direct involvement was needed and were reassured by the mother and baby unit's positive view of the mother as a new parent. However new information about possible alcohol misuse by the mother, as well as tension between the couple, suggested that the situation had changed since the mother first entered the mother and baby unit, and so this was an opportunity for the mother and baby unit to undertake a fresh assessment and if necessary to have created a new management plan.

7.2 Overall there appeared to be a settled outcome from this incident and it was not apparent that much more needed to be done at that time by either the Police or CSC. The NICU outreach workers were informed and the support staff in the mother and baby unit were also aware. The health visitor was also informed, so in this way all the key professionals involved with Child H were made aware. However the health visitor's visit to the couple the next day was a missed opportunity to explore the tensions in the relationship and of any possible impact on the baby's care. Interestingly, as further incidents of concern developed, this incident was generally looked back on as some evidence of the mother's poor parenting and alcohol misuse rather than a potentially irresponsible act by the father in taking a small premature baby, only a few days since hospital discharge, away from his mother. In her contribution to this SCR the mother claimed that there was no danger to her baby in her presence at the party on this occasion. Clearly both parents have given different versions of the same incident, which in summary probably reflected a certain level of inappropriate behaviour on both their parts. Had the health visitor discussed the incident with the parents at her visit, a greater understanding of the incident may have emerged.

7.3 In essence all of the hospital admissionswhich Child H had were, to varying degrees, key opportunities for assessment and decision making. In all there were seven hospital admissions, although two of these related to quick readmissions for similar reasons. In summary these were:

Approx Age of child	Duration	Details
1 month	Overnight	Child H crying and inconsolable – had vomited
1 month	Overnight	Hospital asked the father to return Child H – had

		become aware of previous abduction incident
2 months	Overnight	Breathing difficulties
3 months	Overnight	Concerns about vomiting blood
3 months	2 nights	Continued concerns about cause of vomiting blood
4 months	Overnight	Bruising to the head and to the ear
5 months	10 days	Extensive injuries – considered non accidental

7.4 It was the early hospital admissions which led to referrals being made to the Police and CSC from the paediatrician regarding the conflict between the parents and of their apparent chaotic lifestyle. When linked with the previous incidentof the father taking the baby at the party, and the descriptions by him of the mother's neglectful care, a worrying picture was emerging, and so this was an appropriately made referral.

Core Assessment

7.5 Following the Strategy Discussion, the decision for CSC to undertake an Initial Assessment and then a Core Assessment was a sound one. It was clear that full information was needed about the parental backgrounds, though more particularly about their relationship and their respective parenting strengths and weaknesses and from this of any potential risks to Child H.

7.6 Unfortunately the Core Assessment was of very poor quality in terms of its collation of information and its analysis, though it gave a very positive view of the father as a "capable and competent father" and that "since he has been in his father's care, all Child H's needs have been met appropriately, adequately and consistently". Soon after the assessment began, it was considered that Child H's needs were being more appropriately met by the father being his main carer, rather than by the mother. The positive views of the father were balanced by a view of inadequate care and attitude by the mother to the baby to such an extent that it was recommended that child protection procedures be instigated if she again became regularly involved in Child H's care. It was questionable whether there was the evidence for such a strong stance to be taken, but if there were these levels of concern then there was enough to warrant an Initial Child Protection Conference to be called. There was however no reference to any discussion about the need to consider this.

7.7 Of significant importance was the information gained from the Police of the father's offending history, although it was not clear if all the specific details of this were given. Nevertheless, it was clear that the father had a history of some violent offences although it was not apparent that these were discussed with the father and there was no evidence that information was sought from the Youth Offending Service or Probation, whereas, based on the information from the Police, the social worker should have realised that they were very likely to have been involved. These agencies had information about the father's challenges in trying to control his anger, and the level of violence from the father's offences was of a very concerning level. Understanding the possible impact on parenting of this background should have been a key component of the assessment and yet the recorded analysis was that "no offences would be concerning in relation to caring for a child". Such a sweeping statement could not realistically be made in respect of either the violent offences or the

drug offence. This was an unacceptable finding in these circumstances – as a minimum the detail of the offences should have been recorded, and without these the assessment gave an overall false positive picture of the father's background and of his parenting ability. Additionally the language used by the social worker in the assessment was misleading, as the statements which were made gave the impression that greater detailed information was gained by the social worker in order to make such a positive analysis of the father.

7.8 The CSC IMR gives a detailed analysis of the poor quality of this Core Assessment– in effect it did not meet basic professional standards. The Core Assessment should have been completed by mid-October although it was not finalised for a further three weeks. However for the period of time that the assessment was being conducted, a number of incidents occurred which gave additional material that should have been used to inform the assessment. For example, there were occasions when incidents occurred which showed that the father sometimes could not provide basic care such as feeding – in fact the paramedics described him as "clueless" in this regard on one occasion. The father had also proved elusive at times of requests for hospital admissions for Child H and it was not clear where he was actually living with Child H, who he was living with, and the amount of support he was in fact receiving from any of his relatives.

7.9 Professionals other than the social worker had spoken of the father having commitment to the baby and of demonstrating good parenting abilities and there were clearly examples of this when seen by practitioners. It was apparent that not only was the father able to demonstrate his own child care abilities, he was also clear in his negative view of the mother as a parent. Whilst the mother's behaviour and commitment to her baby was concerning at this time, it was difficult to understand how she could be seen so positively in the ante natal and early post natal stages by health professionals and the Supported Housing staff, and yet within a month, her care was seen as so neglectful as to warrant child protection responses if she resumed care of her baby. It should have been seen as an essential component of the assessment to get as accurate a picture of her situation as possible and of her attitude to parenting, without so much reliance on the father's views of her. In essence the Core Assessment did not include the mother in any meaningful way and was very positive in respect of the father, and negative in respect of the mother, and only evidence and analysis to support these views were promulgated. In her contribution to this SCR, the mother said that she recalled having very little contact with a social worker and that it was the father who told her that his care of the baby was being supported by CSC.

7.10 For the Police and CSC to agree at this time to support a plan for the father to be the main carer for Child H was premature in that there was still much un-assessed information before such a confident position could be taken. The father then went on to use this "support" to confirm to other professionals that he was now the main carer and that he had somehow been approved by CSC, and for example sought housing for him and Child H based on this situation.

7.11 Although CSC stipulated the need for supervised contact for the mother with the baby, it was not managed in any formal way and apparently left to the father and one of his extended family (who was supposed to provide the supervision) to manage this. Certainly

the mother in her contribution to this SCR said that she was not formally told by CSC about contact arrangements and that this was left to the father to explain this. The fact that she had contact of just one hour a week was not in itself a child focussed approach to the situation and was effectively compromising any attachment development between the mother and her son. Although this contact was eventually extended to a two-hour session a week, in agreement with the father and his aunt, who by now was saying that the mother was managing the baby well, this was still a very small amount of contact and something that professionals should have helped to resolve.

Hospital Admission re breathing difficulty

7.12 The cause of the breathing difficulty for which Child H was briefly admitted at age 2 months, was not found, although the father had mentioned that Child H's breathing was not right following the recent fire in one of the bedrooms at the mother and baby unit. This admission followed increased concerns being presented by the father about the mother's care of the baby and of her drinking and socialising behaviours. He had expressed concerns about Child H's condition and care when handed over to him for contact, and then on this occasion took him to the local out of hours service.

7.13 By this time a further Strategy Discussion had been initiated by the Police following the involvement of paramedics recently, though with the information about the latest concerns about the mother's care, this was felt sufficient to support the father retaining the care of Child H. Nonetheless, the Police record of this discussion was that CSC would set up an Initial Child Protection Conference (ICPC), although there was no corresponding record of this decision in the CSC files, and in fact no ICPC was set up. This was significant conflicting information about an important decision.

Hospital Admissions - October 2011

7.14 These admissions related to the occasions of Child H bleeding from the mouth and the inability to identify the cause. Whilst the hospital records show that there were some concerns about the potential of NAI as a cause, this view tended to recede, but it was nevertheless appropriate that information in respect of the admission was relayed to CSC. There was some confusion however, in that whilst the first contact from the paediatrician expressed some concerns about the bleeding, a second call just 12 minutes later to seek clarification from the paediatrician emphasised to the social worker that this was not a child protection matter and was being dealt with by an ENT referral. It appeared as though the communication from the hospital was for information sharing purposes rather than a referral to CSC, who did not take any action as a result. The eventual letter to ENT did say that a Strategy Discussion had been held in respect of the incident but did not explicitly say that there had been any child protection concerns. In fact there had not been a Strategy Discussion although the local hospital had initially shared information about the bleeding which in reality could not have been described as a formal discussion in this way. This was one of the examples of confusion among agencies about what constituted a Strategy Discussion. CSC took no further action in respect of this incident and in this way appeared to have deferred to the medical view as being the determinant that there were insufficient reasons to be concerned about the care of the baby.

7.15 Although the GP saw Child H a few days after receiving the discharge summary from the Hospital, for routine immunisations, this once again appeared to the GP as insufficient reason to review the father's records and consider the potential importance of his history now that some initial concerns were being raised about his childcare abilities. This was evidence of the GP surgery receiving information without any apparent analysis of it or of using it to inform how to respond to Child H and the father in the most effective way. This was also a missed opportunity to check with CSC about their role with Child H and to ensure that they were aware of the father's background.

7.16 At Child H's attendance at ENT just over a week later, no concerns were noted. The referral letter to the ENT Dept. did give helpful background social information and whilst it did not specify if NAI had specifically been considered as a differential diagnosis, the letter did imply this by saying that no bruises had been found and that the frenulum was intact. There was a significant delay in the sharing of the outcome of this appointment with the referring doctor, as the letter giving this information was dated three weeks after the appointment. No concerns about a delay were however raised within the referring hospital's IMR.

7.17 Whilst these hospital admissions did not eventually generate child protection concerns, actions could have been taken for the health visitor to be alerted, either by the hospital or CSC, and for her to make contact with the father and Child H in order to ensure that he was managing the baby satisfactorily at this time. In fact the discharge reports were sent to the health visitor who received them within a few days. The respective IMR does not comment on whether it would have been appropriate practice for an immediate follow up visit to have been made by the health visitor, although in the circumstances this would have been a reassuring action to take. The health visitor did undertake a "routine visit" three days after the ENT appointment, and although an important link could have been made with the hospital admissions, the opportunity was not used and there was no record that the "bleeding" incidents were discussed.

<u>Hospital Admission – November 2011</u>

7.18 This admission related to the head injury, said to have been caused while the father was in the bath with the baby. Not only were there concerns about the injury itself, but there was significant difficulty in locating the fatherin order to get him to take Child H to the hospital for a detailed examination. As the initial examination by the MIU recorded that there was a suspicion of a skull fracture, it is difficult to understand why the initiative was left with the father, who had no access to transportation, to take Child H to the regional hospital some miles away. In effect approximately 10 hours elapsed before the father arrived with the baby at the hospital after he had been located by EDS and told to attend.

7.19 In the hospital there was noted to be an inconsistency in the account given about how the bruising to the head and ear occurred. However, the inconsistencies in the explanations were not significantly different, but nevertheless appropriately raised concerns. Whilst no skull fracture was identified, a referral was therefore made to the out of hours CSC – (EDS). A Strategy Discussion followed on the next day, as Child H had been detained overnight. However, it was apparent that the Strategy Discussion was in two parts, firstly between the Paediatrician and CSC, and then later between CSC and the Police.

7.20 The paediatrician understood that after the first meeting, that CSC would discuss with the Police, the need for further investigation, potentially a child protection investigation under Sec. 47 of 1989 Children Act. However in the later meeting, an agreement was reached between CSC and the Police that there would be no need for a Police investigation, and their involvement in this incident ceased at this point. The Police recording of the circumstances of this hospital admission made no reference to the possible different accounts for the injury, nor for the delayed presentation at the hospital. This is difficult to understand as these were the two key factors which had raised the child protection concerns. Also the Police made no links in asking what had happened to the ICPC as an outcome as they understood it from a previous Strategy Meeting.

7.21 In agreement with CSC, the hospital then discharged Child H back to his father, but with the proviso that both went to stay with the relative who had previously provided support. The recently completed Core Assessment gave such a positive view of the father, that this no doubt had an influence regarding the confidence of discharging the baby back to his father.

7.22 The father explained that he first sought advice from his health visitor about where to take Child H with the injury. In fact it was because the father had quickly contacted the health visitor which led to some sense of reassurance that the father had acted responsibly at the outset. It was in a telephone conversation with the father a few days later that the health visitor agreed to visit in a month's time – she was now aware of the recent admission and so these circumstances should have led to a home visit being undertaken as soon as was practicable to do so. When the duty social worker contacted the health visitor on the next day their records showed that the health visitor did not have any concerns about the father's parenting and that the differences in explanations for the injury could be accounted for and that she believed his actions in response to the injury had been appropriate. She also confirmed that he had contacted her at the time of the incident

7.23 Once again the GP saw Child H for routine immunisations less than a week after this incident and although the GP surgery had only received detailed information about the hospital admission on the same day as the immunisations were undertaken, this still represented a missed opportunity for the GP to again make the links with what was known about the father's past, or at least to make contact with other agencies to clarify the current view about any risks to Child H. In this way the GP surgery was a passive recipient of information which took no proactive initiatives to consider if there were any risks to Child H or to consult with professional colleagues.

7.24 The outcome from this injury and hospital admission, as decided between the agencies, was for CSC to undertake a "parenting assessment" although what this meant in practice was unclear as it does not have status as a formal assessment. In effect, what transpired was a "welfare visit" by the social worker to see the father, along with the relative with whom he was to be staying with, and Child H. In fact only the relative was present despite this being a pre-arranged visit. This was not a good indicator of the father's commitment to engage with the social worker and to discuss all that had recently happened. As there was no further action from CSC, this was a most ineffective response to the recent concerns, and certainly did not match the agreement to assess the situation and particularly the parenting

of the father. The health visitor was advised by the social worker that the assessment had not been undertaken, but between them did not agree any possible further response or completion of the work.

Strategy Meetings/Discussions

7.25 The purpose of a Strategy Discussion is to share available information and primarily to agree the conduct and timing of any criminal investigation as well as deciding whether a Section 47 child protection investigation is needed and if so, plan how this should be undertaken[5]. However it was not always apparent in the management of the risks as they emerged in this case, that the purpose of the Strategy Meetings/Discussions was clear, what the outcomes were and how actions were to be recorded and monitored.

7.26 Potentially a Strategy Discussion could have been called at the time of the alleged "abduction" of Child H from the party, although the efficient response by the Police probably negated the need for one. The other Strategy Discussions which took place were appropriate and demonstrated a commitment to joint agency information sharing and decision making.

7.27 However, their status was sometimes confused in that the meetings were occasionally also referred to as "discharge planning meetings" or "multi agency meetings", and the representation at such meetings did not always reflect the expected purpose. The confusion about the status of these meetings and the outcomes was compounded by the lack of formal minutes being produced by CSC as the lead agency, which were needed to identify agreed actions.

7.28 This sort of confusion appeared to exist to some extent in the other Strategy Meetings/Discussions, for example in November 2011 when two separate meetings were held, and in the latter meeting it was concerning that the Police did not seem to be made aware of the reasons for the child protection concerns.

7.29 With the lack of recorded decisions or actions and who was responsible for them from the meetings, then it was difficult for professionals to monitor what had been achieved or if appropriate actions had been taken. For example, the quality of the Core Assessment did not reflect the concerns from the earlier Strategy Meeting, there was no ICPC as expected by the Police after the September meeting, and the "parenting assessment" did not take place as agreed following the November meeting. It was also concerning that the Strategy Discussions tended to focus on the particular presenting incident rather than taking a more holistic perspective and considering past concerns and historical information. The final Strategy Discussions were however effective in achieving appropriate outcomes.

7.30 By the time that the decision had been made at the end of December 2011 to transfer Child H to the regional children's hospital, discussions between CSC, the hospital and the Police had identified the likelihood of NAI as a cause of these significant injuries, and yet the father was allowed to accompany Child H in the ambulance. Whilst the father would not have been

[5] Paragraph 5.57, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

on his own with Child H in the ambulance, it was a contradiction to identify possible NAI concerns and allow one of his parents to accompany Child H so soon after the injury had been discovered.

8. <u>The Understanding of Thresholds</u>:- Was the case consistent with agency, LSCB and South West CP Procedures and wider professional standards? Did agencies have relevant Policies and Procedures in place and were practitioners knowledgeable about potential indicators of abuse or neglect?

8.1 All IMRs referred to appropriate internal safeguarding policies and procedures being in place to support the work of their staff, and that overall their safeguarding training needs were met. Whilst there was a housing protocol for teenagers jointly created with CSC, the IMR for Housing Options considered that this needs reviewing and updating. Additionally, IMRs generally were confident that the staff involved in working with the family were knowledgeable about potential indicators of abuse and neglect. Nevertheless there were errors of judgement by some practitioners in this case, and so this reflects not only the importance of update training but also the pivotal role played by supervisors and line managers in helping staff to retain an enquiring and objective mind set when working with families, particularly those who for much of the time appear to operate just below the threshold for child protection.

8.2 The complicated process about the Pre CAF, and of some mixed understanding about the need to conduct a CAF as best practice in respect of a teenage pregnancy, has already been referred to. It was apparent that the lack of a coherent policy at that time, being substituted with interim arrangements, impacted on this. The CAF could have been completed by the Midwife or the Connexions advisor for the mother, and if a CAF had been completed during the ante natal, and potentially early post natal, stage, then it could have been influential to practitioners in understanding the dynamics and needs of the family, and how to address them.

8.3 Also, from a health visitor perspective, the IMR considered that the case should have met the criteria for the "Universal Partnership Plus" category[6], which would have meant that there would have been greater direct involvement with the family than actually occurred. However these threshold criteria were not established until a few weeks after Child H's birth, and the IMR does not explain if the new thresholds could have immediately been utilised with families. It was however apparent that the circumstances of Child H's care were not taken seriously enough and that the optimistic views about the father's parenting did not seem to lead to a robust assessment of what his support needs would be as a parent.

8.4 For the case to have reached the child protection threshold, then this would have been more achievable if the earlier threshold levels of the CAF, perhaps then moving to a Team Around the Child process, had been activated. Although there were a number of agencies

[6]. The 3 levels of need are Universal, Universal Plus (for children with additional needs that can be met by the HV service) and Universal Partnership Plus (for children with complex needs requiring a multiagency approach).

involved soon after Child H's birth, there was no coordination of this work and no one agency or professional taking a lead. It appeared that once CSC became involved, no matter how fleetingly, that inappropriate assumptions were made that the case was being fully managed by them.

8.5 The latest local Multi Agency Threshold Documentwas produced in September 2011, and this does provide clarity regarding about the role of CAF and the Team Around the Child, and also makes reference to Multi Agency Forums, (MAF) which would have seemed ideally placed to coordinate work and to support decision about appropriate referrals to other agencies if needed. However, there was no reference to the use of this process in any of the IMRs, which may have been because processes such as the MAF were not operational at this time.

8.6 Paediatric staff appropriately made referrals to CSC in a timely fashion on each relevant occasion, and Strategy Discussions/inter-agency meetings were regularly held to consider new concerns, and yet the case did not formally reach the threshold for child protection interventions until the eventual very serious injuries to Child H at the end of 2011. However, based on an accumulation of the concerns, the threshold for an ICPC had been reached some months earlier, evidenced by the incidents of concern that had taken place.

8.7 There appeared to be a number of reasons for the lack of progress to the child protection threshold. Firstly, the positive views that had developed in respect of the father as a parent became a dominant feature among a number of professionals. The findings of the Core Assessment created an over optimistic view of the father and his parenting which permeated other considerations of possible concerns as they arose. Key information, such as the father's offending history, was not shared with practitioners outside of the Police andCSC, which would have created contra indications to the positive views that were being generated of him.

8.8 Additionally, incidents of concern tended to be seen in isolation and the lack of an ICPC meant that a more holistic view was never taken. Until the final admission to hospital, there was never a definitive view taken about whether the earlier hospital admissions and other incidents in relation to Child H, reflected child protection concerns, although on occasions questions were appropriately raised in this regard. Nevertheless the purpose of Sec 47 enquiries is to enquire into concerning circumstances that are not otherwise clear, and the details of this case met these criteria, but on no occasion were child protection enquiries formally taken up. One major reason for this was probably the inefficiency of the Strategy Meetings/Discussions and the lack of follow up on outcomes. To some degree, it appeared that the fact that a Strategy Discussion had been held was in itself reassuring to professionals that the case was being appropriately managed.

9. Sensitivity to the needs of the child

9.1 There was clear evidence of the sensitivity to Child H's medical and emotional needs by the hospital staff during his numerous hospital admissions. This was supported by referrals to appropriate agencies when necessary. Similarly the hospital staff were mindful of the

contact arrangements for parents and extended family and managed them well when there were particular concerns about the cause of Child H's injuries.

9.2 Because Child H was a young baby at this time, then inevitably much of the professional focus was on the parents. However there could have been greater description of Child H in the records or of observations of how he presented. The NICU outreach workers clearly gave attention to Child H and monitored his development, as did the health visitor, recording this accordingly. The staff at the mother and baby unit as well as the Children's Centre worker were alert to Child H's situation and care. The Children's Centre IMR recognised the need for staff observations of the baby to be more consistently recorded in the records of visits. The NICU outreach worker and the health visitor witnessed tense relationships between the parents, with the outreach worker also noticing on one occasion that the mother had a bruised cheek. Neither workers appeared to address this with the parents, nor try to understand what the impact of this tension may have upon Child H. The reasons for not doing so were unclear but it clearly represented a missed opportunity to gain greater insight into their difficulties. To have discussed with the parents how their relationship would affect Child H's emotional security may have helped them to consider how to manage any differences.Information about the injury to the mother should also have been forwarded to CSC although whether it would have elicited any formal response was questionable.

9.3 There were occasions when Child H should have been seen more regularly by professionals, but because the father was quite elusive, and professionals were not persistent enough, this did not always happen. For example, CSC social workers only saw Child H on three occasions and for their final visit, there was a failure to see him despite this being an agreed assessment visit following Child H's hospital admission after sustaining bruising.It was an agreed outcome between the Police, the hospital and CSC of the need for this "parenting assessment" to happen, and yet it was clearly ineffectual to undertake the visit to the relative's house without the child or father present and then not to return to see them as a matter of urgency. Clearly, observation of the child should have been an essential component of such a visit.There was also no evidence that the failure to see Child H was fed back to other agencies apart from the health visitor– overall this was very poor practice. Additionally there seemed to be very few, if any occasions when the father's flat was visited, even though this was where Child H lived for much of the time. Also although the relative was seen as a supportive influence in the care of Child H, this person was not interviewed by a social worker or health visitor in terms of background and suitability.

10. Communication and information sharing among professionals, including those providing out of hours services

10.1 Because the case did not formally reach the child protection threshold and also because the implementation of a CAF was bypassed, with no Team Around the Child process enacted, then in effect there were no professional forums to support efficient communication and the sharing of information. This was a failing of the inter agency practice in this case which no doubt had a significant impact on information sharing. With hindsight, it was apparent that some agencies (as noted in their IMRs) would have wanted more information shared with

them by the statutory agencies, and perhaps to have had invitations to the Strategy Meetings which were held. However, this appears to reflect some of the confusion about the role of such meetings, which had a purpose much more than just information sharing. The absence of other professional meetings to coordinate the community service provision to this family may have led to the inappropriate expectation that the Strategy Meeting format could or should have filled this gap.

10.2 There were certainly occasions when agencies such as Housing Options, the Children's Centre and the mother and baby unit, felt that they should have been provided with more information, particularly by CSC or some of the health practitioners. Because the case, in the eyes of CSC, did not meet the threshold for child protection, then they likely perceived their accountability for information sharing to be less at this lower level. However there were certainly occasions when the lack of a continuous service by CSC was linked to the fact that support services were already being provided, so this did bring with it the responsibility to share proportionate information to enable other agencies to effectively provide their services.

10.3 There were occasions when CSC did not feedback to professionals who had referred incidents to them, and this should have been undertaken as part of safeguarding procedures. Also there was a strong sense among some of the community support agencies that their staff most often had to take the initiative to obtain information which was not readily forthcoming from CSC. As an example within the Housing Options service, they reported difficulties in receiving information and updates from CSC, but also recognised that their organisational structure meant that it was less clear to them who had responsibility for chasing up and challenging any perceived lack of shared information. Furthermore, at the time of the Core Assessment, the social worker did not seek information from the range of agencies who held information about the family currently or in the past. In this way other agencies did not have an opportunity to contribute to the assessment and embark on a process of sharing information. The only recorded communication was when the social worker wrote to the health visitor to request information for the Core Assessment, but there was no written response although there were telephone conversations noted to have taken place in relation to this.

10.4 Despite the lack of professional forums to share information and coordinate services, there was a significant amount of professional communication that nevertheless went on, especially between the Children's Centre, the health visitor and the mother and baby unit, alongside communication with the hospital outreach staff when necessary. For example the IMR in respect of health visiting notes that the liaison between professionals either by letter or telephone was "prolific". Overall this level of communication was commendable and gave evidence of the commitment of practitioners to work as collaboratively as possible. However this could have been achieved much more effectively if formal processes within the framework of Child H as a "child in need" or as a "child in need of protection".

10.5 There was one occasion when the Children's Centre outreach worker was made aware of unconfirmed information that the father may have a violent background, and shared this with the health visitor. This was appropriate as they often undertook joint home visits to

see the father and the baby. When the outreach worker tried to get this information confirmed by CSC, the duty worker refused to do this and said that as the information was hearsay, that they would make no record of the enquiry. As the CSC IMR has found no record of this conversation on their files, then it was apparent that no record was made. As a minimum however this contact should have been recorded, and the response by the social worker was generally very unhelpful and not made in the spirit of effective multi agency working. It could be argued that the Children's Centre needed confirmation of some detail of past offences as they were endeavouring to provide an important service to the father as the sole carer of a baby, and so it would have been relevant to have shared proportionate information in order to support that work.

10.6 This case featured occasions when inappropriate assumptions were made by practitioners about another agency's actions or the delivery of services. The main example of this was when the CAF was not progressed because of the inaccurate assumption about CSC involvement. Additionally there was some misinformation contained in records which again led to assumptions being made about the status of services to the family. For example, the GP records noted incorrectly that the father was "under child protection" and also that "Dad had custody" of Child H. Whilst the GP IMR identified that they were given no explanation by other agencies about the change of "custody" from the mother to the father, in effect it was an important enough issue for the GP surgery to have made enquiries. Whilst the GP surgeries did have some involvement with the parents and some limited contact with Child H, in effect they were quite peripheral to the work that was going on in the community, and although the father's GP surgery was in receipt of information from Child H's hospital admissions, and could have linked this with the information they held about the father, there was no action by way of follow up. There was also no evidence of regular communication taking place between the health visitor and the GP or vice versa. It was concerning that whilst the GP surgery could have played an important role as part of coordinated services to the family, they remained outside any multi agency working. This would clearly be unhelpful for effective safeguarding practice in the future.

10.7 As referred to previously, there were some issues about the perceived inadequacy of information sharing and liaison between the Midwifery Service, the Hospital and also with the health visitor. However, a new "Liaison Pathway"[7] has recently been developed to support and improve liaison between midwives and health visitors, so it should address some of the shortfalls in communication which occurred in this case.

10.8 There was considerable involvement in out of hours services by the Police, CSC (via the EDS) and health services, and generally the communication was effective between the relative agencies and in the process of informing their counterparts who worked in office hours. Inevitably because of the limited staff resources available out of hours, then there were some challenges in terms of inter-agency communication not always being timely or detailed, but generally the overall response to Child H's needs out of office hours, was effectively undertaken.

[7] Midwifery – Health Visitor Liaison Pathway – Wiltshire, Swindon and N. E. Somerset – March 2012

11. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

11.1 There was clearly the potential within this family that the issue of race and ethnicity could have had an impact on the parent'sindividual self-esteem, upon their relationship or upon their parenting capacity. The parents had different cultural and racial backgrounds, and the Core Assessment should have explored issues of cultural identity and its potential impact upon both parentsand their parenting abilities. Similarly, interventions by other professionals should have given attention to these issues

11.2 Overall therefore, the issue of race and identity was given scant regard by agencies working with the family when it had the potential to be a significant issue.

12 The role of management and supervisory practice

12.1 In terms of paediatric involvement and more generally in relation to Child H's hospital attendances, then it was considered by the respective IMRs that there was appropriate management oversight and accountability for decision making. Generally their actions were in line with procedural expectations and they provided a proactive and effective response to Child H's needs.

12.2 It was apparent that for a number of agencies, the fact that Child H's circumstances did not formally reach a child protection threshold, meant that the case was not raised in supervision, and management support was not sought to advise on interventions with the family. However, had there been greater management oversight at the early stages of intervention, this might have ensured the completion of a CAF and of a move to establishing a Team Around the Child process. In fact the issue of inappropriate assumptions again featured in this respect with for example the midwife not mentioning the case to supervisors because there were no adverse concerns and because of the expectation of a CAF being completed by others. Although the complexities of the Pre CAF and CAF processes at the time make it difficult to identify which agency or practitioner needed to progress this work, in effect no such initiatives were instigated, and there should have been some level of management accountability for this failing. At a later date, when concerns began to accumulate, then the health visitor did appropriately seek advice from the safeguarding nurse

12.3 In respect of CSC involvement, senior management were not involved until the serious injuries occurred which led to Child H being hospitalised and then placed in Local Authority care. However there should have been much greater involvement of first line managers than otherwise happened in this case. There was insufficient management oversight which allowed such a poor quality Core Assessment to be completed and which very much set the tone for future involvement, particularly with the father being viewed as such a positive figure. If the social worker had been challenged about some of the findings and asked to provide the evidence for these or for any contra indicators, then the frailty of the analysis would have been exposed. The way in which the Core Assessment was written presented challenges for management oversight for instance when it stated that the father's past

offences were not relevant, without the report giving the detail of what these offences were.

12.4 Similarly, there was insufficient management oversight and accountability for the final contact that was made to the relative's home following a clear action from the November Strategy Meeting, which not only failed to see the child but also failed to see the father. It was very concerning that there was no recording of how a decision was made not to follow up this abortive visit or to reconvene a Strategy Discussion. Overall, the CSC IMR identified that supervision arrangements were "not adequate" due primarily to organisational issues and that the case suffered from the lack of a consistent manager to overview the work being undertaken.

12.5 From a Police perspective, the IMR commented that staff resources did not allow for each Strategy Meeting/Discussion to be quality assured or have management oversight for the decisions reached, but that this was not seen as a deficit and there was consideration that the Police staff involved were nevertheless sufficiently trained to make appropriate decisions or to escalate to more senior management as necessary. Because no Sec 47 investigations were commenced following any of the Strategy Meetings/Discussions then no referrals were passed to the Police Child Abuse Investigation Team so in this way there was no specialist child protection input to the process. However some actions which the Police understood were due to follow Strategy Discussions, such as the ICPC and the "parenting assessment", did not in fact take place. In particular, it appeared as though there was no management oversight which picked up the lack of an ICPC taking place and no enquiry therefore made of CSC in respect of this.

13 Organisational and contextual issues

13.1 The IMR for CSC has identified that the internal organisational changes being made in 2011, in particular with the Referral and Assessment teams being centralised and combined under one manager, had an impact on the quality of service delivery. As part of staff changing their location and preference of which type of service provision that they wanted to work in, the IMR stated that the skills of the staff within these Referral and Assessment teams did not fit well with the requirements and challenges of this area of social work practice.

13.2 Additionally the role of assistant team manager (ATM) in Wiltshire, which in effect is the first line manager role, was compromised in that only two of the five ATM posts were operational during the latter half of 2011, meaning that there was a lack of consistent supervision practice, as well as insufficient capacity to provide the necessary oversight and quality assurance of practice.

13.3 Whilst the Annual Children's Services Assessment by Ofsted in July 2011 identified that children's services "perform well" and that the contact, referral and assessment arrangements were "satisfactory", it did identify areas for development. However the Safeguarding Inspection conducted in early March 2012[8] found that safeguarding practice

[8] Wiltshire Inspection of safeguarding and looked after children - Care Quality Commission/Ofsted – published April 2012

was “inadequate”, and of particular relevance to the practice issues in this case, identified inadequacy “in the level and robustness of managerial oversight and decision-making” and that this lack of challenge led to poor quality core assessments. Whilst this case did not reach the child protection threshold, which was the area of practice that this inspection primarily focussed on, the findings in this case nevertheless support the analysis of poor quality assessments and insufficient management oversight as being key factors in thwarting the child protection threshold being reached.

13.4 As a result of the Inspection findings, an Improvement Plan has been drawn up and at the time of writing, is being established with a range of actions accompanying it. This work will therefore need to be born in mind in the consideration of recommendations from this SCR so as not to create unnecessary duplication. For example, a number of areas of improvement identified by Ofsted as priority actions would reflect similar learning from the professional practice in this case.

13.5 Whilst there were staffing difficulties in both the health visiting and the midwifery service, it was not considered that these impacted on the services given to the mother, the father and Child H. The fact that the NICU and the midwifery services are managed by different health organisations, was nevertheless considered to have created communication difficulties between respective practitioners within this case, and potentially will continue to do so in the future unless it is addressed. A new Health Visiting Strategy was implemented in October 2011, and the IMR author considered that this “may well have impacted on staff and caused some frustration and feelings of disempowerment” at the time.

14 Lessons Learned and areas for development

The IMRs have separately identified some important lessons and areas for development, although some of the key lessons learned when considering the analysis of individual and inter agency practice in this case can be summarised as: -

14.1 It is potentially dangerous practice for professionals to make assumptions about the actions or decisions of other agencies or other practitioners, without checking out the accuracy of that assumption with the other agency involved.

14.2 To take an optimistic stance in respect of parenting by a professional, and to not support this with objective evidence, or to not identify contra indicators, will inevitably compromise the assessment, and potentially retain a child in an at-risk situation.

14.3 Being sensitive to a baby’s needs should be reflected by practitioners seeing the infant as often as possible and recording and commenting on their presentation, behaviours and relationships and responses with carers. To not do so will mean that interventions are not child focussed and will leave practitioners unable to have any understanding of the child’s lived experience.

14.4 Organisational restructuring can have the impact of disrupting front line services in such a way that the quality of child care practice can be significantly compromised in the short term.

14.5 If terminology used by professionals is ambiguous, such as "welfare visit", "discharge meeting" or "parenting assessment" then it will likely mean different things to different professionals and potentially give false assurances that certain actions to address the risk to a child will be or have been undertaken.

14.6 Initial and Core Assessments which fail to seek information from other agencies and practitioners known to have worked with the family, will lead to an incomplete analysis of parental strengths and weaknesses, and therefore compromise the validity of any findings.

14.7 For any professional practice to be effective, first line management oversight and quality assurance processes need to be consistently applied. When this does not occur, any shortfalls in direct practice will not be picked up, with the likelihood that there will be a significant risk of safeguarding concerns going undetected.

14.8 In the early stages of this case, the explicit support by CSC for the father to retain care of his child, was not only misinterpreted by the parents regarding the formal authority of this, but it also generated confusion between professionals which impacted on the later management of the case. Professionals must therefore be completely clear about the messages given to parents regarding the actions being undertaken on their behalf, checking out what the parents understand about the status of any support and if possible to put this in writing, so as to avoid any later possible confusion or misinterpretation.

14.9 For practitioners not to take account of racial and cultural issues will not only undermine any assessment of need or risk, but giving the issue insufficient sensitivity and attention may adversely influence the quality of any professional relationship that can be developed with a parent or child.

14.10 If escalation processes are not used by practitioners and managers to effectively challenge the professional practice or decisions of another agency, then poor or inappropriate practice will go unchallenged and potentially leave a child in an at-risk situation.

14.11 If agreed threshold arrangements are not employed in respect of early intervention services such as CAF, then this will significantly impact on the types of services, or lack of them, which will follow. Whilst Munro speaks of the "child's journey"[9], in this case Child H's "journey" took the wrong course from the outset.

15. Recommendations

15.1 Wiltshire LSCB needs to be assured by its constituent members and via reports from the Safeguarding and Improvements Board, that they have fully considered the individual "lessons learned" identified above within this Serious Case Review and accommodated them where relevant within the "Improvement Plan" identified from the most recent Ofsted safeguarding inspection.

15.2 The LSCB will need to commission an audit of the use, effectivenessand understanding of Strategy Meetings among agencies and their staff, and based on its findings, issue clear

[9] The Munro Review of Child Protection – The Child's Journey – July 2011

direction and guidance about their purpose, criteria and management in order to establish efficiency in their pivotal role as part of safeguarding practice.

15.3 The recently published Teenage Pregnancy Policy needs to reviewed in the light of the findings in this case, particularly in respect of the role of the CAF, and then the Policy's use and effectiveness audited in order to demonstrate that it is enhancing service delivery.

15.4 An audit should be undertaken to identify that effective communication is taking place: -

-between agencies at the time when Initial and Core Assessments are undertaken,

- or when referrals are made to Children's Social Care and feedback of the outcomes of actions needs to be made back to the referrer.

15.5 Multi agency guidance needs to be developed and issued in respect of Hospital Discharge Planning Meetings, in particular regarding the criteria for their use when children are identified in addition to any medical needs as being vulnerable or at potential risk of significant harm. The guidance should identify who should attend such meetings, and how decisions which are made or actions agreed, are recorded and monitored.

15.6 Constituent agencies will need to demonstrate to the LSCB that their staff are sufficiently and effectively trained in order to address the racial and cultural needs of families who they work with, and provide evidence that their service delivery reflects this.

15.7 The LSCB needs to be assured that the threshold criteria for prevention and early help services are clear to agencies and reflect effective multi agency coordination of services and of the effective use of the CAF. Evidence will need to be provided which demonstrates that multi agency forums are operating effectively at the prevention and early help level and that in relevant circumstances, they effectively identify and provide information to support any need to advance interventions to the status of child protection.

15.8 The LSCB needs to be assured by its constituent agencies that they have escalation procedures in place which have been disseminated to all staff who are additionally given sufficient support to be able to use them with confidence when necessary.

Ron Lock

21.9.12