CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review

Child BF

OVERVIEW REPORT

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Date presented to the Cumbria LSCB: 11th January 2018

1. Summary of the Learning

1.1. Child BF was three months old when she received injuries that may be life-changing. This Serious Case Review, which considers the professional involvement with BF and her family, has identified a number of learning points for the individual agencies involved and for the Cumbria Local Safeguarding Children Board (LSCB).

1.2. The areas where learning has been identified can be summarised as follows:

- Challenging poor engagement, and providing extra support to vulnerable young parents, when this has an impact on the child.
- When a baby is at risk of neglect, they may also be vulnerable to being physically harmed.

- Ensuring fathers are a key part of the assessment processes and any plans that are in place.
- Taking appropriate early action when risks are identified in pre-birth.
- Managing transitions well through effective and robust sharing of information.
- Recognising the important role that GPs can play in gathering information for assessments.
- The police should be informed in a timely way when a child is presented at hospital with an injury that could potentially be non-accidental.

2. Methodology

2.1. The LSCB agreed that this Serious Case Review (SCR) should be undertaken using the Significant Incident Learning Process (SILP) methodology. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time.[1]

2.2. SILP reviews are characterised by a large number of practitioners, managers and agency safeguarding leads coming together for a Learning Event with independent lead reviewers[2]. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to consider the first draft of the overview report, and identify the learning from the SCR at a Recall Event. They make an invaluable contribution to the review[3].

2.3. It was agreed that the timescale being considered by this review would be from the 20th January 2016 to the 20th January 2017. This covers the period of Mother's pregnancy with BF until the strategy meeting that followed her injuries.

2.4. The parents were contacted in writing in an attempt to ensure their views were considered and heard as part of the review. An initial appointment was offered on 19th October 2017. However, neither parent made themselves available to meet the lead reviewer, despite several attempts of contact being made. Further attempts to contact the parents were made prior to the publication of this report.

2.5. The Department for Education (DfE) expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that re-

[1] Working Together 2015 states that SCRs and other case reviews should be conducted in a way which; recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did; seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings. This SCR has been undertaken using the SILP model which ensures that these principles have been followed and provides a systems review of the case.

[2] The lead reviewers in this case are Mark Granby, who is also the author of this report and Nicki Pettitt. Mark is a retired senior police officer and Nicki was a senior manager in a local authority children's social care department. Both are experienced and accredited SILP associate reviewers who are entirely independent of CLSCB and its partner agencies.

[3] The SCR was planned at a scoping meeting held in June 2017 with the Cumbria LSCB Serious Case Review sub-group. Terms of Reference were compiled and agency reports were requested, along with a chronology of agency involvement. A briefing meeting for agency report authors was held following the scoping meeting to clarify expectations. A Learning Event was held on 13th September 2017. All the agency reports were available and had been circulated in advance with the chronology. This ensured that all staff attending were able to fully understand the multi-agency information and focus of the review. The event was well attended by practitioners and their immediate managers as well as agency report authors. The Recall Event was held on 20th October 2017. Participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the contents and clarify their involvement and perspective. All those involved contributed to the conclusions and the identified learning from this review. The final version of this Overview Report was presented to the Cumbria LSCB on 23rd January 2018

quirement, and to protect the right to an appropriate degree of privacy for the family, confidential historical family information will not be disclosed in this report.

3 The Case

3.1 The subject of this review is a child to be known as BF. She was just over three months old when she received non-accidental injuries comprising of a subacute haemorrhage and a bilateral haemorrhage. Her father has since been convicted of grievous bodily harm and received a custodial sentence.

3.2 BF lived with her parents. BF had been placed on a Child Protection Plan prior to her birth under the category 'at risk of neglect' due to professional concerns about how the parents would manage to care for a baby.

3.3 BF is the first born child to the parents and she had no siblings. The parents are referred to in this report as Mother and Father. Other family members will be referred to by their family title e.g. Paternal Grandmother.

3.4 Mother and Father lived together with BF. They lived in rented accommodation which they shared with another male who was not a family member.

4. The background prior to the scoped period

4.1 Mother was well known to local services as a child. She had been assessed as having moderate learning difficulties at school and had a significant history of self-harm and overdoses, leading to involvement with CAMHS. A referral was made to the NSPCC over concerns that she was being sexually exploited, however she did not engage fully with the service. She had been exposed to parental alcohol misuse and domestic violence and spent time in foster care.

4.2 Father was unknown to services in Cumbria. He moved into the area in 2014, having spent his childhood in another part of the country where he was known to Children's Services. He was exposed to domestic violence, drugs and criminality in his immediate family. Father was largely brought up by his maternal grandmother. He was diagnosed as having ADHD[4] while at school. From age 16 he spent 3 years in the armed services. He moved to Cumbria to be near his father. Father acknowledged cannabis use and accessed treatment services.

4.3 Mother and Father met in Cumbria. Father is eight years older than Mother. They had been together for about four weeks when Mother discovered that she was pregnant. At the time Mother was living with her mother.

5. Key Episodes

5.1 The time under review has been divided into three Key Episodes. These are periods of intervention that are judged to be significant to understanding the way that the case developed and was managed. The term 'key' emphasises that they do not form a complete history of the case but include the professional interventions that are key in informing the review.

5.2 The first Key Episode covers the time from Mother notifying services of her pregnancy through to her 30th week of pregnancy. This includes the agency responses to the preg-

[4] ADHD – Attention Deficit Hyperactivity Disorder

nancy and information sharing when Mother and Father moved from one area in Cumbria to another.

5.3 The second episode covers the pre-birth assessment, the Initial Child Protection Conference (ICPC) and the start of the Public Law Outline[5] (PLO) process.

5.4 The third episode covers the period from BF's birth to the strategy meeting held following her injuries. It captures how agencies worked together to implement the Child Protection Plan (CPP) following her birth.

Key Episode 1: Notification of pregnancy to approximately 30 weeks

5.5 Mother was approximately 10 weeks pregnant when she presented at the GP in Area 1. Mother told the Midwife that she was happy to be pregnant and detailed that she had been involved with Children's Services up to the age of 18 and that she had had learning difficulties whilst at school. The Midwife advised her of multi-agency support available via an Early Help Assessment (EHA) and referred her to appropriate teenage pregnancy services.

5.6 It then became difficult to contact Mother and the Area 1 Midwife took the case to a Vulnerable Child Meeting[6]. It was established that the parents were moving to Area 2 and would be house-sharing with a man who was known to Father from the substance misuse treatment service. The Community Midwife at the hospital in Area 2 made telephone contact with the Safeguarding Hub at the 15/16 week stage of Mother's pregnancy and expressed concerns in relation to Mother's learning difficulties and Father's mental health issues. The Hub passed the contact to a health professional, who was part of the service and who advised that an EHA should be completed. At this time decision making in the hub was not overseen by a manager, as it is now.

5.7 A referral was also made to the Family Nurse Partnership[7] for additional support by the Midwife. The parents did not engage with the service however and the place was given to another pregnant teenager.

5.8 At the 23/24 week stage of the pregnancy the Community Midwife received information that Mother was leaving Area 2 and wished to return to Area 1 where she would in effect be homeless. A further contact was made with the Safeguarding Hub (in writing) who made the decision for a Child and Family Assessment[8] to be undertaken and the unborn BF was allocated to a social worker. A referral was made to the Family Support Team for a pre-birth assessment[9] to establish the capacity and understanding of Mother and Father.

Key Episode 2: Pre-birth assessment and Initial Child Protection Conference

5.8 The Midwives from both areas met and acknowledged their increasing concerns. Mother had disclosed that she now intended to live back in Area 2. The Safeguarding Hub had al-

[5] The Public Law Outline sets out case management procedures for dealing with public law children's cases. The aim is to identify and focus on the key issues for the child, with the aim of making the best decisions for the child within the timetable set by the Court, and avoiding the need for unnecessary evidence or hearings. The parents are fully involved in the PLO. In this case, psychological assessments of both parents were commissioned.

[6] A Vulnerable Child Meeting takes place at a GP's practice between the Midwife and Health Visitor.

[7] The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly; from the early stages of pregnancy until their child is two. The FNP programme aims to enable young mums to: Have a healthy pregnancy; Improve their child's health and development; Plan their own futures and achieve their aspirations. The Family Nurse Partnership in Cumbria has now been decommissioned.

[8] A Child and Family Assessment is an assessment conducted by a social worker using an assessment tool and drawing upon information from the family and other agencies.

[9] A pre-birth assessment is an assessment conducted by a midwife using a standard tool to make an assessment of the parenting capacity of the mother and father/partner.

located the case and the duty Social Worker in Area 2 began an assessment, and recommended a strategy meeting[10]. The Social Worker met both parents and completed section 47[11] enquiries. This included seeking information from the GP in Area 2 after Mother had been prompted several times to register at a practice, but not from the previous GP in Area 1. It was recognised that the parents would not manage without support and that a number of risk factors were present. A request was made for an Initial Child Protection Conference (ICPC). The primary concern was around the parents' inability to understand the impact that parenthood would have on them, and how this could be a risk to the baby.

5.9 The Midwife had commenced an EHA but it was not completed. The gathering of information was made difficult by the Mother moving back and forward between areas. Mother was referred to the Teenage Pregnancy Service but she was declined as she was too old for their criteria.

5.10 The pre-birth assessment was initially difficult due to the parent's lack of commitment to the process. They were avoidant and gave numerous excuses for failing to engage. Following the ICPC, transport was arranged for them. Consideration was given to carrying out the assessment work at the home address but the presence of the other tenant was an issue. The decision was taken that BF should be placed on a Child Protection Plan (CPP) as she was at risk of neglect.

5.11 The parents were invited to participate in a seven week course for vulnerable parents run by a Third Sector agency[12]. Mother attended 6 sessions and Father 5.

5.12 A decision was made to commence the Public Law Outline (PLO) due to the vulnerability of BF and the following assessed concerns:

- Mother's learning difficulties which appeared to continue to be an issue, particularly with her difficulty in retaining information.
- Mother's history of self-harming and her potential continuing vulnerability.
- Mother's poor childhood experience, including time spent in care. She was a young parent who was felt to be very vulnerable herself.
- Father's past and potentially on-going mental health and drug misuse issues.
- Father's poor childhood experience.
- Parent's limited engagement with the assessment process.
- Potentially unsuitable accommodation and presence of another tenant.
- Lack of family support.

Key Episode 3: BF's birth to the date of the incident

5.13 When BF was born Mother and baby had an extended stay on the ward to support her with feeding issues. A formal discharge meeting did not take place at the hospital but there was a meeting with the Social Worker and Family Support Worker who noted that Mother appeared to be doing well. The Health Visitor did not take part in this meeting as she was not made aware that it was taking place.

[10] Whenever there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, following a referral or at any other time after this, a strategy discussion/meeting should be held, as stated in the CLSCB procedures.
[11] Local Authority enquiries conducted under Section 47 of the Children Act 1989 aim to determine whether action is needed to promote and safeguard the welfare of the child who is the subject of the enquiries.
[12] The course was designed to equip vulnerable parents with the skills to care effectively for their babies.

5.14 Following the discharge, concerns were raised with Mother by the Midwives about her self-care. BF had contracted an infection, so arrangements were made for Mother and BF to return to hospital. Mother did not attend, and did not collect the prescription that had been ordered for her. The Midwife collected this and ensured that Mother had administered it. Father said that he was unable to collect the medication as his family were visiting.

5.15 Home visits from professionals continued and it was noted that Father was becoming less visible, with Mother saying he was in bed because he had provided the night feeds. It was noted that Mother was looking increasingly tired although BF was gaining weight. The Social Worker expressed concern to the Midwife that Mother was not acting on advice.

5.16 The Review Child Protection Conference (RCPC) took place just over 3 weeks after BF's birth and the third PLO[13] meeting took place a week later. The on-going concerns were noted but it was believed that the threshold to initiate care proceedings was not met, as there had not been a specific incident where BF was thought to have suffered significant harm.

5.17 The Health Visitor, Social Worker and Family Support Worker continued to make regular visits. Engagement from the parents, and in particular Father, was poor. At one unannounced home visit, 2 months after the birth, Mother disclosed to the Social Worker that she wished Father had a better bond with BF and that he got stressed easily. It was also established that there were growing financial pressures on the parents. When the Social Worker managed to speak to Father he reported that he felt that BF did not like him and only wanted her Mother.

5.18 Father's engagement decreased further and the Health Visitor and Family Support worker noted on a joint visit that Mother was receiving very little family support and was feeling very low. It was established that the parents had significant financial difficulties and it was noted that BF was also less responsive. The Health Visitor used an assessment tool to grade Mother's levels of anxiety and depression and she scored moderate to high. She did not however display behaviour to suggest self-harm or suicide ideation. Mother declined the suggestion of a counselling service but accepted an appointment to see her GP. The Health Visitor organised an appointment for the following day for blood tests to check for anaemia. Mother was given a routine appointment to see the GP in just over one week's time. An earlier appointment was not given as the risk was not assessed as being at crisis level.

5.19 The Family Support Worker contacted Social Worker's manager in absence of the Social Worker to share her concerns and enquire about further financial support for the family. The concerns raised were:-

- Financial problems
- Lack of food in the home
- Cold home environment – there was no gas or electric and it was December.
- Mother's presentation
- Lack of engagement from Father
- Father's lack of attachment with BF
- BF less responsive – not as much eye contact with Mother.

[13] The outcome of the psychological assessments of the parents was still awaited before final decisions could be made. Typically the PLO process will take about 6 months.

5.20 Further financial support was provided to the family. The Family Support Worker sent an email documenting the observations from her visit, the concerns and her visiting plans for the family to Social Worker and her Manager. At this stage the Family Support Worker and Health Visitor were so concerned about the situation that between them they carried out daily visits. The Family Support Worker returned to the home address and this time both parents were present. Mother admitted that she had forgotten to attend the GP's for her blood test.

5.21 Five days later a Third Sector Agency professional visited Mother to discuss her participation in a programme to take better care of the home environment[14]. Mother was reluctant to participate but they gained agreement by the end of the appointment. The professional noted that BF appeared happy and content for the duration of the visit.

5.22 Three days after the Third Sector Agency professional had met with Mother; the Social Worker visited and challenged both parents about their lack of engagement and availability to work with services. Mother said she had not attended her GP appointment in relation to her depression and anxiety as she felt it was not necessary.

5.23 Later that day Mother and BF went by ambulance to the hospital. Mother stated she had fed the baby and then gone out leaving her with Father. When she returned she saw that BF was 'floppy' and called the ambulance. The child was extremely unwell upon her arrival at hospital. Subsequent tests revealed the presence of the injuries. Children's Services were notified by the hospital after they had identified that BF was subject of a CPP and the police were later informed. Protective actions were taken in respect of BF and a criminal investigation began.

6. Analysis by Theme

6.1 From the information provided in the agency reports; from the discussions at the Learning Events and Recall Events; several themes have emerged which lead us to the learning in this case. These can be summarised as:

- Engagement
- Parental capacity
- Fathers
- Assessments and delay
- Transitions
- Multi-Agency working
- Response to the injuries

Engagement

6.2 The Midwives quickly recognised the vulnerability of Mother and Father and had concerns in respect of their capacity to parent. These concerns lead to referrals for advice and in turn the commissioning of assessments and support. From the outset of the assessment processes a recurring concern about the engagement of the parents was recorded. This lack of engagement continued to be an issue throughout Mother's pregnancy with BF. The table summarises the support offered to the parents and how they engaged with each offer.

[14] This was a programme designed to support vulnerable parents in taking more pride in and care of their home.

Support offered	Parental Engagement
Early Help Assessment	Explored the background information and current support needs, but Mother's moves impacted on its completion.
Family Nurse Partnership	Failed to engage and lost place
Child and Family Assessment	Increasingly reluctant to engage – specifically Father
Pre-birth Assessment undertaken by the family support worker	Poor levels of engagement from both parents. Transport provided.
Heath visitor visits	Limited engagement
Course for vulnerable parents	Mother 6/7; Father 5/7 sessions
Hospital re-admission (Mother)	Failed to attend
Counselling service (Mother)	Declined service
GP appointment & blood test (Mother)	Failed to attend appointments
Home environment programme	Accepted – but incident preceded course

6.3 The referral to the Family Nurse Partnership was a good one that could have provided the parents with additional support. However the lack of engagement by the parents with the referral meant their place was given to another family. This service was de-commissioned shortly after the referral had been made however, and confusion about the provision of the programme at this time impacted on the lack of challenge given to Mother to ensure she engaged with the service. At the Recall Event this was thought to potentially be a missed opportunity for the parents to receive much needed practical and emotional support.

6.4 The Health Visitor reported that she had often had difficulty in contacting the parents. At a number of planned parenting assessment sessions with the Family Support Worker either neither parent attended or Mother alone attended. Concerns about lack of parental engagement were recorded at the Core Group meeting and a genogram of Mother and Father's family networks was prepared to assist in the identification of support networks available. This revealed that there was very little family support available for the parents. Professionals had to take the unusual step of arranging transport for the parents so they could attend assessment sessions, and this helped.

6.5 When concerns in relation to Mother's mood and anxiety were raised by the Health Visitor to the GP, appointments were made for blood tests to check for anaemia and to discuss Mother's depression and anxiety. Mother failed to attend the appointments. This may be linked to her low mood and lack of motivation which was emerging in the month prior to BF's injuries.

6.6 Professionals did challenge the parents in relation to their lack of attendance at sessions and their unwillingness to make themselves available for appointments. The lack of parental co-operation was fed back and considered within the PLO process, and was of concern to those involved. It was planned to discuss this at the next meeting, where the psychological assessments were also going to be discussed. This was due to be held on a date which ended up being after the injuries to BF.

6.7 The Triennial Analysis of Serious Case Reviews 2011-2014[15] details that parental lack of or inconsistent cooperation is commonly seen in SCRs. This can often lead to a case being closed or drift and delay in planning for a child. The professionals involved in this case recognised this as an issue however and were both persistent and persuasive in trying to ensure the engagement of both parents.

Learning:

- In cases where there are concerns about the capacity of parents to meet their children's needs and where the parents are showing increasing vulnerabilities such as depression or relationship problems, continued non-engagement with assessments and support should be recognised as significantly increasing the risk to the child.
- When lack of engagement is recognised in cases where the parents have vulnerabilities, an approach that provides additional support, such as in this case where transport was provided and extra visits were undertaken, is good practice.

Parental Capacity

6.8 Mother had an extensive history of contact with Children's Services as a child. Over a 15 year period between the ages of 2 to 17 there was a total of 49 recorded contacts. These flagged issues around mental health, self-harm, overdoses, child sexual exploitation, parental domestic violence, misuse of alcohol and drugs, and risk taking behaviour. At primary school Mother had a Statement of Special Education Needs and it is understood that she had learning difficulties, resulting in School Action[16]. Mother was accommodated by the Local Authority when she was 15 and between the ages of 16 and 18 she was recorded as having 18 placement/address moves.

6.9 There were well documented and acknowledged concerns about Mother's capability to care effectively for a child. Her vulnerabilities were recognised by all of those involved with her. The Ofsted Publication "Ages of concern: learning lessons from serious case reviews"[17] makes specific reference to the impact on young parents of their own childhood experiences and includes as a learning point that assessment of pregnant teenagers must take account of their own family background and experience.

6.10 At a parenting assessment session following the ICPC the parents stated that they could not see why the plan was needed and could not see the need for additional support and assistance with parenting. This inability to reflect on their personal experiences and skills and to recognise the need to change represented an additional risk.

6.11 Mother expressed her worry that Father was not bonding with BF and he stated to the Social Worker that he felt that BF did not like him. His inability to understand that a three month old child could not form such opinions was of concern to those involved and again represented a risk.

6.12 The Ofsted Publication "Ages of concern" draws on the learning from nearly 500 serious case reviews and notes that children under the age of one year are disproportionately

[15] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011- 2014. Brandon and Sidesbotham May 2016 - http://seriouscasereviews.rip.org.uk/wp-content/uploads/Triennial_Analysis_of_SCRs_2011-2014_Pathways_to_harm_and_protection_299616.pdf

[16] School Action is a category of support when a child is acknowledged as having Special Education Needs. It is a lower level of support targeting at children who are not making expected progress and action is needed to address their learning difficulties.

[17] This document can be accessed by following the below link:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526976/Ages_of_concern_learning_lessons_from_serious_case_reviews.pdf

represented as victims of abuse. The key findings show that in many cases:

- There were shortcomings in the quality and timeliness of pre-birth assessments
- The risks about the parents' own needs were underestimated, particularly given the vulnerability of babies
- There had been insufficient support for young parents
- The role of fathers had been marginalised
- There was a need for an improved assessment of, and support for, parenting capacity
- There were particular lessons for both commissioning and provide health agencies, whose practitioners are often the main, or only agencies involved with the family in the early months
- Practitioners underestimated the fragility of the baby

6.13 In this case the recognition of the risk to BF was established prior to her birth, and a plan was in place that considered the risk of neglect. The need for support was recognised and professionals worked hard to engage the couple and enable them to care safely for BF. The risk of physical harm had not been considered, as neither parent had a history of violence. However there are numerous cases where children have been killed or physically harmed in circumstances very similar to these.

Learning:

- In case where an unborn baby of first time parents is thought to be at risk of neglect due to the predisposing vulnerabilities and risks, the possibility that the baby may be at risk of physical harm should also be considered.

Fathers

6.14 Professionals had access to information which afforded them a good understanding of Mother's vulnerability and the associated risk factors. Father was more of an unknown quantity. Having lived in Cumbria for just over 2 years there was very little information held by local agencies on Father. This created an additional onus of responsibility on services to understand his capacity to be an effective parent. Some background information on Father was gathered during the pre-birth assessment process and enquiries were made in the area where he had previously lived as part of the Child and Family Assessment. A thorough assessment of his strengths and the risks he may pose was required, but professionals found Father's lack of availability to be challenging.

6.15 Father appeared to engage quite well with universal services during the early stages of the pregnancy. It was reported that he attended all the ante-natal appointments with Mother. However, as time progressed he became increasingly disengaged from professionals. Father had admitted to cannabis use and he had previously participated in a programme to help manage his drug misuse. As he became less visible to professionals it became more difficult to assess whether he continued to use cannabis. Father stated that he had ADHD but minimised the effects it had on him. He had failed to attend GP appointments in Area 2 in relation to his ADHD and drug abuse.

6.16 Following BF's birth, there were further concerns noted about the lack of co-operation and engagement from Father. Midwives visited the family daily following Mother's discharge from hospital and it was noted that Father was often not present for the visits. He frequently remained in bed upstairs whilst the visit took place. Mother and BF were both unwell not long after arriving home and it was the Midwife who had to collect the medication and

insist that it was taken. Father did not show either the initiative or inclination to assist.

6.17 Mother was initially defensive of Father's limitations but as time passed she reported her concerns to professionals, especially his inability to form a close bond with BF. The parents were facing significant financial difficulties but it was alleged that Father had spent a large part of their limited resources on a television, games console and games. This led professionals to question his priorities.

6.18 The 'invisible male' is a key theme in a large number of serious case reviews. Professionals often fail to identify, and frequently discount or ignore the men in a child's life. Mothers are regularly seen as the 'key' parent for children, and the men or other significant adult living with a child can be seen a secondary, or not considered at all. Ofsted's "Ages of Concern" publication highlights risk where the role of the father is marginalised. In this case Father was considered, was assessed and was included in the planning for BF, but the difficulties identified did not led to challenge in the way they would have been if Mother had shown similar behaviour.

6.19 Professionals can struggle to engage with fathers, and their expectations of fathers can be minimal. When making plans to support or protect children it is often assumed by professionals, and the parents themselves, that 'parent' actually means 'mother'. Research undertaken by the Family Rights Group[18] argues that social workers tend to see men in a family as either 'a risk or a resource' rather than as an equal parent who needs to be assessed, supported and challenged along with the mother. They state that it is a challenge to identify interventions that enhance the protective factors a father or partner may bring, 'while keeping the risk under control.' In this case professionals were able to build an early relationship with Father but struggled to maintain the engagement as he became increasingly remote. This compromised the accuracy of the assessment of risk.

6.20 The information shared that Father was struggling in his relationship with BF was significant, especially alongside Mother's low mood and the noted change in the baby's demeanour. BF's 'voice' was clearly showing at this time that all was not well. Those involved noticed and noted this, and it was added to the evidence being gathered that the baby was at continuing risk of neglect and emotional harm in her family. The risk of a physical injury was not considered however.

Learning:

- Professionals should ensure that they apply robust professional curiosity in relation to fathers; particularly when they disengage from services and from their parenting role with their child. This curiosity should be supplemented by robust challenge to fathers regarding their parenting role.

Assessments and delay

6.21 The table below summarises the various assessments that were commissioned; who carried them out and whether it was completed.

Assessment	Undertaken by:	Completed?
Ante-natal Booking Assessment	Midwife Area 1/Health Visitor	Yes
Early Help Assessment	Midwife Area 2	No
Section 47 Enquiries	Social Worker Area 2	Yes (pre-birth)

[18] Family Rights Group, Fatherhood Institute, Daryl Dugdale (Bristol university), Professor Brigid Featherstone (Open University) 2012

Child and Family Assessment	Social Worker Area 2	Yes (pre-birth)
Initial Child Protection Conference Report	Social Worker and all agencies except GP	Yes (pre-birth)
Pre-birth Assessment	Family Support Worker	Yes (pre-birth)
Post-birth Assessment	Ward Midwife	Yes (Oct 2016)
Parenting Assessment	Family Support Worker	Yes (post-birth Dec 2016)
Cognitive Assessment	Independent Psychologist	Yes (Dec 2016)
Psychological Assessment	Independent Psychologist	Yes (Dec 2016)
Risk and Resilience Assessment	Health Visitor	Yes – and ongoing
GP New Patient Assessments	GP	Yes – Mother and Father (in 2014)
6 Week Postnatal Check	GP	Yes – Mother and BF
Review Child Protection Conference Report	Social Worker and all agencies	Yes – and ongoing
Perinatal Mental Health Assessment	Health Visitor	Yes (Jan 2017)

6.22 The first assessment commissioned was the EHA that the Area 2 Midwife was asked to produce on the advice of the Safeguarding Hub. This was started but not completed. It was reported that the Midwife found it difficult to secure information as Mother was moving backwards and forwards between the two areas.

6.23 The Child and Family Assessment benefited from good gathering of information. The Parenting Assessment was comprehensive and well evidenced but greater consideration could have been given to what the behaviour of the parents could mean for BF in the short, medium and longer term.

6.24 The cognitive and psychological assessments were completed by appropriately accredited professionals and it was appropriate that they were commissioned. The issue related to the timing of the commissioning which meant that the assessments were not available to inform child protection planning prior to the birth of BF. Had the case received an assessment by Children's Social Care following the initial referral made by the midwife to the Hub, there might have been the opportunity to have the assessments completed prior to or close to the birth of BF.

6.25 The Pre and Post Birth Assessments were both completed in a timely manner and drew upon appropriate information. However, it was noted that Father disengaged from the Post Birth Assessment and became more and more invisible from that time.

6.26 The Perinatal Mental Health Assessment was completed by the Health Visitor when she noticed a significant change in Mother's mood. This showed high levels of depression and anxiety. However, as suicide ideation was not apparent, the assessment did not trigger a crisis referral to see the GP immediately. Nevertheless, this change, when taken in the context of Father's increasing withdrawal and a lack of family support, represented an increase in the risk for BF.

6.27 Delays were evident in starting the Child and Family Assessment. This impacted on the timing of the pre-birth assessment; the ICPC; holding the Legal Gateway meeting; implementing the PLO and the specialist psychological assessments which were only commenced a month before BF's due date. These delays compromised the effectiveness of the assessment and planning as important information in relation to the parents' mental capacity was not available at the time that the baby was born and when she was discharged from hospital to her parents care. This was primarily due to the Safeguarding Hub assessing that the initial contact from the Area 2 Midwife did not meet the threshold for intervention. A timely telephone referral for advice from the Hub was made but at that time, although the Midwives had identified risk factors as being present, the advice was that an EHA should be undertaken. This was predominantly on the grounds that the baby was not due for a further 6 months and that completion of an EHA would give the parents an opportunity to engage in the process. However, the early contact could have provided an opportunity to commence a social work assessment of the capacity of the parents earlier in the pregnancy. At the Recall Event it was reported that the Safeguarding Hub had just undertaken procedural changes which encourages early contact from professionals in pregnancies where risk to the unborn child is evident. However it is important that these changes are communicated to professionals in a way that they will be fully understood, and ensures they are aware they can refer as soon as possible.

6.28 It is clear that once assessments were requested, they were broadly produced in a timely manner. However, the consequential impact of the initial delay in commissioning the children and families assessment and the pre-birth assessment resulted in BF being three months old and there still being gaps in the information, risk assessment and awareness of the parent's meaningful willingness to engage.

6.29 It is noted however that the quality of involvement with the family from those involved was good, once they became involved. They had a good understanding of the needs of the baby and were increasingly aware of the limitations of the parents. There was a lot of positive and targeted work undertaken with the family and good challenge regarding the lack of engagement.

Learning:

- Without a prompt and decisive response to a pre-birth referral there will be babies going home from hospital without the required assessment and parenting work being completed. The time available prior to the child's birth needs to be utilised to ensure there is an understanding of the risks and protective factors and a plan that enables those involved to work towards providing preventive and protective interventions as required.
- Where an assessment indicates a significant change in a parent that increases the risk factors they present, this assessment should be shared expeditiously with appropriate professionals who are involved in the Child Protection Plan and PLO.

Transitions

6.30 The case flags a number of issues in relation to transitions. Firstly, there is the transition of Mother from being a child known to services through to being an expectant mother in just over 12 months. Secondly, there are geographical boundary transitions as Mother moved from one area of Cumbria to another. Father also moved to Cumbria having received support as a child elsewhere in the country.

6.31 Mother had been a Looked After Child under a Section 20[19] agreement. However, her mother removed her consent to the agreement and Mother moved back into the family home prior to her 18th birthday. The outcome of this was that Mother was not eligible for leaving care services post age 18.

6.32 Mother had been referred to CAMHS[20] due to concerns about her mental health and self-harming. However, she had not engaged with the service and as a consequence her record was closed when she turned 18. She would not then have met the criteria for adult mental health services, so this opportunity to assess her to see if she met the criteria for on-going support was missed.

6.33 Father had grown up in another area of the country and there were not records held on him by agencies in Cumbria.

6.34 Mother was registered with a GP in Area 1. It was in this area that she met Father and became pregnant and where she had first contact with the Community Midwife Service. Just over 2 months after first registering her pregnancy Mother moved to Area 2 and after several prompts from the Midwife in Area 2, registered with a GP there. In the next few months Mother was unclear where she intended to live, often changing her mind.

6.35 A referral was made to an obstetric consultant and shared care was requested. The obstetrician saw Mother at 28 weeks after the scan but her history of mental health issues were not felt to be significant enough to require consultant care.

6.36 The Midwife in Area 1 took Mother's vulnerability into consideration when planning her individual care needs and also recognised the risk factors for the unborn child. As a consequence she raised the pregnancy at the Vulnerable Child Meeting with the GP in Area 1. This was good practice. When Mother moved to Area 2 she met with the Area 2 Midwife along with Father. Mother had forgotten to bring her hand held pregnancy notes and only a limited amount of information had been transferred over from Area 1. As a consequence the professionals who were working with the parents at this stage did so with limited information.

6.37 Mother registered with Father's GP in Area 2 after several prompts from the Midwife and a new patient health check was carried out. At this time the practices in Area 1 and Area 2 operated on different I.T systems (they now operate on the same system) so the detailed information that the Area 1 GP practice had on Mother was not available to the Area 2 practice and the safeguarding alert was not present. Again, this reduced the amount of information readily available to the professionals now working with the parents.

6.38 It is evident therefore that Mother's transition between childhood and adulthood, Father move from another area of the country, and Mother's movement between the two areas presented barriers in relation to the effective sharing of information and opportunities for support. This had the potential for professionals to miss or underestimate the risk factors that were present in relation to the unborn baby and the capacity of the parents to care for BF following her birth.

Learning:

[19] Section 20 of Children Act 1989 refers to the duty on a local authority to find a child a place to live if they do not have a home, or a safe home.

[20] Child and Adolescent Mental Health Service

- Professionals transferring cases involving vulnerable parents to colleagues in other areas must satisfy themselves that all relevant information is shared and accurately recorded, and that there is a shared understanding of the vulnerabilities and risks, particularly if there is a view that a referral to the Safeguarding Hub is required.

Multi-Agency working

6.39 A strategy meeting was convened following the Child and Family Assessment, when it was established that the unborn child may be at risk of suffering significant harm. The Social Worker met the parents and obtained information from them as part of the Section 47 enquiries. The GP was also consulted as part of these enquiries. The police were invited but could not attend, but did send the information they held on the parents.

6.40 The ICPC was attended by the Social Worker and the Midwife. The Family Support Worker was not available but did send a report and the police reported that they were not invited but they were aware of the outcome. There is no record of the GP being invited or asked for information. It was reported at the Learning Event that changes in the Egress system[21] should reduce the likelihood of the GP being missed from the attendance list. The third sector agency that was asked to provide support was not invited. The ICPC meeting was not quorate. This is not unusual in pre-birth meetings however as there are often relatively few agencies involved with these new families, so it went ahead.

6.41 The Core Group meetings involved the Social Worker, Family Support Worker and the midwife/health visitor. There was good liaison between the Midwife and the Health Visitor and effective handover at the required time. The Midwife produced good notes for the Health Visitor following the initial conference which meant she was able to attend the first Core Group meeting in an informed position.

6.42 Generally information sharing between agencies was effective and open. The weakness was in the sharing of information within the same agencies but across geographical boundaries. For example, the GP records and the Midwife in Area 2 did not have access to Mother's notes and history until over 6 months after the pregnancy was notified to services.

Learning

- It is important for all professionals and agencies that hold relevant information on a child or their family to be invited to contribute to strategy meetings, child protection conferences and core groups. Conference chairs should make particular efforts to ensure that the relevant GP is invited and receives the record of meetings.

Response to the injuries

6.43 Mother attended at Accident and Emergency in the evening by ambulance with BF who was described as being 'floppy' with reduced levels of consciousness and was extremely unwell. Earlier that day parents had been visited at home by the Social Worker who had challenged them about their lack of attendance at meetings and levels of engagement. Later in the day Mother had allegedly fed BF and then left the home for a short period of time leaving BF in Father's care. Upon her return she reported the change in BF's condition and called the ambulance.

6.44 BF required resuscitation and life-saving treatment. She was later admitted to a children's ward for observations and investigation. A locum paediatrician diagnosed sepsis however

[21] Egress is a secure data transfer system that facilitates the sending of emails and data files.

non-accidental injury was also considered. Subsequently a consultant paediatrician was contacted and the case was discussed. It was agreed that BF would be transferred to another hospital for an MRI scan. It was here, later on in the evening, that the haemorrhage was detected. Mother informed the staff at that hospital that the family was known to Children's Services, but minimised the level of involvement.

6.45 Approximately two hours after BF's arrival at Accident and Emergency the senior nurse caring for her identified that she was on a Child Protection Plan and notified the Children's Services Emergency Duty Team. In the early hours of the following day the duty Social Worker called the hospital confirming that BF was the subject of a Child Protection Plan. The hospital informed Mother that Children's Services had been informed and that the police may be involved.

6.46 The police were notified the following day and a criminal investigation commenced and a Police Protection Order was taken out whilst BF was in hospital. The parents were subsequently arrested.

6.47 The delay in notifying the police had the potential to expose BF to risk of harm given that up until the Police Protection Order being put in place the parents had free access to her whilst on the ward. Moreover, the delay exposed the criminal investigation to potential risk as evidence could have been disposed of or the parents could have fled the area.

Learning:

- Where a child presents at Accident and Emergency and Non-Accidental Injury is one potential cause of the presentation and a referral to Children's Services has been made, early consideration should be made to notifying the police.

Good Practice

6.48 Good practice was identified across all the agencies involved. The level of commitment to BF and her parents was noted, along with the skills of a number of professionals involved with the family. Whilst some of the practice reflects expected standards it is nonetheless important that this positive work is highlighted. Examples include:

- There was good communication and co-operation between those involved.
- Professionals showed persistence. There was very little drift in focus.
- Once formally commissioned the speed and timeliness of actions was good.
- The family were clear about the concerns of the professionals.
- The Health Visitor, Social Worker and Family Support Worker visited BF in hospital after the incident.
- Professionals built up good relationships between themselves and with the family, notwithstanding how difficult they were to engage with.
- The initial Section 47 investigation was conducted thoroughly and there was good social work practice throughout.
- There was good management oversight of the case.
- The Public Law Outline system was robust.
- Professionals demonstrated pragmatic optimism.
- The Review Child Protection Conference took place within 28 days of BF's birth.
- Midwives in both areas spoke to each other and shared concerns.

- The Health Visitor rang the GP to check records in relation to A and E visits to ensure she had this information to take to the core group with her.
- Sharing of information with the Social Worker and staff on the ward prior to BFs discharge showed sensitivity to the families' situation.
- Mother was able to remain in hospital for an extra day.

7 Conclusion and recommendations

7.1. The 2016 Triennial Analysis of SCRs states that, for many of the children who are the subject of an SCR, 'the harms they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.' There was no doubt that there was a lot of conscientious practice across agencies in this case, and that a great deal of consideration had been given to the work that was required with Mother and Father to enable them to care safely for BF. This review has identified significant amounts of good practice and effective multi-agency work taking place in the area.

7.2. The legal processes that had been instigated by agencies were moving in the direction of care proceedings. The increasing lack of engagement that the parents were demonstrating was well documented and served to evidence that further statutory intervention would be required albeit that BF had gained weight and largely appeared to be a happy and thriving child. There has not been information shared during this review that would indicate that the injuries sustained by BF could have been foreseen. The greater risk was of neglect or emotional harm, as identified in the child protection plan.

7.3. The review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour" (Woods et al[22]).

7.4. In their response to this overview report, the LSCB will outline any changes that have been made since this incident. The changes that have been discussed during the review include:

- The recording template for assessments has been modified to enable a record to be made of a parent's background.
- The revision of the Safeguarding Hub's processes for pre-birth referrals.
- Management oversight of all decisions made about referrals to the Safeguarding Hub.
- The GP practices in both areas now share the same computer system making information sharing much easier.

7.5. It is recognised that actions have already been made in relation to some of the individual agency's identified learning. Agency reports completed for this review included recommendations which this review endorses. The purpose of providing additional recommendations is to ensure that the LSCB and all professionals in the partner agencies of the Board are confident that the areas identified as learning opportunities in this review are addressed.

7.6 The main issues that have been identified as learning from this case have been identified within the analysis section above as clear statements. Consideration of the learning has led to the identification of recommendations for the LSCB. They are:

[22] David D Woods et al. Behind Human Error. 2010

Recommendation 1:

The Board should commission an exercise to map the services available to vulnerable families such as the family in this case, and to identify where the gaps in provision exist. Specific consideration should be given to projects that work with fathers and the Board should assure itself that there is capacity to engage effectively with fathers in all stages of assessments. Where gaps are identified consideration should be given to commissioning appropriate new services to fill them.

Recommendation 2:

The Board should consider the revised pre-birth referral processes in the Safeguarding Hub and ensure that there is clarity of understanding across agencies and in particular in relation to the exceptions that apply between week 12 and 16 of a reported pregnancy.

Recommendation 3:

The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:-

- Where a vulnerable parent moves into a new area, professionals must ensure there is effective communication with the area they have moved from.
- When a baby is at risk of neglect, consideration should also be given to the risk of physical injury.
- The need to challenge poor engagement.
- Ensuring fathers are a key part of the assessment processes and any plans that are in place.
- Taking appropriate early action when risks are identified in pre-birth.
- Recognising the important role that GPs can play in gathering information for assessments.
- The police should be informed in a timely way when a child is presented at hospital with an injury that could potentially be non-accidental.