



Child A

Serious Case Review

Final Report

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EXECUTIVE SUMMARY

Initiation of Serious Case Review

This review was initiated by Dudley Safeguarding Children Board as Child A had suffered serious physical harm and there were concerns about the way agencies had worked together.

Both mother and father were arrested and a decision as to whether there are grounds for prosecution is awaited.

The child

Child A was the first born child for both parents. Whilst mother's pregnancy was unplanned mother's pregnancy was confirmed by the GP within the first trimester and Child A was born by ventouse delivery at term. Child A had bruising normally associated with this type of delivery, otherwise no abnormalities were apparent. Child A was developing appropriately and there was nothing about Child A that caused concern other than Child A's weight had dropped from the 75th centile at birth to the 50th centile.

Summary of Case

The period covered by this review is from the time child A was conceived, November 2015, up until the parents were arrested on suspicion of causing Child A physical harm in September 2016.

The child in this case was 10 weeks old when found to have injuries that it is believed could only have been caused non-accidentally.

Child A's parents were both teenagers and were receiving intensive support through the Family Nurse Programme. There was no children's social care involvement.

Mother had a diagnosis of Type 1 Diabetes and received enhanced support through the joint diabetic antenatal clinic. There were concerns pre pregnancy about mother's care of her diabetes however, these reduced during pregnancy when compliance improved and she engaged well.

Mother had a history of using legal highs prior to and during the pregnancy; she was not under the care of specialist drug services.

There were difficulties in the relationship between mother and grandmother 1 which led to increased instability. Grandmother 1 had a diagnosis of depression and was prescribed anti-depressants; at times she chose not to take her medication and this, coupled with misuse of alcohol, led to deteriorations in her mental health. It was at these times that difficulties arose between grandparent 1 and mother.

As a result of these difficulties housing became involved and mother, father and Child A moved to independent living in supported accommodation when Child A was 6 weeks old.

Within days of moving into supported accommodation there were the following concerns:

- Possible cannabis use

- Father had punched a hole in a wall
- Child A had visited hospital with father as he was continually crying, not taking feeds and looked pale
- Father was crying and distressed in A&E
- Mother reported she was not coping and didn't feel she or father had bonded with Child A
- There were unexplained marks/bruises on Child A's body

Community health staff were concerned regarding the marks on Child A, suspecting illness so Child A was admitted to hospital.

During Child A's admission it became more obvious the marks were bruises and a referral to children services was requested. There was a delay in this referral being made and parents continued to have care of Child A whilst in Hospital.

Further bruising was seen by hospital staff and maternal grandmother and it transpired Child A had possibly sustained further injury.

A referral was then made to children's social care and child protection systems came into force with a joint investigation between the police and children's social care, which protected Child A sustaining further harm.

Summary of Findings

It is clear that the professionals working with Child A and family had not anticipated Child A would come to physical harm. There is evidence of professionals being proactive and working hard to support mother and father during mother's pregnancy and in the weeks following the birth of Child A. What was lacking was recognition that this case met the threshold for child protection and that this was a child and a couple who needed and would have benefited from a multi-agency approach and comprehensive plan in pregnancy.

Mother and father were a young teenage couple; both had seemingly experienced domestic violence in childhood. Mother had experienced additional challenges as a result of her mothers' alcohol misuse and depression; during her childhood there was evidence of parental neglect of her diabetes and on-going relationship issues between mother and grandmother 1.

Mother was not attending the diabetes clinic and was using legal highs when pregnancy was confirmed. A lack of recognition of the significance of past and present indicators likely to impact on Child A and mother during mother's pregnancy meant systems and processes set up to protect vulnerable children in pregnancy were not used in this case; specifically the DSCB unborn baby procedures.

It is clear in the days leading to the initial injury there were increasingly worrying signs that the couple were not coping. For a child as young and as vulnerable as Child A, the need for professionals to recognise and respond decisively to those signs is crucial. In this case, many professionals either did not recognise the significance of the signs or deferred to colleagues to make the decisions or act on their behalf without clarity of communication; there was a lack of urgency.

Procedures, processes and systems, in place to ensure vulnerable children are safe and reach their potential in Dudley were flawed or not followed, crucially this resulted in Child A being left in the care of parents and suffering additional harm whilst seemingly under the care of professionals.

The following are the specific findings of the lead reviewer from this serious case review

- 1: Current management of parental distress is not sufficiently robust. Children must be seen by suitably qualified paediatric staff in secondary care services. Whilst completion of a paediatric liaison form will alert community staff over time, direct contact is required in specific circumstances. Health professionals are trained to consider signs of distress and depression in new mothers, however assessments of mood and depression in fathers, who might also be struggling, are less likely.
- 2: Current assessments are biased to assessing mothers rather than assessing both parents. Parents have joint parental responsibility and as such should be seen as of equal importance by professionals
- 3: Obtaining fathers past histories, understanding their behaviours and issues, and considering them in the context of a families likely functioning, is a challenge well known to professionals. There is a likelihood that fathers will remain unknown to professionals because of the way services are currently designed and delivered.
- 4: Within Dudley there is evidence that communication within and between partner agencies, in this case health and housing, is sometimes lacking or insufficient.
- 5: Professionals need to increase their curiosity and understand the reasons behind cancelled and rearranged appointments. Multiple cancellations and rearrangements require a greater degree of professional curiosity and heightened consideration.
- 6: The health lead unborn baby network meeting needs to become part of a wider multi-agency safeguarding forum linked into a wider multiagency response.
- 7: Professionals are not routinely placing new information or changes within families in context of what is known. This is leading to a lack of analysis, consideration of whether existing plans will address all a child's needs and onward referral.
- 8: There was an over reliance on Family Nurse Partnership as deliverers of an intensive programme by all partner agencies involved.
- 9: Professionals are not affording the same level of concern to damage to property as damage to a person.
- 10: Current procedures do not guide professionals, particularly those whose expertise does not lie in substance misuse, to consider use of 'legal' highs in the same way as the use of illegal substances. The response of professionals to the use of 'legal' highs in this case suggests this may be an unexplored area of risk.
- 11: Systems and processes designed to safeguard children were not followed when bruising/marks were identified on Child A meaning that Child A continued to be placed at risk. There was poor use of body charts which might have assisted professionals to recognise Child A was continuing to be harmed. There was a lack of continued oversight of progression of the case by trained safeguarding professionals.
- 12: The system and process around notification of serious incidents to the serious case review group was not sufficiently robust. Since this case there have been

changes to the process which have addressed the issue therefore no recommendation has been made.

Recommendations

Each agency has made recommendations as a result of their Single Agency Analysis Reports that the Lead Reviewer and Serious Case Review Panel endorse. (See Appendix 3)

The Lead Reviewer has made the following additional recommendations

- 1: The DSCB and its health partners to consider whether current practice in the ED department, and the paediatric liaison service are meeting recognised safeguarding standards.
- 2: DSCB and its partners to review current assessment tools to ensure they place importance on assessing both parents robustly.
- 3: DSCB and its partners to consider how best to eradicate gaps in and between the services delivered to unborn babies, and strengthen relationships thus improving the interface between services and agencies. Consideration should be given to how social workers can be best involved in the antenatal phase. Consideration should also be given to the lead professional role and its allocation to the most appropriate professional.
- 4: The DSCB and its partners to consider how to reduce professional anxieties around communicating and information sharing with partners, and foster a culture that supports open communication between professionals.
- 5: The DSCB and its partners to consider how to foster a culture where professional curiosity is increased and consider how practitioners can be further assisted to develop their analytical skills and take decisive action.
- 6: The DSCB and its partners to ensure its recently revised multi-agency procedures and systems of working with unborn babies dovetail effectively with single agency procedures and systems, and where concerns are identified, provide clear guidance of when cases need to be stepped up into a pre-birth child protection conference.
- 7: The DSCB and its partners to consider how best to maintain the good work of FNP whilst recognising that a health only programme cannot replace Children Social Care involvement when a multi-agency response is required.
- 8: The DSCB needs to assure itself that the response of professionals to indicators of domestic abuse is in line with existing policies and procedures.
- 9: The DSCB and its partners need to review current policies, procedures and guidelines in relation to the use of all substances that are having an effect on a person's functioning and assure themselves that the response of professionals to the use of these substances reduces the possibility of harm to both unborn and live children.
- 10: The DSCB to assure itself that service configuration, systems and practice within acute hospital services is safeguarding children.

What will the LSCB do in response to this?

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

1 INTRODUCTION

1.1 Initiation of Serious Case Review

- 1.1.1 This Serious Case Review (SCR) was instigated by Dudley Safeguarding Children Board (DSCB) under the auspices of Working Together 2015 and local Serious Case Review Policy.
- 1.1.2 Dudley Group NHS Foundation Trust referred this case to the DSCB Serious Case Review Sub-group on 31st October 2016 with a request being sent to all agencies for information on the 3rd November 2016.
- 1.1.3 The case was discussed at Serious Case Review Sub-Group on the 1st December 2016 to consider if the case met the threshold for a SCR. The SCR Sub-Group decided this case met the threshold because:
- Abuse or neglect was known as Child A had been subject to non-accidental injuries
 - Child A had been subject to serious harm as Child A had received serious injuries that were noted to include two broken legs by the age of 10 weeks
 - There were emerging concerns about how the agencies worked together as there was information known to agencies that indicated Child A may be at risk of abuse or neglect for example:
 - cannabis use in the home,
 - father inflicted damage to the property,
 - anti-social behaviour,
 - struggling young parents and,
 - possible domestic abuseand these concerns were not shared between agencies
 - There was a lack of professional inquisitiveness and curiosity around Child A's first presentation to hospital and it appears that referrals were not made at the right time.
- 1.1.4 The decision to initiate a Serious Case Review was taken by DSCB's Independent Chair Liz Murphy.
- 1.1.5 Notification was sent to the National Panel on 7th December 2016 with a confirmation of receipt and a request for updates as the review progressed.

1.2 Agencies and local authorities involved

- 1.2.1 The following is a list of the agencies involved with the family and the services they offered. Where abbreviations have been identified these will be used throughout the report to denote the organisation the author is referring to:
- Dudley Group NHS Foundation Trust
 - Midwifery
 - Accident and Emergency
 - Acute Paediatrics
 - Dudley Clinical Commissioning Group
 - GP Services

- West Midlands Police

- Dudley Council (Children’s Social Care (CSC))
 - Family Solutions
 - Early Help

- Black Country Partnership NHS Foundation Trust
 - Family Nurse Partnership

- Housing
 - Bromford Housing

- Education
 - College including the in-house counselling service

- 1.2.2 The review was managed by a review panel (see appendix 2), consisting of senior managers of the involved agencies, working with the independent lead reviewer (Nicki Walker-Hall).

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

- 1.2.4 The Serious Case Review Sub-group and the panel agreed the key focus points for the review and highlighted the following lines of enquiry for consideration:
 - How do practitioners interpret and respond to parental distress? At what point are assessments of mood and depression offered/ completed, or concerns regarding a parents mental wellbeing shared?
 - What were the circumstances that led to an apparent lack of professional inquisitiveness and curiosity around Child A’s first presentation to hospital?
 - How can we better understand parent’s backgrounds and relationships and incorporate them in assessments and plans?
 - How can we create stronger multi-agency communication systems to identify and intervene in situations of abuse and neglect?
 - There is a confused picture around parental engagement. Does active cancellation of multiple arranged appointments require a similar approach to that afforded to those that fail to attend appointments?
 - How can practitioners work more effectively together, in a manner which takes account of a family’s needs, yet keeps children’s needs as the focus of intervention?
 - Is there an undue over reliance on Family Nurse Programme (FNP)? What are the challenges to managing matters of abuse and neglect when a family are receiving intensive support from the FNP? Did the involvement of FNP alter practitioner’s responses to abusive situations? What was the alternative to FNP?
 - Given this was the couple’s first child, coupled with their age, inexperience and complex relationships with their extended family support network, was there a sufficiently robust plan in place at the point they moved into increased independent living? Was consideration given to holding a team around the family meeting to formulate plans and implement them at the point they were effectively homeless? Was the early help offer made at the right point?

- What is the difference between a domestic incident and domestic abuse? Do practitioners respond differently to the two terms? What was the impact in this case and the learning for other cases?
- Are practitioners responding appropriately to disclosures of recent drug use, and self-reports of cessation of use?
- Is there evidence of consideration of the need to refer concerns, by any of the practitioners who noted bruising/marks on Child A, a non-mobile baby? Was there an over reliance on others initiating child protection procedures?
- How is further bruising in non-mobile babies captured and managed, giving appropriate consideration to safeguarding in an acute paediatric setting?
- What prompts professionals to communicate with each other and what prevented all indicators of abuse being shared as they arose?
- What led to the delay between the serious incident, the notification of the serious incident to the serious case review group and subsequent discussion?

Process

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

1.2.6 The process used included:

- Chronologies from all involved agencies
- Single agency analysis reports (SAAR's)
- Group practitioner and management sessions to maximise learning for those involved with the family at the time, and those managing the services currently.
- The lead reviewer was given access to key documents on request.

Timeline

1.2.7 The timeframe from the outset aimed to promote compliance with statutory timescales commencing on the 6th March 17 with a proposed finish date of 31st August 2017. Dudley commenced three SCR's at the same time so proposed to the national panel to complete this review by the end of December; the proposal was accepted.

1.2.8 Delays in receipt of the CSC SAAR report and the need to hold an additional learning event threatened to impact on completion of the report, however timescales were met.

1.2.9 The following is the final timeline:

- Serious Case Review Planning Meeting- 30th January 2017
- 1st Serious Case Review Panel – 6th March 2017
 - Chronology 27th March 2017
 - Submission 1st iteration SAAR 10th April 2017
- 2nd Serious Case Review Panel – 27th April 2017
 - Submission of 2nd iteration SAARs – 11th May 2017
 - Submission of narrative – 11th May 2017
- 3rd Serious Case Review Panel - 18th May 2017
 - Practitioners Event – 5th June 2017

- 4th Serious Case Review Panel – 6th July 2017
 - Practitioners Event 19th July 2017
 - Submission of 1st draft Overview Report – 21st August 2017
- 5th Serious Case Review Panel – 24th August 2017
 - Submission of 2nd draft Overview Report – 22nd September 2017
- 6th Serious Case Review Panel – 28th September 2017
 - Practitioner review of the report – 28th September 2017
- DSCB Presentation – 16th November 2017
- Send SCR to Ofsted, DfE and the national panel
- Publish SCR – Date to be confirmed
- Annual DSCB Learning from Case Reviews Event – Date to be confirmed

Parallel Processes

1.2.10 This review has been cognisant of the criminal and family court processes. Advice has been provided by the police and CSC representatives to the panel on when and if staff could participate in practitioner’s events, and on when/if it was appropriate to contact the family.

Family participation

1.2.11 The family were made aware that this Serious Case Review was in progress. There was a hope that the criminal proceedings would advance to a point that the Lead Reviewer could meet with the family however, at time of writing, the case is still waiting a decision by the Crown Prosecution Service.

Limitations

1.2.12 The lead reviewer would have welcomed an opportunity to speak to mother and father and Child A’s grandparents, believing this would have provided insight on the whole family, the functioning of the family unit and their experiences of the professionals involved. A number of the professionals involved in this case are no longer employed by local agencies, the Lead Reviewer has therefore not been able to gain their viewpoint.

1.2.13 An additional limitation, recognised towards the end of the process, was the lack of a community antenatal and postnatal midwifery SAAR. This was deemed unnecessary by the agency panel member but is a gap.

1.3 Structure of the report

1.3.1 The report is structured as follows:

- **Chapter 2** provides a summary of the overall context:
 - a summary of what happened
 - details of family members and a description of what was known about the children in the family, in particular the child
- **Chapter 3** describes what happened from the perspective of the professionals involved at the time, explains the rationale for actions and decisions and appraises the practice

- **Chapter 4** provides an analysis of the themes emerging from the practice in this case:
- **Chapter 5** provides the conclusions, overall findings and recommendations

2 CONTEXT

2.1 The Family

2.1.1 The following table demonstrates the family as was known to professionals during their involvement with mother and father. Please note the absence of mother's half siblings.

TABLE 1

| Term used in report | Relationship to child | Age at the end of September 2016 |
|---------------------|-----------------------------|----------------------------------|
| Child A | Subject of the review | 10 weeks |
| Mother | Mother of subject | 18 |
| Father | Father of subject | 18 |
| Grandmother 1 | Maternal Grandmother | N/A |
| Grandfather 1 | Maternal Grandfather | N/A |
| Step Grandfather 1 | Maternal Step Grandfather 1 | N/A |
| Step Grandfather 2 | Maternal Step Grandfather 2 | N/A |
| Grandmother 2 | Paternal Grandmother | N/A |
| Grandfather 2 | Paternal Grandfather | N/A |
| Sibling 1 | Aunt | N/A |
| Sibling 2 | Aunt | N/A |

The child

2.1.2 Child A was born on the 14th July 2016. Birth weight was 3660g. Child A had normal bruising associated with a ventouse delivery, otherwise no abnormalities were found. Child A was the first born child to mother and father.

Family Dynamics

- 2.1.3 Grandmother 1 and grandfather 1 separated during mother's childhood. Mother lived predominantly with grandmother 1. The Lead Reviewer understands the relationship between mother and grandmother 1 was turbulent. Grandmother 1 had a diagnosis of depression and was prescribed anti-depressants; at times she chose not to take her medication and this, coupled with misuse of alcohol, led to deteriorations in her mental health. At these times difficulties arose between grandparent 1 and mother.
- 2.1.4 Grandfather 1 remained in contact with mother following his separation from grandmother 1. Grandfather 1 and step grandfather 1, on occasions, expressed concerns regarding grandmother 1's abilities to care for mother; in particular, managing mother's diabetes.
- 2.1.5 Grandmother 1 had other relationships following her separation from grandfather 1, mother has half siblings from two of these relationships, the lead reviewer is not aware of any details of mother's relationship with her half siblings.
- 2.1.6 Less is known regarding father's family. Mother indicated to professionals that grandfather 2 had 'hit' father as a child and was controlling of grandmother 2.
- 2.1.7 Neither mother or father had been on child protection plans or in Local Authority care as children.

Parental background

- 2.1.8 Mother was the eldest child born to grandmother 1 in 1998. Her parents separated when she was young; mother lived with grandmother 1 having contact with grandfather 1 throughout her childhood. Father's background is less well documented. Grandmother 1 has had other significant relationships and produced two further children. The middle child resided with mother and grandmother 1 for a number of years; it is believed the child now lives with her father (step grandfather 1), although the date of transfer of care is unknown to professionals or agencies. Mother has a younger sibling who remains in the care of grandmother 1 and its father (step grandfather 2); this child's existence was not known to many of the professionals involved with mother and father.
- 2.1.9 Father lived with his parents who, the lead reviewer believes, remained a unit throughout his childhood; it is not known to the Lead Reviewer, nor any of the agencies involved, if he has any siblings.

Background prior to period under review

- 2.1.10 The following section will provide relevant background information held within key agencies records predating the review period. There is no record of any CSC involvement with father and no specific health issues identified.
- 2.1.11 Mother's GP records contain evidence that between 1998 and 2004 there were a number of attendances for chest infections, ear infections, infected nappy rash, acute asthma, impetigo and scabies. Mother's parenting of her child may have been impacted upon by her own experiences as a child and so relevant contacts with professionals will be highlighted in this section.
- 2.1.12 In 2005-06 there are two contacts from mother's grandparents to the CSC suggesting grandmother 1's parenting and care of mother was causing concern, an allegation of alcohol misuse led to an assessment but the allegation was unsubstantiated. In 2006 there was a DART notification re a medium risk incident – it is not clear if mother (then aged 8) or her half sibling (then aged 3) were present during this incident.
- 2.1.13 In November 2009 mother was diagnosed with Type 1 Diabetes (aged 11). There followed a number of attendances to ED and admissions to hospital all relating to her diabetes. The following concerns were raised:
- Grandfather 1 raised concerns re mother's diabetic management whilst in grandmother1's care on two occasions.
 - Mother's consultant raised concerns in a letter to the GP that she was missing appointments, her diabetes was poorly controlled and she was non-compliant.
 - Grandmother 1 took mothers discharge against medical advice. Ten days' later mother was re-admitted with severe DKA¹, her blood glucose was too high to be measured.
 - Mother missed retinopathy² screening appointments required because of her diabetes. Three years after diagnosis professionals believed that mother was mixing her long and short acting insulins and not carbohydrate counting she was advised to

¹ DKA – Diabetic Ketoacidosis - is a potentially life-threatening complication of diabetes mellitus

² Diabetic retinopathy affects blood vessels in the light-sensitive tissue called the retina that lines the back of the eye. It is the most common cause of vision loss among people with diabetes

let grandparent 1 supervise her administration to insulin. Mother said she could not recognise a hypoglycaemic³ attack.

- Mother reported that she had been referred to CAMHS in view of grandmother 1's supervision at home, the fact that mother had a lot of time off school and had failed to attend several appointments as mother had reportedly been hiding the appointment letters.
- Grandfather 1 thought that mother was scared to mention to professionals what was going on at home.
- A CAF was completed at school due to concerns around poor diabetes management.

2.1.14 In 2010 there was an incident of domestic abuse between grandmother1 and her then partner – the children were not present so no further action was taken by CSC and it was deemed there was no role identified for Children's Social Care.

2.1.15 From 2013 – 2015 there was little contact between mother and professionals.

2.1.16 In September 2014 mother commenced college. In October care of mother's diabetes transferred to adult care; mother's HbA1c⁴ was 59 and she reported she was coping well with her diabetes. Mother demonstrated poor attendance at college; the college followed usual measures and in March 2015 mother left college.

2.1.17 During the summer prior to the review period there was a 999 call mother and grandmother 1 made allegations and counter allegations of assault. Mother alleged grandmother 1 drank a lot and suffered with depression.

Comment:

There was clear evidence of neglect of mothers' health needs during her childhood; she was also living in a household where the adults had longstanding issues with alcohol and depression and where domestic violence was a feature. There has been no direct input by CSC throughout mothers' childhood. Whilst there is evidence that family members referred their concerns to CSC, and information was shared by the police about domestic violence incidents, there were no referrals regarding grandmother1's neglect of mothers' health needs. An Ofsted inspection in 2016 found that Neglect was a significant feature in Dudley, but there was no partnership-wide strategy to address this,⁵ and that partner agencies did not fully understand thresholds.

³ Hypo - Hypoglycemia, also known as low blood sugar, is when blood sugar decreases to below normal levels. In people with diabetes levels below 3.9 mmol/L (70 mg/dL) is diagnostic.

⁴ HbA1c is a blood test which provides an important average measure of how well a person's diabetes is being controlled over the previous 2 to 3 months. For people without diabetes, the normal range for the hemoglobin A1c level is between 4% and 5.6%

⁵ Ofsted (2016) Ofsted single inspection of LA children's services and review of the LSCB

3 NARRATIVE AND APPRAISAL OF PRACTICE

3.1 Introduction

- 3.1.1 Section 3 provides a commentary on professional practice during the period under review.
- 3.1.2 To understand the rationale for professional practice, what happened is described, where possible, from the perspective of those professionals involved at the time. The information is derived from agency records, practitioners and information provided after Child A's injuries were sustained.
- 3.1.3 3.2 – 3.2.69 gives the details of what happened, broken into time periods. The commentary within the shaded boxes at the end of each time period is an appraisal of professional practice. Where such appraisal and explanation reflects a recurrent theme regarding the service provided, there is a cross reference to subsequent analysis and/or findings.

3.2 Case Summary

November-January 2015 – First Trimester

- 3.2.1 Mother attended A&E with erratic behaviour having taken legal highs and having not taken her insulin. This resulted in hyperglycaemia⁶ and vomiting.
- 3.2.2 Three days' later mother was taken to her GP by grandmother 1 who had found her in the garden after using legal highs. Grandmother 1 expressed her worries that mother did not want to stop and mother was angry with grandmother 1 because she felt grandmother 1 didn't trust her. The GP gave them contact details for the 'What Centre' counselling service.
- 3.2.3 A week later mother attended the GP approximately 4-6 weeks pregnant. Mother indicated she had stopped using legal highs.
- 3.2.4 Mother attended a joint antenatal/diabetic clinic. Mother indicated poor monitoring of her diabetes x 4 tests in the last week and her HbA1c was 93 (very high).
- 3.2.5 Five days later mother had a severe hypoglycaemic attack; she indicated to the paramedic in attendance, poor dietary control and failure to comply with medication. A referral was made to CSC.
- 3.2.6 Two days later mother again attended A&E; mother indicated she was 6-9 weeks pregnant she had taken legal highs and was not taking her insulin, she was hyperglycaemic. The following day mother had another severe hypoglycaemic episode, records indicate this had occurred on 4 consecutive days. On the same day mother attended her antenatal booking appointment, she indicated she was unsure of her dates and reported smoking and drug misuse until one month ago. Mother stated she had good support from her partner but their parents were not sure about the pregnancy. Being under 18, mother met the criteria for FNP, a home visiting programme providing on-going intensive support to first-time young mums and families, and was therefore referred to Family Nurse Partnership (FNP).

⁶ Hyperglycaemia – abnormally high blood glucose

- 3.2.7 A single assessment in line with Working Together 2015 was undertaken by CSC which concluded that mother was able to understand fully the impact of not managing her diabetes on her unborn baby. Both grandmother 1 and mother reported having a positive relationship, and that mother would receive her primary support from grandmother. Father was mentioned as someone providing support, but no background details were obtained. The relevant health services in respect of the management of her diabetes and the midwifery services were contacted.
- 3.2.8 An initial visit by CSC to the family was carried out. During the course of the assessment grandmother 1 was spoken to about the history of domestic violence and she reported that she had a history with a previous partner in 2003 where she made a decision to move to a refuge to protect herself and her children. There was no mention of the domestic incidents reported in 2006 and 2010, and this was not raised by the social worker completing the assessment.
- 3.2.9 Grandmother 1 also admitted that both she and her current husband were experiencing issues and misusing alcohol. Grandmother 1 stated they were trying to manage these issues themselves; grandmother 1 acknowledged that the use of alcohol impacted on her mental health.
- 3.2.10 Grandmother 1 indicated that her relationship with mother was fragile, due to 'previous trauma'; there was no probing as to what this meant. There were also concerns raised by grandmother that mother had suffered the bereavement of both of her maternal grandparents and had not yet come to terms with this. Mothers relationship with her birth father had also recently broken down.
- 3.2.11 Case direction after that assessment visit was very clear; the management decision concluded that, "There are clearly concerns that mother is self-harming refusing to take her medication placing herself at risk of harm and that of her unborn. There is a history of social care involvement within the family home of DV whilst there was a gap between 2006 to 2010 again DV it may indicate that mother is exposed to parental conflict and this may have impacted on her emotional wellbeing. Assessment should gather her wishes and feelings exploring her views and feelings of self-esteem. It is not uncommon for young people to struggle with medication and not take appropriately assessment should include liaising with health professionals to ensure appropriate support is in place and exploration of support groups".
- 3.2.12 A further social worker visit took place. It was recorded that mother was being supported by grandmother 1 and the relationship between the two was much better mother felt positive and she had turned a corner. Mother was accessing support from the midwife and the social worker discussed the possibility of a referral to the FNP. Mother reported that paternal grandparents were unhappy about the pregnancy and would not allow mother into their home. Grandfather 2 was reported to be controlling and grandmother 2 submissive; father, was not looking to them for support, and was of the view that grandfather 2 was a negative influence.
- 3.2.13 In January 2016 mothers' diabetic consultant noted concerns about mother's low mood, and poor self-management of her diabetes. A referral was made to the Specialist Midwife for Vulnerable Women. FNP received a pregnancy referral from midwifery; no concerns were identified by the referring midwife. Within 10 days the FNP nurse made contact with mother and arranged a visit. Mother attended a joint antenatal/diabetic clinic appointment, – use of legal highs, smoking and diabetes were disclosed. Mother had a positive urine toxicology for legal highs, the sample

was negative for all other substances. The following day both mother and father met with the FN at grandparent 1's house; mother and father were both enthusiastic regarding the FNP programme. Mother indicated there had been a recent referral to social care following a hypoglycaemic attack where she had refused care by the ambulance service. Mother reportedly relented and met with a social worker, Mother reported no outcome from the referral. Three appointments were made with the FN, however the first appointment was cancelled by mother.

Comment:

There were a number of occasions when the GP and ED staff could have made referrals to CSC in respect of mother who was a child in her own right (17). Mothers behaviours were placing her life, and that of her unborn baby in danger.

The referral from the Ambulance Service to CSC provided an opportunity for a comprehensive multi-agency pre-birth assessment with associated strategy meeting/discussion. Had this taken place all agencies would have had a clearer picture of the family unit and an opportunity to tailor their services accordingly. There were shortcomings to the CSC single assessment which was completed over two months. The assessment didn't include a discussion with father, didn't consider all members of the household and there was limited contact with health professionals, some of whom were unaware any assessment was taking place.

The referral from Midwifery to FNP was completed on the agreed referral form but not completed in full. The form is designed to be brief and requires the person completing the form to give full consideration to what information is relevant to include. There was no reference to mothers' recent drug misuse, the Ambulance referral to CSC or the outcome; it contained scant information. This limited the FN's knowledge of the family and reduced opportunities to consider developing issues in the context of what was already known about the family.

Opportunities presented themselves for mother to be referred to Switch, a local substance misuse service for young people in Dudley, for use of legal highs; there is no evidence this was considered by either ED staff or the GP. Professionals accepted mother's self-report that she had stopped using legal highs.

Opportunities to follow up whether mother had contacted the counselling service offered previously were not taken.

The reasoning behind mother's poor management of her diabetes is not recorded. Mother had been diabetic for 7 years at this stage. Mother's HbA1c is very high indicating poor long-term control of her condition, 48 would be good control. It is not unusual for teenagers to demonstrate poor control of their diabetes, research has shown missing shots is related to the desire for control⁷. In the context of mothers circumstances, it would have been helpful for health professionals to pursue this further. Adolescents face numerous obstacles to adherence, including developmental behaviours, flux in family dynamics, and perceived social pressures, which compound the relative insulin resistance brought on by pubertal physiology⁸. Mother was experiencing many changes as a result of puberty and pregnancy at a point of particular instability in her family. It is likely some of her behaviours were learned

⁷ Weissberg-Benchell, J et al (1995) Adolescent Diabetes Management and Mismanagement

⁸ Borus, J.S and Laffel, L (2010) Adherence challenges in the management of type 1 diabetes in adolescents: prevention and intervention

behaviours. It has been found that Motivational interviewing can effect behavioural changes in teenagers with type 1 diabetes with subsequent improvement in their glycaemic control, however this can only be undertaken if the teen engages and attends their appointments⁹

February – April 2016 – Second Trimester

- 3.2.14 In February 2016 Grandmother 1 contacted the police as mother was late home. The Police contacted mother who reported she had missed her bus; grandfather 2 was going to give her a lift home; mother was not recorded as missing but the police incident was kept open until she returned home.
- 3.2.15 Both mother and father were present for a home visit by the FN. They were excited about the baby but reported a mixed response from their families. The couple indicated they were reducing their smoking. There was no mention of other substances. The couple identified they had six supporters.
- 3.2.16 CSC made a decision to close the case recording, “There is plentiful support in place for mother and her unborn child. She is being supported by her mother and stepfather with whom she lives, and her boyfriend is also supportive of her. Professionally, mother has the support of the midwife (health visitor upon child being born), her diabetes consultant and diabetic nurse. A Children's Centre is situated locally and mother and baby can access support and courses from the Centre - health visitor can support with this. Mother is aware that the case will be closed to Social Care, as there are now no safeguarding concerns which warrant ongoing involvement from this Department. Case to be closed – No further action.”
- 3.2.17 Mother attended her joint antenatal/diabetic clinic appointment and reported random hypoglycaemic and hyperglycaemic episodes all self-corrected. Mother reported a history of taking legal highs. There was a second cancellation of an FNP appointment which was attributed to typical behaviour characteristic of a teenager.
- 3.2.18 In March 2016 the FNP nurse made 3 attempts to re-arrange the appointment – Mother reported they had a sickness bug and had been busy with visiting family but agreed to a visit. Mother attended the joint diabetic/ antenatal appointment; her urine glucose level was very high. It was reported mother’s hand held ante-natal notes had been lost. Mother and father were not at home when the FN visited; grandparent 1 was tearful and concerned she had not seen much of mother who had been kicked out of college.
- 3.2.19 The MW and FN shared contact details for mother and discussed their concerns. The MW felt mother was hiding from her clinic appointments. They planned to discuss their concerns at Unborn Baby Safeguarding Network (UBN) meeting the following month.

⁹ Channon, S.J et al (2007) A Multicenter Randomized Controlled Trial of Motivational Interviewing in Teenagers With Diabetes. Diabetes Care Jun 2007, 30 (6) 1390-1395; DOI: 10.2337/dc06-2260

- 3.2.20 Mother attended GP smoking cessation and reported grandparent 1 was kicking her out of the house. Mother stated grandmother 1 was not taking her medication and drinking. This information was shared with the CMW and FN.
- 3.2.21 Mother informed the FN grandmother 1 had kicked her out and she was living with father's parents. Mother requested advice regarding housing. FN advised mother to go to the council. Mother was very anxious regarding her relationship with grandmother 1 and her accommodation issues. Mother reported grandfather 2 had hit father in the past. Mother reported her smoking had reduced to two cigarettes a day but that she used street drugs on 7 out of the previous 14 days, six times on each of those days. A Hospital Anxiety and Depression Score tool was completed, mother's score indicated no further action was required.
- 3.2.22 Six days later the FN referred mother to supported housing and made a visit to the couple. Mother reported they continued to smoke but were drug free and didn't want support. Mother reported she was staying with her Grandfather but was unable to supply an address, mother appeared reluctant to live independently and just wanted Grandmother 1. Mother expressed fears that the baby would be taken away; she was very tearful but declined GP contact. The FN discussed the case in clinical supervision with a decision to consider CAF. The FN contacted Switch to discuss the implications of mother quitting legal highs. The FN was told there would be no physical effects however there was a possible psychological dependency; there was a lack of evidence of the impact of synthetic cannabis on the unborn at that time. The FN was advised to believe mother if she reported abstinence.
- 3.2.23 In April 2016 there was a reported improvement in the relationship between mother and grandmother 1. The couple attended an antenatal appointment and a further appointment was arranged to complete a new set of notes. Mother's average blood glucose readings remained moderately high at 7.8. The MW informed FN 1 of her concerns re mother's "scatty approach".
- 3.2.24 The FN saw both parents three times at grandmother 1's over the month. Mother signed a supported accommodation referral and agreed to a CAF which commenced. Mother reported no use of legal highs. The FN contacted the supported accommodation and was informed Mother had indicated to a housing worker that she had taken an overdose during the previous November and that she couldn't be left alone because of her diabetes.

Comment:

The Police, whilst not registering mother as a missing person, demonstrated care and concern for mother's welfare. Not registering mother as missing in the circumstances did not breach the force missing person procedure; however, had they notified CSC they would have found the case was open to CSC and other professionals could have been alerted to a change in mothers' circumstances.

Mother was residing with fathers' parents, having previously identified relationship difficulties; it is not clear when/if these issues were resolved. Mother was indicating to professionals that she had used legal highs and at one point indicated a marked increase in usage. Each of these occasions provided an opportunity for professionals to explore this further and seek advice and support for mother and ultimately for Child A. The lack of research and known side effects of the drugs mother was reporting to be using, coupled with the fact these drugs were termed 'legal', influenced the professionals thinking and actions/inactions in this case. Despite mother's disclosure that she had used street drugs for 7 out of 14 days, when abstinence was indicated 6

days later this was believed and no onward referrals were made. The lack of referral is understandable because of the advice given by Switch, to believe mother if she reported abstinence. The practitioner informed the lead reviewer mother had looked better. The practitioner had used her clinical skills and experience in her decision making on what actions to take. The lead reviewer believes a degree of healthy scepticism was still required, coupled with greater understanding of mothers need for specialist treatment and support.

Mothers antenatal handheld records went missing; this may indicate a degree of chaos, could be evidence of control within the relationship but was believed by professionals to be due to mother being 'scatty'.

There is evidence of instability in key relationships; grandmother 1 is alternately expressing concerns for her daughter and then asking her to leave the family home. Mother is expressing anxiety re independent living, just wanting to be with her mother; there appears to be an unhealthy co-dependency in their relationship. Mothers behaviours deteriorate when her relationship with grandmother 1 breaks down and her overall situation becomes less stable.

May –July 2016 – third trimester

- 3.2.25 The following month a Professional networking meeting was held. Mother and father were to be offered floating support (FS) from housing. FN continued to meet with the parents and liaise with other professionals, a CAF was completed. Mother continued to report no illicit substance misuse. FN requested FS with benefits and emailed the CAF to the SPA team. Information was shared that family nurse partnership planned to initiate the CAF process, but there was positive engagement with services at the time. Historic concerns for mother's mental health, management of her diabetes, substance misuse and housing were all shared and the fact that mother was residing with grandmother 1 who suffered with depression. A management decision was made in CSC that the case met the threshold for Early Help level 2 (CAF now known as Early Help).
- 3.2.26 Mother attended the joint antenatal/diabetic clinic – Mother's diabetes control was much improved. Mother was advised to increase insulin if blood sugar level's continued to be high in the morning.
- 3.2.27 After a few settled weeks the relationship between mother and grandmother 1 started to deteriorate again. Mother reported grandmother 1 using alcohol and not taking her anti-depressants. Mother missed an antenatal appointment with the MW due to late arrival. An Early help meeting was arranged for June, neither Diabetic Nurse or the Midwife can attend. The case was discussed at the UBB network towards the end of May. Mother attended a GP antenatal clinic. Mothers' urine was negative for all substances including street highs. Mother reported nocturnal hypoglycaemic attacks.
- 3.2.28 In June 2016 Early help commenced, Mother was reported to be engaging with antenatal/diabetes treatment and attending appointments, partner was reported supportive. The group were looking at supported housing. Mother reported reduced smoking and no use of legal highs. Liaison and information sharing between services was facilitated by the FN. During July 2016 there was appropriate engagement with professionals. Parents were working well with FNP programme.

Comment:

Whilst there is clear evidence that the agencies were coming together to put a support package together for the couple and beginning to work together, there is a lack of analysis of the issues. Issues are described as historical; whilst some of the issues had their origins in the past, they were ongoing. There is a sense that the professionals are “starting again” rather than continuing involvement in an ongoing case. The professionals are reporting on a short period of relative calm and are not placing this in the context of how the family operates. It can be difficult for professionals to stay objective about a family when they are working closely with them. The use of reflective supervision is a way of assisting however only the FN discusses this case in supervision.

Post birth – the first six weeks

- 3.2.29 Child A was born following induction in mid-July; Birth weight was 3660g Child A had bruising to the head from a Ventouse delivery. Mother had an Episiotomy. They were discharged to grandmother 1s. Mother was iron deficient. Mother and Child A were readmitted 6 days later for maternal perineal infection which was treated with antibiotics.
- 3.2.30 Mother reported to the FN that Child A had also been reviewed at Hospital around the same time due to concerns re breathing and a possible heart murmur.

Comment:

There is no corresponding entry at the Hospital suggesting this might not be true.

- 3.2.31 Father took Child A to the Urgent Care Centre because he had noticed the umbilical stump had become scabbed and a small amount of discharge. The Doctor noted Child A was a well-baby, took a swab of the discharge and discharged Child A. The following day Father took Child A to the GP with white patches on the tongue; this was curd and there were no signs of oral thrush.
- 3.2.32 In August 2016_mother attended the GP with a painful perineum; she was prescribed antibiotics for infection. A few days later mother reported to the FN feeling tired and tearful, arrangements are made for her mental health (depression) to be reviewed. Child A’s weight was on the 75th centile.
- 3.2.33 Mother cancelled an appointment with the FN which was re-arranged and took place 4 days later. Child A had a cough and parents were advised to take Child A to the GP if they were concerned. Mother indicated she was not happy with the GP and local options were discussed. Child A’s weight was dropping slightly from 75th centile mother was planning to try SMA comfort formula. Father left during the FN’s visit for an appointment. Mother presented as flat in her demeanour; a HAD¹⁰ assessment of depression was completed indicating mild depression. Mother agreed to access the GP with the support of grandparent 1. Mother reported she was having some relationship issues with father.
- 3.2.34 Mother attended the GP and was diagnosed with Post Natal Depression and prescribed anti-depressants.

¹⁰ Hospital Anxiety and Depression Scale

- 3.2.35 The couple were offered a place at supported accommodation and were reported excited re the pending move.
- 3.2.36 A week later mother had her 6 week check. Mother had problems with the episiotomy since delivery. Mother had taken multiple Antibiotics, there was breakdown of the wound, which was red and painful.
- 3.2.37 Mother's diabetes was reviewed, she reported a history of taking illegal highs complicated by unstable diabetes however there was no indication of her current status.

Comment:

When father left for his appointment an opportunity presented itself to explore further the relationship issues; this was a missed opportunity.

Mother took a considerable length of time to heal post-delivery, it is not clear whether all explanations for this had been fully considered. Possible explanations are:

- *Poorly controlled diabetes*
- *poor general health*
- *anaemia*
- *potential sexual abuse/assault*

No referral was made for mother to receive counselling or talking therapies following diagnosis of depression, and no screening tool was used to assess the severity of mothers' depression by the GP.

Mother made a comment about being excited about the pending move into supported Accommodation, days after stating she and Child A's father were having relationship issues – professionals did not explore this further.

The move to and time in supported accommodation

- 3.2.38 The following month a FN visit was cancelled by mother. Child A was taken for 6 week check with the GP by mother. FNP support was noted. No developmental concerns were noted. The following day the FN received a telephone call from mother who was very distressed and stated they had been told to leave the family home by grandmother 1. Mother reported there had been a delay on the supported accommodation but they were next on the list and this delay had led to a break down in mother and grandmother 1's relationship. FN 1 made phone calls to agencies to assist mother, visiting the following day. Child A's weight had dropped to the 50th centile, all measurements were now on the 50th centile. Father was seen handling Child A sensitively. Mother reported an improvement in Child A's routine.
- 3.2.39 Two days later the family had already moved into supported accommodation. There were early concerns; father reported damage to the property, repairs and cannabis use threatened the tenancy. The couple had little furniture and offers were made to apply to charities.
- 3.2.40 The following day the couple had to be assisted to settle Child A. Mother requested staff attend the flat following an argument with father. Mother was sitting on floor next to Child A very upset and crying, she stated she could not cope anymore and did not want to feel like this. Contact with the FN was offered and accepted by mother.

- 3.2.41 Later the same day Child A attended A&E with father who stated that the baby was continually crying, not taking feeds and looked pale. Father was crying. Mother, reportedly, had not attended as they couldn't afford the bus fare. The triage nurse reviewing Child A wrote 'it sounds like parents not coping'. A Dr saw baby and noted that baby had gained weight. The Dr wrote a diagnosis of viral upper respiratory tract infection, possible Gastro oesophageal reflux and feeding problems due to giving the milk too cold. Feeding advice was given and baby was discharged. A Paediatric Liaison service referral was made for advice and support from the health visitor.
- 3.2.42 The following day father reported he had caused damage to the flat –he had smashed a hole in a wall. Child A was seen with mother in the flat. Grandmother 1 and mother 's youngest sibling were present. Discussed damage, anger management and supported housings' Safeguarding process initiated as Child A was present when the damage was caused.
- 3.2.43 Supported housing contacted the FN to advise that mother and father had moved into supported accommodation on Monday and that there had been a domestic incident involving father in which he had caused damage to the property and had reported it to staff shortly after father had done it.
- 3.2.44 Housing staff reported to the FN that mother had 'broken down' as mother felt they were not bonding with Child A; mother was reluctant to take her anti-depressant medication. The professional agreed the following actions: Housing worker to see how mother was feeling today and the FN would contact mother to arrange an earlier visit and attend a G P appointment with mother if she agreed.
- 3.2.45 Mother reported to the housing worker father had not been violent towards her in the past, but had thrown things. Father was to discuss removal of his name from tenancy agreement. It was agreed the housing worker and FN would speak in three days, after the weekend, to arrange an Early Help meeting to support mother.
- 3.2.46 Three days later the FN had a telephone update with the housing worker and was advised the FN planned to visit and agreed to attend the Early Help meeting convened for later that afternoon with father and mother to discuss the recent domestic incident. Supported housing had not referred to social care, and there was an open discussion re additional agency involvement.
- 3.2.47 The FN visited mother's home address, mother, father and Child A were present. Infancy visit completed as per FNP schedule. Mother and father advised the FN Child A had just been fed. The FN observed Child A to be sleepy and being handled gently by father during the visit.
- 3.2.48 The FN explored with mother and father around their tenancy, father reported they would be spending the nights at their respective mum's.
- 3.2.49 Child A's Weight was 5.30 kg (below 50th centile). It was noted Child A's weight was down on the centile and this was discussed with parents. Mother and father reported that Child A had been unsettled and not feeding as well and mother reported Child A had attended ED and had been seen by a doctor who had diagnosed a sore throat and possible reflux.
- 3.2.50 Mother pointed to 2 small pinprick marks to Child A's right arm, mother was unable to explain them. The FN was uncertain as to the origin but thought they may relate to the possible viral infection diagnosed by the doctor at the hospital. When father

lifted naked Child A prior to placing onto the scales, mother pointed to 2 small red dry patches to the right side of the spine. Father and mother stated they had not seen the marks before. The FN did not know what they were so attempted to obtain a GP appointment via telephone but no appointment was available despite the FN stressing concerns, they were advised to access emergency care via ED. The FN advised that mother and father accessed the emergency care centre for a medical review. Mother was tearful at the visit and was advised to review her mood with the GP; mother was reluctant to access her GP or take the medication previously prescribed. The FN also discussed the recent domestic incident and the impact on young babies of any parental tensions and domestic incidents. The FN reviewed patterns and expectations on babies and baby cues as per FNP programme schedule. Mother and father agreed they were having some relationship issues and agreed they needed space. Grandmother 1 had agreed to baby sit for them so they could go out with friends.

- 3.2.51 The same day there was a meeting between, a Manager from supported housing, mother, father and Child A. They discussed the implications of father's recent damage to the property, his honesty was acknowledged and father admitted he can get angry at times. The FN reiterated the impact of domestic incidents on young baby's and that other agencies may become involved. They explored around help for father's anger and father agreed to stay on the tenancy agreement. It was agreed to arrange an Early Help meeting for the next month. Parents were reminded of the need to review Child A with a doctor.

Comment:

Father causing damage to the property provided an opportunity for housing staff to make a child protection referral. NB: Referral for anger management outside of a child protection plan would not have been an appropriate action for a perpetrator of domestic abuse.

Admission to Hospital

- 3.2.52 Child A attended the ED. The following was noted "2 x red and round patches were noted on Child A's back. Looked grazed. Also 3 x pin prick purple marks to lower leg. Non-Blanching. Difficulty feeding. Wet nappies. Bowels open 1/7 ago." Father wanted to take Child A home as they had run out of milk and there would be no buses running soon. A Paediatric liaison form was completed in case of non-accidental injury (NAI) and also because father wished to take Child A's discharge when he thought they had been waiting too long. In the end father agreed to stay.
- 3.2.53 Child A was admitted to the Paediatric Ward where 2 red marks on back were noted, 1 non blanching spot on leg and right side of cheek. Record states no bruising noted. Diagnosis was Gastro oesophageal reflux disease, friction burns on back. Parents were arguing and swearing at each other when staff were not in the room. Child A was reviewed by the registrar who asked for a family background check to be made with Children's Social Care and Child A to be seen by a consultant in the morning. Mother was resident overnight and provided care.
- 3.2.54 The following day Child A was seen and examined during Consultant 1's ward round. 2 abrasions were seen on the back, 1 bruise on left shoulder a second bruise medial to it and a bruise on the left knee. Parents gave possible explanations for the marks

as a rough covering on the sofa or lying on the carpet naked. A doctor had documented nurses to check with children's social care. Parents were seen by consultant 1 and advised that Child A would require specific investigations due to unexplained bruising, a referral to children's social care and photography. A Senior nurse made a check with children's social care and spoke to an administrative member of staff and was advised that Child A was not known to children's social care.

- 3.2.55 Child A was examined by the Paediatrician covering child protection that week with Consultant 1 who saw Child A earlier. A similar story was given and the marks were documented with an additional comment that the bruise on Child A's left shoulder and the marks on the back could be accidental or non-accidental injuries (NAI). The advice given was that the investigations already ordered were to be completed and a formal referral to children's social care was to be made. Child A was not for discharge until children's social care had cleared it.
- 3.2.56 The FN received a call from mother. Mother reported hospital staff were concerned about the cause of the marks and were considering if they were non-accidental. Mother reported the hospital were planning a CT scan, X-Rays and a referral to social care. Mother reported she was going home to collect some things for Child A while father stayed at the hospital. The FN reminded mother of their planned visit next week.
- 3.2.57 At 23.45 the nurse noted that Child A seemed very unsettled; father was with Child A and giving all care.
- 3.2.58 The following day the FN and FN supervisor had Clinical Supervision. FNS completed Kolb cycle¹¹, ongoing key issues summary and the seven P's with the FN. They explored the current safeguarding issues, mother's low mood, emotional captivity and relationship issues with father and grandmother 1. Advised to inform BCPFT safeguarding children's team, update the G.P, liaise with social care as appropriate, and to make enquires with regard to anger management locally for support for father and encourage mother to seek support.
- 3.2.59 The following day mother was admitted with 3 to 4day history of worsening breathlessness. Taking salbutamol "constantly". Condition deteriorated and transferred to High Dependency Unit with diabetic ketoacidosis.
- 3.2.60 The following day a senior nurse had written that bruising to Child A's face appeared more evident today across eyes and nose. A medical registrar was informed and was aware of this. Father was very upset as mother was in HDU with breathing problems. Grandmother 1 was present and stated there were new marks under Child A's left ear since yesterday. On examination there was bruising to Child A's face and ear not previously documented. The results of the skeletal survey were followed up and. Showed fractures to the lower legs. Consultant 4 requested that children's social care were informed. At 8PM. CSC noted a contact from the Hospital with an update.

¹¹ Kolb is a learning cycle with four elements Experience-doing it, Observations and reflections-reviewing and reflecting on the experience, Development of ideas- learning from the experience and Testing ideas in practice- planning, trying out what you have learned.

- 3.2.61 A strategy discussion was held between EDT and the police. Child A had been admitted to ED with marks to the back, this was potentially an unexplained injury. CT and skeletal scan took place which revealed two fractures of the legs, extensive bruising to the child's face, marks on the back, a scratch mark under the chin and abrasion on the neck. The duty social worker advised there be no contact from the parents.
- 3.2.62 Father was advised of this. Before leaving the ward father had a long conversation with another patients' parent who stated she was a child protection solicitor and gave him detailed advice with telephone numbers of people to contact regarding his situation.

Comment:

During admission there were opportunities for community staff to communicate and inform hospital staff of recent concerns. Whilst the FN had a conversation with the paediatric liaison nurse, there was no direct conversation with ward staff or from other community workers.

Deterioration in mother's health during Child A's admission might have been due to stress caused by the situation, however staff were not aware of her admission until it was reported by father. There was no communication between primary care and secondary care at this time.

There was a lack of:

- *a bruising protocol for non-mobile infants*
- *progression and oversight of the paediatrician's plans around referrals and investigations – this led to a request for information rather than a referral*
- *Lack of risk assessment which ultimately led to a situation where Child A could, and did, suffer further harm*

- 3.2.63 A Joint Section 47 Investigation commenced on the day of referral. Parents were to have no unsupervised contact, Child A was not to be discharged without police and children's social care consent. Police attended the hospital and spoke with both parents. Father has been asked to leave the hospital by police.
- 3.2.64 Both parents were spoken to at the police station the following day. The Police log states Child A presented at hospital with injuries. During admission time, a number of possible non-accidental injuries were recorded. Investigation into how these injuries occurred was ongoing.
- 3.2.65 The following day mother was informed of the findings from the skeletal survey and children's social care involvement. Grandmother 1 was then informed by mother who rang the ward upset. A written referral to children's social care was emailed. Police spoke to consultant 4 on the ward. The GP was contacted by the medical ward, Mother had been admitted with an acute and severe asthma relapse. Mother had gone into DKA and been transferred to High Dependency Unit; Intra-Venous steroids were required. Subsequently a discharge letter was received by the surgery. The safeguarding issues with Child A were reported. Child A was to be transferred to foster carers with no current contact with mother or father.
- 3.2.66 Three days after the S47 commenced there was:
- a discussion between CSC and supported housing – information shared; the couple had only been there two weeks. Prior to this mother was living with her parents and father was living with his parents. Several days after they

moved in there were concerns and the housing support worker wrote an incident of concern form. The couple had a row and father punched a hole in the wall. Mother said she was scared of him as he throws things at her. Mother told the housing support worker that father frequently loses his temper. They had held a meeting four days earlier to discuss these concerns. A home visit completed by the FN who saw the marks and advised mother to take Child A to the hospital. They were not aware mother had been admitted to hospital.

- The FN telephoned the Named Nurse for advice.
- The FN had a telephone call with the SW and, advised Child A's injuries were deemed non accidental. Mother and father were to have no contact with Child A. Police involved.
- A Strategy Meeting was held. Child A's marks were deemed to be non-accidental, further bruises/marks noted on the day prior to referral and the day of referral – mother and father advised of no contact from the date of referral. The results of the skeletal scan revealed 2 distal tibia fractures to the right and left leg. Father had been spoken to by police and mother was due to be spoken to. Awaiting blood results, second opinion and dating of fractures. Plan: Child A to be discharged to foster care, parental contact supervised by social care, child protection conference to support care proceedings, further meeting once all actions are in place.
- Visit to Child A by social worker at Hospital. Child A had some darkening under the eyes and a clear bruise on the right cheek. The Dr stated that she did not believe there could be any other explanation than non-accidental injury and wrote a note to this effect in Child A's notes. A Dr then attended and performed a full examination of Child A. Section 20 discussed with mother; mother was distressed and given opportunity to reflect and consider the section 20 agreement overnight so that she could rest and make an informed choice after discussing the matter with father. Father was noted to be calm and casual.

3.2.67 The following day both parents were advised to seek legal advice and arrangements were made for supervised contact the following day. Parents were to have 1 hour supervised contact daily until an Interim Care Order was gained.

3.2.68 Child A developed no further bruising.

3.2.69 Two days later an interim Care Order was granted and Child A was discharged into Foster Care.

Comment:

From the point the referral was made and a S47 investigation commenced, the case was progressed in line with DSCB procedures and Child A was safeguarded from further harm. The social worker allocated to the case was given sufficient time and managerial support to progress the case and partner agencies contributed and worked well together.

4 ANALYSIS OF THE KEY ISSUES, FINDINGS AND RECOMMENDATIONS

4.1 Introduction

- 4.1.1 This section analyses the events that occurred up to diagnosis of non-accidental injuries, and looks at why actions or decisions were made, trying to identify when practice strayed from what was expected, or was significantly good. It is always easy in hindsight to say what might have happened; where anything looks inexplicable, evidence of what staff' thought processes were at the time has been sought. Although this SCR will appraise practice, the overall purpose is to identify areas of practice that can be improved or from which others can learn. The analysis is done chronologically, where practical, as a way of considering whether a difference could have been made in this case; each of the questions in the Terms of Reference is borne in mind during the analysis. Showing areas of concern in the context of the case serves to demonstrate real risks, not just theoretical learning points. Recommendations from this SCR overview are in bold italics.

4.2 Parental Distress

- 4.2.1 This section covers the question; was there a lack of professional inquisitiveness and curiosity around Child A's first presentation to hospital?
- 4.2.2 When father took Child A to hospital on the first occasion fathers' distress was evident to professionals. Research shows that entry into hospital can be a reason for parents to get stressed and upset¹² so it is not unusual for parents to be tearful in ED. Understanding the cause of distress and putting that in context requires an assessment by suitably qualified staff. ED staff informed the paediatric liaison nurse who completed a form to share with community staff, in line with policy, however relying on this form of communication can have difficulties. This form was not received by its intended recipient for twelve days by which time Child A had suffered serious harm.
- 4.2.3 Forge¹³ (2010) found that "in the case of EDs, written documentation can be unclear, insufficiently focused on the child, illegible and incomplete. Risk factors are not always recognised and existing written records may not provide a format that enables staff to record information comprehensively. Shortcomings in documentation may create multiple difficulties for another agency or professional to which the child is referred. Inaccurate accounts may lead to the failure to safeguard a child". Whilst the ED recordings are electronic the Paediatric Liaison forms are not.
- 4.2.4 Mother did not attend with the child which is unusual for two reasons, the couple had only one child and Child A's age. The reason behind this were explored by triage staff, father indicated this was for financial reasons as they couldn't afford the bus fare however reception record they came via car; this was not challenged. There is nothing recorded to indicate fathers distress or mothers' non-attendance prompted further exploration by the doctor. Child A and father were seen by a locum ED doctor not a regular member of staff nor a paediatrician. Child A and father left the

¹² Shields. L. (2001) A review of the literature from developed and developing countries into the effects of hospitalisation on children and parents.

¹³ Forge, J. (2010). 'Safeguarding children by means of information sharing.' Community Practitioner, 83 (1),16–19

department in the early hours of the morning. Admission to Paediatrics for observation overnight was an option open to the attending doctor. It has not been possible to discuss this with the doctor, as he was a locum and was not contactable, to understand why Child A was not admitted.

- 4.2.5 FNP were aware of some of the dynamics within the family and had completed a depression questionnaire with mother, but the couples' abilities to cope and care for Child A independently were masked until they moved into supported housing. There had been no concerns regarding father's ability to cope or mental wellbeing until that point, indeed father had been noted to handle and respond well to Child A.

Finding: Current management of parental distress is not sufficiently robust. Children must be seen by suitably qualified paediatric staff in secondary care services. Whilst completion of a paediatric liaison form will alert community staff over time, direct contact is required in specific circumstances. Health professionals are trained to consider signs of distress and depression in new mothers, however assessments of mood and depression in fathers, who might also be struggling, are less likely.

Recommendation 1: The DSCB and its health partners to consider whether current practice in the ED department, and the paediatric liaison service are meeting recognised safeguarding standards¹⁴.

4.3 Parental Backgrounds

- 4.3.1 This section will consider the following issues: How can we better understand parent's backgrounds and relationships and incorporate them in assessments and plans?
- 4.3.2 It is only through the comprehensive use of assessment tools professionals can make sense of parents backgrounds and relationships and understand how they may affect parenting. In this case mother had a significantly troubling background lacking in care and stability. She had experienced domestic violence between grandmother 1 and her partners during her life. In addition, grandmother 1 had a longstanding, fluctuating alcohol problem and suffered from depression. In short a trio of vulnerabilities, the 'toxic trio'¹⁵ were mothers lived experience. How parents have been parented can be a predictor of how they may parent. Newcomb and Locke (2001)¹⁶ have explored the intergenerational transmission of child maltreatment in a sample of 383 parents and found that child maltreatment was related to poor parenting for both mothers and fathers.
- 4.3.3 The ability of grandmother 1 to meet mothers' needs had been a cause for concern for her father and step-father and although referrals had been made to CSC, mother had not been the subject of a CP plan or received any additional support from services as a result.

¹⁴ RCPCH (2012) Standards for Children and Young People in Emergency Care Settings

¹⁵ Brandon et al. (2009) Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07

¹⁶ Newcomb, M.D. & Locke, T.F. (2001). Intergenerational cycle of maltreatment: a popular concept obscured by methodological limitations. *Child Abuse & Neglect*, 25, 1219-1240

- 4.3.4 Health staff also had concerns regarding care of mothers Type 1 diabetes and her long-term control was poor. Grandmother1's failure to take mother to appointments was flagged up by secondary care to the GP however at no point was referral into CSC considered by professionals. In the practitioners' event health staff were of the opinion CSC would not have acted on failure to attend health problems having experienced being told it was a health problem. CSC staff were clear that they would act on failure to attend appointments if they understood there were likely serious implications of this for the child. In mothers' case she was, at times, at risk of death and her life expectancy may have been impacted by the sub-optimal care of her condition throughout childhood.
- 4.3.5 Fathers background was largely unknown to professionals involved. Mother provided some information to health professionals which suggested father too had a troubling background being witness to domestic violence however no professional spoke to father about his history.
- 4.3.6 Parents histories are useful guides for professionals as to their likely needs and as a potential indicator of their own abilities to parent. It is essential for services and individuals to be proactive in ensuring they have sufficient information to be able to complete their assessments and plans holistically.
- 4.3.7 There is evidence that the professional's involved with the couple, during the timeframe of this review, were aware of some of the historical information in particular grandmother 1's care of mother however, there is little evidence that this influenced their thinking around any limitations this might have had on the support offered to the couple post Child A's birth. It is a challenge for professionals to remain cognisant of the limitations of grandparents whom have traditionally been seen as supportive.

Finding: Current assessments are biased to assessing mothers rather than assessing both parents. Parents have joint parental responsibility and as such should be seen as of equal importance by professionals.

Recommendation 2: DSCB and its partners to review current assessment tools to ensure they place importance on assessing both parents robustly.

Finding: Obtaining fathers past histories, understanding their behaviours and issues, and considering them in the context of a families likely functioning, is a challenge well known to professionals. There is a likelihood that fathers will remain unknown to professionals because of the way services are currently designed and delivered.

Recommendation 3: DSCB and its partners to consider how best to eradicate gaps in and between the services delivered to unborn babies, and strengthen relationships thus improving the interface between services and agencies. Consideration should be given to how social workers can be best involved in the antenatal phase. Consideration should also be given to the lead professional role and its allocation to the most appropriate professional.

4.4 Communication

- 4.4.1 This section will consider how can we create stronger multi-agency communication systems to identify and intervene in situations of abuse and neglect. It will also consider what prompts professionals to communicate with each other and what prevented all indicators of abuse being shared as they arose.
- 4.4.2 Difficulties in or lack of communication is a common feature within Serious Case Reviews and has come under scrutiny by senior safeguarding professionals and researchers alike. In a world where there are increasing modes of communication it sometimes feels frustrating that it remains such a difficulty, however those modes of communication can act as a barrier particularly when systems do not ‘talk’ to each other. SAARs have identified where this is an issue and have made appropriate recommendation to address this.
- 4.4.3 Whilst professionals are bound by legislation and there will always be a need to consider what we can legally share with colleagues, when there are safeguarding concerns there should be no barriers to involving statutory services like CSC and the Police. National guidance¹⁷ is clear that the “early sharing of information is the key to providing effective early help where there are emerging problems”, so why does it remain an issue?
- 4.4.4 In an uptake of training and support needs survey by the NSPCC, with over 19000 respondents¹⁸ they explored a number of barriers or difficulties that people reported experiencing in deciding what to do about their concerns. They are as follows:
- Being unsure as to whether abuse was taking place (28%)
 - Being worried that if they did something it would have a negative impact on their relationship with the child’s parents/carers (13.18%)
 - Thinking that it might make the situation worse for the child if they did something (7%)
- 4.4.5 What is clear is that current communication and information sharing practice within and between agencies in Dudley was not effective in this case, an overuse of forms and an underuse of direct verbal communication meant professionals did not receive information at a time when assessments were being made. In addition, no one person or agency had an accurate record of all the information.
- 4.4.6 The challenge is for professionals to communicate effectively with each other even when systems and anxieties are not assisting them to do so.
- 4.4.7 Within the practitioners event it was clear that professionals are greatly influenced by their previous experiences of communicating with other professionals; they can overthink, and are anticipating, the response of the person whom they are considering communicating with.

Finding: Within Dudley there is evidence that communication with partner agencies is sometimes lacking or insufficient.

¹⁷ Working Together to Safeguard Children 2015

¹⁸ Cloke, C. NSPCC Uptake of Training and Support Needs Survey referenced in Safeguarding Children: the importance of multi professionals and multi-agency working ppt 2007

Recommendation 4: The DSCB and its partners to consider how to reduce professional anxieties around communicating and information sharing with partners, and foster a culture that supports open communication between professionals.

4.5 Engaging parents in services

- 4.5.1 This section will cover parental engagement and the specific question, does active cancellation of multiple arranged appointments require a similar approach to that afforded to those that fail to attend appointments?
- 4.5.2 Within this case different professionals had different perceptions of the parents engagement with services. FNP had the most frequent involvement and identified in their SAAR that during pregnancy there were 12 completed visits out of 13 expected, however 4 had been cancelled and rearranged and 1 was a 'did not attend' (DNA) Three of the cancelled visits were just after the enrolment visit, this is common when first developing a therapeutic relationship with teenagers.
- 4.5.3 Postnatally there were 6 completed visits, 2 were cancelled and there were 0 DNA's in a period of 9 weeks. Therefore, in line with FNP guidance this would not be seen as disengagement or multiple cancellations and wouldn't currently warrant further exploration or action. So how can this be addressed? What is important is seeking an explanation for the cancellation, considering whether the explanation is plausible and placing it in context of what is known of the family. Professionals need to be able to provide high support and high challenge. Clear expectations are vital.
- 4.5.4 Mothers' engagement with other services increased during pregnancy indicating increasing compliance, indeed it is recorded mother recognised the implications of her actions on her unborn child. Mother had greater contact with Diabetic services throughout her pregnancy demonstrating improved engagement and improved diabetic control. Mother also engaged with midwifery services and therefore professionals were not alerted to take any additional actions.

Finding: Professionals need to increase their curiosity and understand the reasons behind cancelled and rearranged appointments. Multiple cancellations and rearrangements require a greater degree of professional curiosity and heightened consideration.

Recommendation 5: The DSCB and its partners to consider how to foster a culture where professional curiosity is increased and consider how practitioners can be further assisted to develop their analytical skills and take decisive action.

4.6 Multi-agency working

- 4.6.1 This section will consider how practitioners can work more effectively together, in a manner which takes account of a family's needs, yet keeps children's needs as the focus of intervention. It will also consider whether there was a sufficiently robust plan in place at the point the family moved into increased independent living and whether there had been consideration given to holding a team around the family

meeting to formulate plans and implement them at the point the family were effectively homeless.

- 4.6.2 There were concerning signs that all was not well from early pregnancy. Mothers actions were putting the life of her unborn in danger and therefore Child A needed protecting as did mother; then still a child. The Ambulance service made an appropriate referral which led to an assessment. This assessment did not reach recognised standards, was too focused on mother in the here and now, not sufficiently focused on mothers lived experiences and the likely impact of the poor parenting she had experienced on her abilities to parent. The assessment did not take account of father; he features only in terms of what mother knew of his past and the assessment lacked focus on the likely impact on the unborn. There was evidence of managerial oversight with clear directions during the assessment, however, at the point the case was closed it is difficult to see that all actions previously identified as being required had been completed. The decision that there was no role for CSC and to move the case into early help was flawed. It was also pivotal as it influenced the way the case was worked next. Furthermore, the assessment and its conclusions were not shared with the professionals involved with mother and father, reducing the opportunity for challenge. Without sharing the conclusions no-one was able to challenge CSC's decision that there was no role for CSC and early help was the correct level of intervention.
- 4.6.3 Whilst referrals were made to FNP, Specialist Midwifery and Housing, all of which became actively involved, what was lacking was recognition by those agencies that this case met the threshold for child protection and that a co-ordinated multi-agency approach was required. Existing policies and procedures did not assist.
- 4.6.4 The interface between the health led unborn baby network and DSCB policy was not robust at the time of this case and whilst this case was discussed at the unborn baby network meeting this was not until mother was 7 months into the pregnancy. This network meeting had its origins in health and whilst social workers could and did attend to discuss cases they are actively involved with; they did not pick up on new cases. A new policy 'Dudley Safeguarding Children Board Responding to Concerns about Unborn Children' has been introduced with clear guidance to staff however its links to existing fora are not clear.

Finding: The health lead unborn baby network meeting needs to become part of a wider multi-agency safeguarding forum linked into a wider multiagency response.

Recommendation 6: The DSCB and its partners to ensure its recently revised multi-agency procedures and systems of working with unborn babies dovetail effectively with single agency procedures and systems, and where concerns are identified, provide clear guidance of when cases need to be stepped up into a pre-birth child protection conference.

- 4.6.5 There were multiple signs throughout the pregnancy and post birth that all was not well. Factors that are known to impact on parenting were evident and not hidden from professionals. Mother gave glimpses to different professionals that they were struggling as parents. Mother indicated that she did not want to live independently and just wanted an improved relationship with her mother. Mother felt that she and

father were not bonding well with Child A. Child A's weight was falling off the centiles. There was Cannabis use within the supported accommodation. Father punched a hole in a wall within days of the couple moving into supported accommodation, within hours he attended A&E in a distressed state with Child A.

- 4.6.6 The focus of professionals was largely on the parents although there were some discussions between professionals and parents about the impact of their behaviour's on Child A.
- 4.6.7 Mid pregnancy information was shared with CSC however there is no evidence that the professionals working with the couple in later pregnancy or post the birth of Child A considered further referral to CSC and a step up into child protection was required.
- 4.6.8 Maintaining focus on the child has been an issue identified in multiple Serious Case Reviews. In more recent years the focus has been on the voice of the child,¹⁹ however this is difficult for professionals when working with such young children This is a particular challenge when the child is preverbal and professionals have to look to family members for much of the information required to make their assessments.
- 4.6.9 It is important for professionals to maintain focus on whether the actions of parents are supporting or detrimental to the child's physical and psychological development.
- 4.6.10 When a child and family are new to a service there is naturally a 'getting to know' phase. For this reason, when there are seemingly minor concerns it is essential to make contact with, and use the knowledge of other services.
- 4.6.11 Housing within their SAAR identified that they only had the family at the scheme a week before the hospital incident. They concluded this strengthened the argument for doing more before a family moves in, meeting other professionals working with the family and including all agencies into the assessment and support plan.
- 4.6.12 Because of all the issues known with this couple the case met the threshold for statutory services to be involved; certainly at the point the family were effectively homeless, Child A was in need of protection and a suitable plan was required.
- 4.6.13 There were many professionals responding to the couple's needs and the move into supported accommodation was part of an early help plan. Although planned, the final days before the move were somewhat rushed as the move was precipitated by a further breakdown in mother's relationship with grandmother 1. There had been contact and work between supported housing and the parents, including relationship building, in the weeks prior to the move.
- 4.6.14 What is less clear, at this point is how mother truly felt about the move at that time. At other points where there had been a breakdown in mother and grandmother 1's relationship, mother's mood and functioning had been affected. Mother had already been showing signs of stress and depression, was prescribed antidepressants but was reluctant to take her medication.
- 4.6.15 Professionals completing an assessment saw housing as a priority when a wider assessment was required.

¹⁹ Munro, E (2011). The Munro review of child protection: final report. A child-centred system. London: The Stationary office.

- 4.6.16 There is no evidence that a team around the family meeting was considered at the point the family became homeless. The fact that there were already plans for the family to move into supported accommodation channelled professionals into trying to facilitate this move rather than consider the wider implications of the family rift.
- 4.6.17 A plan was later made for an early help meeting to take place but this was prompted by fathers' actions following the family's move into supported accommodation. The housing SAAR has identified that this was something they could have been more proactive about as a housing provider, by arranging professional's meetings before vulnerable families move in. They identified they were overly reliant on the single referral panel for information on parents, a forum which did not necessarily represent the parents, and were looking at how they might use this panel to complete assessments and plans more holistically. Suitable recommendations have been made.

Finding: Professionals are not routinely placing new information or changes within families in context of what is known. This is leading to a lack of analysis, consideration of whether existing plans will address all a child's needs and onward referral. (see recommendation 5)

4.7 Lead agency/professional

- 4.7.1 This section will consider whether there was an undue over reliance on Family Nurse Partnership (FNP).
- 4.7.2 In this case the FN was seen to be leading on the early help offer. FNP is a health commissioned intensive, therapeutic service offered to eligible clients. Mother met the criteria as she was under 19 and referred prior to 24 weeks' gestation. The programme consists of structured weekly or fortnightly home visits from pregnancy until the child reaches the age of two covering; personal health, environmental health, life course, maternal role and family and friends. Engagement in FNP replaces the need for a health visitor in Dudley. The design of the FNP programme means the primary focus of practitioners is on mothers and their babies, and can include other family members e.g. fathers, only with mothers' permission, no such distinction is made for Health Visitors.
- 4.7.3 In discussions at the practitioners event it was clear that the presence of a worker offering intensive support to mother, influenced the thinking and actions of other professionals. There is an assumption that intensive support equals greater knowledge of and influence on the family; this is not necessarily the case. There are challenges to managing matters of abuse and neglect when a mother is receiving intensive support and other agencies are involved through early help. It is crucial to recognise the limitations of the remit of the professionals involved and in particular the lead professional. There will always be situations when additional departments from the same agency or additional agencies need to become involved and referrals be made. Professionals need to take individual responsibility for doing this and not abdicate responsibility to the lead professional. A number of recent Serious Case Reviews have raised the issue of the role of the lead professional²⁰²¹, Dudley could learn from the findings of these reviews.

²⁰ Kingston Family A Overview Report (2015)

²¹ Salford Child R Overview Report (2017)

- 4.7.4 Supported housing in this case were clear that, because FNP were involved with the couple they relied on them to take actions on their behalf. There is evidence that the involvement of FNP altered practitioner's responses when father punched a hole in a wall. The deference to FNP meant practitioners were unwittingly not meeting their individual responsibilities to safeguard Child A; those with the greatest knowledge of the events were not sharing first-hand information with those with the powers to intervene. From an FNP perspective the clarity of the situation and the clarity of what was expected of them was not there.
- 4.7.5 The Housing SAAR made it clear that had FNP not been involved they may have contacted the police and children's social care, when father caused damage to the property, and have made appropriate recommendations regarding this. A referral to CSC and involvement of the Police should have been made.
- 4.7.6 Barlow and Scott,²² based on findings from their literature review, reported that universal services are ideal for assessing families, particularly during pregnancy and the postnatal period. As such, they argued that there is a need to establish transdisciplinary teams, which place social workers within the heart of teams working in children's centres, schools and perinatal services. Whilst this approach is commendable this needs to extend to situations where an intensive service is being provided such as FNP.
- 4.7.7 **Finding: There was an over reliance on Family Nurse Partnership as deliverers of an intensive programme by all partner agencies involved.**

Recommendation 7: The DSCB and its partners to consider how best to maintain the good work of FNP whilst recognising that a health only programme cannot replace Children Social Care involvement when a multi-agency response is required.

4.8 Domestic Abuse

- 4.8.1 The SCR sub-group and SCR panel noted that two terms 'domestic abuse' and 'domestic incident' and wanted to explore whether this was influencing practice. This section will consider whether there is different meaning and implications for practice between what is recorded as a domestic incident and domestic abuse, whether practitioner's respond differently to the two terms and what the impact was in this case and the learning for other cases.
- 4.8.2 The damage to the wall was originally said to have been caused by a door handle which was a plausible explanation however once it was known that father had punched a hole in the wall there was no thought that this constituted domestic abuse.
- 4.8.3 This issue was discussed at length within the practitioner's event. Practitioners felt there was no difference between the two terms. It emerged that different responses were more to do with the type of violence. For example, it was seen as different if the violence was directed at property rather than directed at a person. The impact in

²² Barlow, J. and Scott, J. (2010). Safeguarding in the 21st Century – Where to Now? Dartington: Research in Practice.

this case was significant as no-one considered there was a need to refer violence to property to children's social care or the police; housing acknowledged that damage to one of their rented properties would have brought about a different response.

- 4.8.4 West Midlands Safeguarding Domestic Violence Procedure is clear that, physical violence includes "slapping, punching, pushing, shoving, hair pulling, kicking, stabbing, damage to property or items of sentimental value, attempted murder or murder".

The procedure is clear a referral to CSC should be made.

The procedure includes information on the psychological impact of domestic abuse which can include:

- loss of self-confidence as an individual and parent
- feeling emotionally and physically drained, and distant from the children
- inability to provide appropriate structure, security, or emotional and behavioural boundaries for the children
- difficulty in managing frustrations and not taking them out on the children
- inability to support the child to achieve educationally or otherwise.

It states the impact of the abusive partner's behaviour is such that it can significantly diminish a mother's ability to parent her child. Mother was struggling with depression and stress, expressing difficulties in bonding and tearful. Child A was present during the incident, a further reason to support the need for referral.

Finding: Professionals are not affording the same level of concern to damage to property as damage to a person.

Recommendation 8: The DSCB needs to assure itself that the response of professionals to indicators of domestic abuse is in line with existing policies and procedures.

4.9 Drug misuse

- 4.9.1 This section will consider whether practitioners are responding appropriately to disclosures of recent drug use, and self-reports of cessation of use.
- 4.9.2 Early in pregnancy mother told different professionals that she either was or was not still using legal highs. Self-reports of no drug use were accepted at face value and prompted no communication between professionals. Reports of current drug use brought a mixed response but no one considered referral to local drug services.
- 4.9.3 Advice was sought when mother indicated she had used legal highs in mid pregnancy. Contact was made with the local drug service and advice given that there was currently a lack of evidence about the impact of synthetic cannabis on the unborn child and that there would be no physical effects of quitting just a possible psychological dependency. The advice was given that if the client was saying they had quit, the practitioner should be inclined to believe the client had quit.
- 4.9.4 This advice was specific to mother's case and should therefore have been placed in context of other concerns. Drug services currently find themselves in difficult positions, not knowing the full impact of new drugs on their clients and their unborn

children. This lack of knowledge should serve to heighten professionals concerns not alleviate them. What is known is that some people have died as a result of the use of legal highs.

- 4.9.5 Psychological dependency is a major component of any dependency on drugs and needs specialist treatment. The reasons for mothers' drug use were not explored further and therefore an opportunity to examine triggers for usage and put in a plan to manage these were missed. There was little consideration of what this might mean for Child A either during the pregnancy or in the post-natal period. Mothers using drugs or alcohol are often advised to stay in hospital (in the postnatal ward) for at least 3 days (72 hours) after the baby is born so that the baby's condition can be monitored; this did not happen.
- 4.9.6 The psychological effects of drug use fall into three categories, depression paranoia and anxiety, mother was being treated with anti-depressants and suffering from anxiety; it is impossible to say if these related to her use of legal highs.
- 4.9.7 West Midlands Safeguarding Children Procedures contain the following definition "Substance misuse refers to illicit drugs, alcohol, prescription drugs and solvents, the consumption of which is either dependent use, or use associated with having harmful effects on the individual, other members of their family or the community".
- 4.9.8 **Finding: Current procedures do not guide professionals, particularly those whose expertise does not lie in substance misuse, to consider use of 'legal' highs in the same way as the use of illegal substances. The response of professionals to the use of 'legal' highs in this case suggests this may be an unexplored area of risk.**

Recommendation 9: The DSCB and its partners need to review current policies, procedures and guidelines in relation to the use of all substances that are having an effect on a person's functioning and assure themselves that the response of professionals to the use of these substances reduces the possibility of harm to both unborn and live children.

4.10 Response to bruising in non-mobile babies

- 4.10.1 The following section will explore the response to bruising/marks on Child A, whether there was an over reliance on others initiating child protection procedures and how further emerging bruising in non-mobile babies is captured, managed, and given appropriate consideration to safeguarding in an acute paediatric setting.
- 4.10.2 The professionals who saw Child A in the community did not note any bruising on Child A and were clear in the practitioner's event that they thought the marks they saw were illness related rather than due to any physical injury. They did not connect the recent domestic incident with what they were seeing on the child. The FN was concerned that the possible viral illness, diagnosed days before, might be sepsis and that had prompted her insistence that Child A be seen by the GP and failing this taken to hospital for paediatric opinion.
- 4.10.3 When seen in A&E Child A was noted to have "2 x red and round patches on Child A's back. Looks grazed. Also 3 x pin prick purple marks lower leg." A paediatric liaison form was completed in case of NAI and because father had wanted to take the child home as he felt the child had waited too long. There was no consideration to make a child protection referral at this point. Whilst there was no specific bruising noted,

equally there was nothing in Child A's vital signs to suggest the marks were caused by illness. It is clear that NAI was being considered and this coupled with fathers' behaviour should have prompted a referral to CSC.

- 4.10.4 When admitted to the ward, the marks were documented and the record states "no bruising noted". However, the couple were overheard swearing and shouting at each other – a children's social care check was ordered but there was no consideration that a child protection referral should be made at this point. This was a further opportunity to make a referral.
- 4.10.5 The following day was the first occasion when bruising was noted, one bruise on the left shoulder a second bruise medial to it and a bruise on the left knee. Parents gave possible explanations for the marks as a rough covering on the sofa or lying on the carpet naked; the bruising pattern did not correspond with the explanation. The bruises prompted the doctor to indicate a referral to children's social care and photography were needed. However, this was not followed through. The process around making referral within the acute trust was not robust. The Lead Reviewer learnt this task was sometimes left to a colleague to complete. Parents continued to care for Child A isolated from staff in a cubicle for infection control reasons – no assessment of the risk this might pose or consideration as to whether this was now appropriate, was made.
- 4.10.6 A telephone check was made, as previously requested, with children's social care; who informed that Child A was not known to children's social care, parent's names were not checked and no referral was made. Child A was examined by the Paediatrician covering child protection that week alongside the Consultant who saw Child A earlier; this was good practice. A similar story was given and the marks were documented with an additional comment that the bruise on Child A's left shoulder and the marks on the back could be accidental or non-accidental injuries (NAI).
- 4.10.7 The advice given was that the investigations already ordered were to be completed and a formal referral to children's social care was to be made. Baby was not for discharge until children's social care had cleared it, however there was no assessment of risk or consideration as to whether it remained appropriate for mother and father to care for Child A. Paediatric liaison advised the ward parents were known to children's social care but this information does not appear to have reached the consultant.
- 4.10.8 The referral paperwork was partially completed and attached to the notes. Professionals seeing the notes wrongly assumed that this was a copy of the referral and that the referral had been sent – no-one followed up with CSC at this point. There was a lack of oversight of this case.
- 4.10.9 Two days later Grandmother was present and mentioned a mark under Child A's chin. An explanation by father that this had been caused by a rough towel used when winding Child A was accepted.
- 4.10.10 The following day a senior nurse wrote that bruising to the face appeared more evident across the eyes and nose. The Doctor was informed and aware of this, dad was very upset as mother was in HDU with breathing problems. Maternal grandmother was present and stated there were new marks under the left ear since the day previous. Consultant (4) examined Child A. On examination there was bruising to the face and ear not previously documented. Consultant (4) advised to

follow up the results of the skeletal survey. The results showed fractures to the lower legs and consultant (4) requested that children's social care were informed.

- 4.10.11 Further bruising, noted on Child A following initial discussions that they may be non-accidental in origin, was not captured on a body chart until consultant 4 reviewed the case as part of the ward round.
- 4.10.12 Within the Trust there are Named Professionals to oversee this type of case however the Lead Reviewer learned the Named Doctor role, whilst funded, does not come with the dedicated time to undertake the role so following up on the advice given falls to the ward doctors.

Finding: Systems and processes designed to safeguard children were not followed when bruising/marks were identified on Child A meaning that Child A continued to be placed at risk. There was poor use of body charts which might have assisted professionals to recognise Child A was continuing to be harmed. There was a lack of continued oversight of progression of the case by trained safeguarding professionals.

Recommendation 10: The DSCB to assure itself that service configuration, systems and practice within acute hospital services is safeguarding children.

4.11 What led to the delay between the serious incident, the notification of the serious incident to the serious case review group and subsequent discussion?

- 4.11.1 Examination of this issue identified that the Named Nurse within the Hospital discussed the case with the designated nurse for safeguarding. The designated nurse suggested a referral in to SCR sub group that day and raised that the case was similar to 2 other cases with FNP involvement and asked for time to discuss this case with the appropriate person at Dudley Safeguarding Children's Board as at this time there were three cases with some similarities.
- 4.11.2 The designated nurse requested that a referral be made. Subsequently, the named nurse asked for an electronic copy of the updated form which the designated nurse sent the same day. The named nurse completed this as soon as she received it and returned it the same day. At this time there was no standard timeframe for return of forms.
- 4.11.3 The case was then referred to the serious case review group, however the infrequent meeting of this group led to further delay between referral and subsequent discussion.

Finding: The system and process around notification of serious incidents to the serious case review group was not sufficiently robust. Since this case there have been changes to the process which have addressed the issue therefore no recommendation has been made.

5 CONCLUSION

- 5.1.1 It is clear that the professionals working with Child A and family had not anticipated Child A would come to physical harm. There is evidence of professionals being proactive and working hard to support mother and father during mother's pregnancy and in the weeks following the birth of Child A.
- 5.1.2 Mother and father were a young teenage couple; both had seemingly experienced domestic violence in childhood. Professionals knew little about father as all assessments concentrated on mother and were not holistic. Mother had experienced additional challenges as a result of her mothers' alcohol misuse and depression; during her childhood there was evidence of parental neglect of her diabetes and on-going relationship issues between mother and grandmother 1.
- 5.1.3 A lack of recognition of the significance of the indicators likely to impact on Child A and mother during mother's pregnancy meant systems and processes set up to protect vulnerable children in pregnancy were not used in this case:
- 5.1.4 Post birth there were additional signs that Child A might be at risk of harm
- Fathers distress on attendance at A&E
 - Mothers failure to heal post delivery
 - Mothers post-natal depression and stress
 - Child A's slowed weight gain
 - Mother's self-report she was not coping
 - Mother's report father was throwing items
 - Cannabis use
 - Father damaged a wall in anger
 - Parents effectively homeless
 - Parents arguing and swearing when Child A admitted to hospital
- 5.1.5 What was lacking was recognition that this case met the threshold for child protection and that this was a child and a couple who both needed, and would have benefited from, a multi-agency approach and comprehensive plan in pregnancy. It is difficult to understand how a CSC assessment came to the conclusion that the threshold applicable in this case was early help level 2 and not a pre-birth conference and plan.
- 5.1.6 There were occasions when increased professional curiosity was needed when there were discrepancies between what professionals were being told and what they were observing. This increased curiosity may have promoted further dialogue and clarified concerns thus prompting professionals to make further referrals. In turn this would have provided opportunities for further assessment and intervention.
- 5.1.7 Referrals and assessments that were made lacked the depth and rigour required and as a result did not lead to meaningful plans or interventions.
- 5.1.8 It is clear in the days leading to the initial injury there were increasingly worrying signs that the couple were not coping. For a child as young and as vulnerable as Child A, the need for professionals to recognise and respond decisively to those signs is crucial. In this case, many professionals either did not recognise the significance of the signs or deferred to colleagues to make the decisions or act on their behalf without clarity of communication; there was a lack of urgency.

5.1.9 Procedures, processes and systems, in place to ensure vulnerable children are safe and reach their potential in Dudley were flawed or not followed, crucially this resulted in Child A being left in the care of parents and potentially at risk of suffering additional harm whilst seemingly under the care of professionals.

5.1.10 What has emerged is:

- a delay in acting on concerns and make referrals,
- poor communication and a lack of timely and accurate information sharing
- an over reliance on the FNP
- lack of or poor assessments, with no focus on father
- poor management oversight within services

5.1.11 In short there were failures in the child protection system. Ofsted, in their inspection of services for children in need of help and protection deemed CSC inadequate in April 2016. What this review has identified is shortcomings in partner agencies response to Child A when in need of help and protection.

5.1.12 The practitioners involved have shown real desire and willingness to learn from this case. There is significant learning for all.

5.2 Glossary of Terms & Abbreviations

| | |
|------|---------------------------------------|
| A&E | Accident and Emergency |
| CAF | Common Assessment Framework |
| CiN | Child in Need |
| CP | Child Protection |
| CSC | Children's Social Care |
| DKA | Diabetic Ketoacidosis |
| FN | Family Nurse |
| FNP | Family Nurse Partnership |
| FS | Floating Support |
| GP | General Practitioner |
| HAD | Hospital Anxiety and Depression Scale |
| HV | Health Visitor |
| LA | Local Authority |
| MW | Midwife |
| SAAR | Single Agency Analysis Report |
| TAC | Team Around the Child |

Appendix 1: Panel members

The review panel consisted of the following members:

| AGENCY | ROLE |
|------------------|--|
| | Lead Reviewer and Chair |
| DCCG | Designated Nurse |
| DSCB | Business Manager |
| DMBC | Head of Children and Young People Safeguarding |
| DGNHSFT | Deputy Chief Nurse |
| Bromford Housing | Locality Manager – Black Country |
| DGNHSFT | Consultant Paediatrician Designated Consultant for Safeguarding Children |
| BCPFT | Lead Nurse Child Death Reviews |
| WMP | Detective Chief Inspector |
| DSCB | Lay Adviser |
| DSCB | Business Support Officer |

Appendix 2: Practitioners involved in the SCR process

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

| AGENCY | ROLE |
|----------------------|--|
| BCPFT | Lead Nurse Child Death Reviews |
| DMBC | Social Worker |
| West Midlands Police | Detective Constable |
| DMBC | Team Manager |
| DGNHSFT | Consultant Paediatrician |
| BCPFT | FNP Supervisor |
| DGNHSFT | Community Outreach Nurse |
| DMBC | Manager – Contact Team |
| DGNHSFT | Sister |
| Bromford Housing | Support Worker |
| DGNHSFT | Consultant Paediatrician |
| DGNHSFT | Named Midwife |
| DCCG | Designated Nurse Safeguarding Children |
| DGNHSFT | Named Nurse |
| DMBC | Independent Reviewing Officer |
| BCPFT | Family Nurse |
| DGNHSFT | Consultant Paediatrician |
| DGNHSFT | Named Nurse |
| DGNHSFT | Specialist Doctor Paediatrics |
| DGNHSFT | Consultant Paediatrician |
| DGNHSFT | Consultant Paediatrician |
| WMP | Detective Sergeant |
| DMBC | Team Manager |
| | |
| | |

Appendix 3: Single Agency Recommendations

Dudley Clinical Commissioning Group CCG

- GP practices should record children who fail to attend appointments as “was not brought” rather than “did not attend”.
- Awareness raising around neglect to be aimed at GP staff and to include the introduction of the neglect strategy and the implementation of the GCP2 tool.
- GPs should be supported to recognise substance misuse and mental ill health as potential indicators of domestic abuse.
- Information sharing between health professionals should be improved to ensure that that information is shared where there are concerns and acted on appropriately.
- Health visitors, School Nurses and family Nurses should have access to the GP IT system to enable them to add entries to the records to develop a comprehensive record of the child’s lived experience.

Children’s Social Care

- Dudley SCB must develop as part of the West Midlands Child Protection Procedures Part C a clear guidance document on how to respond to Teenage parents. This should be a multi-agency document and must be linked to a Pre- Birth Guidance, and the Teenage Pregnancy Strategy.
It is noted that the Teenage Pregnancy Strategy document on the DSCB website is out of date and requires an urgent update.
- Dudley SCB as part of the West Midlands Child Protection Procedures Part C must develop a multi-agency Pre-Birth Referral guidance which must include full contribution from the partner agencies; health, police, Probation, housing, mental health, anti-natal and Perinatal services, education and Substance Misuse Services. The writing, planning and consultation of this document must involve multi agency contribution and will need to be carefully timetabled and approved by the DSCB safeguarding board once completed.
- Once the Pre-birth guidance is completed, agreed and published on the DSCB website then there will need to be a planned series of multi-agency practitioner events to raise awareness. There will need to be a strong emphasis on health care providers, who are more likely to be the professionals who first come into contact with expectant parents.
- Consideration needs to be given as to how to support the understanding of the Assessment Framework in social work assessments; the importance of history, the need to include fathers and how to apply critical analysis to support the long term safety of children. We also need to consider the role of authorising managers and the level of scrutiny applied when signing off assessments.
- Children’s Social Care is to provide guidance and advice to all staff about the importance of treating the information about the unborn baby as a record in its own right.
- The Early Help Strategy needs to consider how best to inform Children’s social care as to when babies are born to families who are in receipt of their services.
- There needs to be greater awareness of the impact of synthetic drugs (formerly legal highs), and the likely impact on parenting capacity. This can be achieved through joint working with the substance misusing services and incorporating the information as part of the DSCB multi-agency training on Substance Misuse.

- There is clear evidence of lack of professional curiosity and a failure to draw on previous history when carrying out assessments; commonly known as the “start again syndrome”. The history is a clear indication of the present and the future and perhaps this can be better improved by more detailed transfer and closure summaries.

The Dudley Group NHS Foundation Trust

- Concerns and information shared during Unborn Baby network meetings is not available within the child’s casenotes or to Emergency Department staff. This practice needs to be reviewed and a process for ensuring information available antenatally continues to be available in the child’s notes.
- When an instruction is written in casenotes it must be allocated to a member of staff to complete and actions should be checked for completion. A review of the previous plan of care or list of instructions must be carried out each time a child is seen.
- The interaction between parents and their children is an important part of the child’s assessment and should be included with documentation of care.
- Children in cubicles are not easily visible to staff and some careful consideration should be given to which areas of the ward children are placed in when there are child protection concerns.
- An updated form to track actions when considering child protection has been devised and is awaiting ratification and roll out. This will provide a single record for staff to sign when completing actions relevant for child protection.
- A top to toe assessment of children where there are child protection concerns is carried out by a Consultant Paediatrician/Senior Registrar daily.
- The Trust should have a policy for management of bruising in a non-mobile child.
- Paediatric Medical staff mandatory training compliance for level 3 Children’s safeguarding needs to be increased to >90% in line with Trust target for safeguarding training. All medical staff new to the area should have completed Paediatric safeguarding at induction or within 4 weeks of induction.
- Where there is a decision to admit a child to the Paediatric Ward the Paediatric Admission Assessment Document must be fully completed by the admitting nurse including the skin integrity assessment sheet.
- Individuals who refer to external agencies do so in a secure manner and checked as received after being sent.
- There should be a standardised approach to completing body mapping for a child presenting with marks of unknown origin. This should be used each time there is an assessment of the marks on the child to enable comparison and identification of new marks. This should be filed in the medical notes for ease of access for all disciplines that require this information.
- All staff who look after children in the Paediatric Ward need to be aware that they should complete the Children’s Ward Safeguarding Checklist on admission when a safeguarding concern has been raised.
- The Standard Operating Procedure for Paediatric Assessment Unit should be amended to instruct medical staff to review Soarian records from Emergency Department when a child is admitted to the Paediatric Ward.
- All Emergency Department staff to fully complete handover documentation with relevant information around any safeguarding concerns. This needs to be for any patient admitted to the Trust through an assessment area or directly to a ward.

Black Country Partnership NHS Foundation Trust

- BCPFT Paediatric Liaison Service Policy needs updating in line with national and local policy and guidance, this is due for renewal in September 2017. To be included in this is the documentation of actions taken by the Paediatric Liaison Nurse, storage and appropriate dissemination to appropriate practitioners.
- BCPFT FNP Referral Form will be reviewed due to the lack of information supplied on the referral and relevant training will be provided by the FNP service.
- Practitioners to make enquires when clients report involvement with Children's Social Care even if they report there was no outcome. This needs to be explored within Safeguarding Supervision, and within FNP and to be explored within Family Nurse Partnership Supervision.
- Review the need and processes to request School Health Records to support the assessment and understanding of clients backgrounds. This needs to be reviewed trust wide and the implications weighted by the need so as to implement this and embed within practice appropriately and robustly.
- Understanding Illicit/Illegal Drugs and Scope of Practice. This was identified by FNP as a gap in knowledge in July 2016, or review of the legislation changing in May 2016. Further exploration directed the team to a referral document based on the disclosure of drug use to be developed with the SWITCH team, acknowledging limitations and areas of expertise. This can be reviewed to be rolled out trust wide improving swift, appropriate referrals to Children's Social Care with supporting information.
- CAF/Early Help Review dates need to be implemented and reviewed, this needs to be raised within Safeguarding Supervision and Family Nurse Partnership Supervisor Supervision. This has also resolved somewhat with the implementation of the Early Help offer and Early Help allocation meetings every other week at the local Family Support Centre's. These are new processes and are embedding in, this is included within the Terms of Reference for these allocation meetings and the recruitment of 'champions' across multi agencies.
- Domestic Incident and Domestic Abuse, the commonality of language and how/why practitioners felt that it did not require the same level of concern. This needs to be reviewed on the appointment of the new Domestic Abuse Lead Nurse, BCPFT recruited to commence in September 2017. This will also be explored within Safeguarding Supervision with the FNP Team and Supervisor Supervision. Trust wide the Domestic Abuse Lead Nurse will take this forward within the trust.
- Timely SCR Referral, and the undue reliance on other agencies to submit an SCR. Although this would not have changed the outcome for the child, it would have changed the outcome to the process.
- Documentation of outcomes and planning within FNP. Though there is clear exploration and this is documented, the outcomes and plans need to be documented succinctly as per BCPFT Clinical Record Keeping Policy (Oct 2019).
- Bruising Protocol inclusion on BCPFT intranet March 2018 to raise awareness of bruising in the non-mobile child more formally.

Bromford Housing

- To improve multi agency working.
- To improve the training content to give colleagues clearer guidance
- To review safeguarding policy and process