Serious Case Review: The importance of early planning and continuity of care for children with complex health needs

(BSCB2018-19/01)

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Publication Date:
21st February 2024

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1. Introduction and Background

1.1 Purpose of this Review

This Serious Case Review was commissioned in 2018 to independently consider what happened in this case, and why, in order to identify the lessons that can be learned to reduce the risk of future harm to children.

1.2 Overview of the Case

In November 2017 an ambulance was called to a three year old child who was fitting/not breathing. Upon arrival at Birmingham Children's Hospital, the child was discovered to have sustained a significant fracture to their skull and a serious bleed to the brain which required specialist life support and neurosurgery. Evidence was found of old fractures and previous bleeding on the brain.

The trauma suffered has left the child with life changing injuries requiring specialist care/support services for the rest of their life.

The parents in this case were a young, married couple who arrived in the UK from the Middle East seeking asylum in July 2014, having fled war. They had been known to agencies in Birmingham since the child's premature birth in August 2014.

Six safeguarding referrals were made about the child prior to the incident in November 2017, with a history of missed medical appointments. Two attempts were made to offer family support but these did not come to fruition as it was not possible to either locate or engage mother at that time. The child had five unplanned hospital attendances between April 2015 and September 2017. Three of these were because the child had sustained significant injuries.

The severity of the child's condition following admission to hospital in November 2017 led to an initial focus on palliative care. The child's prognosis improved in January 2018 and the child was pronounced medically fit for discharge in April 2018. However, the complexity of the child's care needs meant that suitable arrangements were not in place and discharge did not take place until March 2020.

The child spent a total of 2 years 4 months (850 days) in hospital following admission in November 2017: this is a significant proportion of this young child's life.

2. Methodology and Process

2.1 Guidance used and approach

This Serious Case Review was conducted in line with the guidance in place at the time the review was commissioned – *Working Together to Safeguard Children 2015.* This guidance was revised during the period of the review and consideration was, therefore, given to both *Working Together to Safeguard Children 2018* and the

practice guidance published by the Child Safeguarding Practice Review Panel in April 2019.[1]

The first two phases of the review were overseen by Jim Stewart as an independent Lead Reviewer, supported by a Review Team made up of safeguarding experts from key local agencies[2] together with a Home Office representative.

The review process was finalised by Wendy Noctor and Zoë Cookson who have helped produce a themed analysis of the learning focused on improving safeguarding practice.

2.2 Time Period for the Review

The Review was conducted in two phases.

Phase One considered agency involvement with, and services offered to, the child prior to admission to hospital in November 2017.

Phase Two was commissioned in 2020 to consider the reasons for the child's lengthy stay in hospital before discharge and the challenges agencies experienced in planning for the child's future care.

2.3 Information from agencies

Fourteen agencies submitted formal reports to phase one of the review.[3]

The second phase concentrated on the effectiveness of inter-agency collaboration between Children's Social Care, West Midlands Police and Birmingham Children's Hospital during the period November 2017 to March 2020.

2.4 Practitioner and manager involvement

Two practitioner learning events took place. The first in November 2018 focused on Phase One.

The second session, in September 2020, engaged managers who had direct operational involvement with post-incident care, support and discharge planning for the child and family. A further two managers who were unable to attend the learning events, were subsequently interviewed by the Lead Reviewer.

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[1] Serious Case Reviews have been replaced by Child Safeguarding Practice Reviews (CSPRs). While this review has considered the guidance for CSPRs, it remains a Serious Case Review.

[2] The Review Team included representatives from Birmingham Hospitals Trust, Clinical Commissioning Groups, Birmingham Children's Trust, Early Years and Childcare Service, the Housing Department, and West Midlands Police.

[3] Birmingham Children's Trust (Birmingham City Council Children's Services before April 2018), Birmingham Community Healthcare NHS Foundation Trust, Birmingham Housing Service, Birmingham and Solihull Clinical Commissioning Group, Birmingham Women's and Children's NHS Foundation Trust, Early Years and Family Support Services, Sandwell and West Birmingham Clinical Commissioning Group, Sandwell and West Birmingham Hospitals NHS Foundation Trust, The Home Office, The NSPCC, University Hospitals Birmingham NHS Foundation Trust, West Midlands Ambulance Services, West Midlands Fire Service, West Midlands Police.

2.5 Family engagement

The child's parents and aunt were informed of the Serious Case Review and its progress. In March 2021, the Lead Reviewer was able to speak with the child's mother in a meeting held online due to the coronavirus pandemic.

3. Analysis and Identification of Learning

3.1 The analysis of learning initially concentrates on **Phase One** examining three specific areas:

- Responding to the needs of migrant families;
- Assessment and support for vulnerable families;
- Unexplained, suspicious, and non-accidental injuries.

This is followed by an analysis of learning from **Phase Two**, focusing on five key factors that contributed to the child's lengthy stay in hospital:

- Child in Need processes were followed instead of Child Protection processes;
- Risk and needs assessment work could have involved different professionals and should have been more pro-active, co-ordinated and multi-agency in nature;
- There were long delays in care planning which had a significant impact on court processes;
- Multi-agency communication was not as good as it could have been;
- There were significant challenges finding a suitable placement.

4. PHASE ONE - Responding to the needs of migrant families

4.1 Background: a young, vulnerable migrant family

The parents in this case were a young, married couple who arrived in the UK from the Middle East seeking asylum in July 2014 having fled war.

Mother was five months pregnant at the time and, at 17 years old, was a child herself. Father was 18 years old.

Both are Muslim and their first language is Arabic.

The couple were initially placed in emergency accommodation in London before being dispersed to a hotel in Birmingham three days later.

Temporary accommodation and support to asylum-seeking families in the Midlands was at that time provided by a Home Office commissioned service called G4S.

The couple were granted financial support the same month they arrived in the UK. The child at the centre of this review was born 14 weeks prematurely in August 2014.

The family lived in ten different addresses during phase one (between 2014 and 2017), with only two periods of stable tenancy during this time.

4.2 Mother's experience

Mother told the Lead Reviewer that she felt safe when she arrived in England as they had escaped war. However, mother faced a different set of challenges in the UK. These included difficulties around language and communication, unfamiliarity with health and childcare systems in England, multiple accommodation moves, and difficulties trying to look after a child in hotel accommodation, alongside experiences of racism.

Effective support from professionals and strong multi-agency working should have helped alleviate some of these challenges. Unfortunately, while there are examples of good practice, too often support was either not available or inadequate for a child with such complex needs.

4.3 Appropriate attention and information not provided on arrival

Upon arrival at Heathrow Airport mother reported that she had experienced a slight bleed during the flight. A screening officer and senior officer should have referred mother to the Port Medical Inspector or called an ambulance. Instead, non-medically trained staff decided that mother did not require immediate medical attention.

Information about the couple's arrival was not communicated to health professionals in Birmingham when they moved to the city. Contrary to Home Office guidance, G4S staff failed to advise or guide the couple to register with health services in July 2014 or to obtain a maternity form.

This meant that professionals in universal services in Birmingham had no knowledge of either parent when mother gave birth in August 2014. Indeed, mother's first contact with a health professional in the UK was when the G4S welfare support officer called an ambulance to transfer her to hospital to give birth.

4.4 Lack of understanding of migrant status by professionals

Between 2014 and 2017 professionals in Birmingham gave insufficient attention to the implications of the family's migrant status on their housing, financial and social situation.

The review found that not all agencies and professionals in Birmingham were aware of the child's parents' countries of origin, the parents' history and journey to the UK, or the national immigration legislation and support available to asylum seekers nationally and in the city. Neither parent's previous experiences were discussed in any detail other than at one GP appointment with the child's father.

Professionals involved with the family frequently assumed that the parents were receiving reliable support from national organisations (such as the No Recourse to Public Funds team or Asylum Support). This was not the case: the family did not receive all the funding they were entitled to and had limited support.

There was a significant delay in the Home Office being notified of the child's birth and G4S failed to deliver some of their contractual obligations. Prior to the child's discharge from Birmingham City Hospital in November 2014, social workers and a health visitor worked under time pressure to ensure that the family had essential items such as a cot and sterilising equipment. This should have been provided by G4S.

The family moved back into temporary accommodation prior to the child's hospital admission in December 2015. At this time, they had no income other than food vouchers and had been advised to apply for Child Benefit by the Housing Options Service.

Later, in September 2017, professionals did not appreciate the child was discharged into temporary accommodation where there wasn't basic equipment such as a cot for the child.

There are occasional references to mother being with a friend and having a friend who spoke English but there is no indication that the level of social isolation of the parents or potential support for them in the community was sufficiently considered.

4.5 Challenges addressing language barriers

The West Midlands Child Protection Procedures highlight the need to use safe and independent interpreters for discussions about parenting and child welfare, even though the family's day-to-day English may appear/be adequate.

All agencies recognised that English was not the first language of either parent. Interpreting services were used, although not consistently.

Staff in Birmingham Women's Hospital worked with interpreters in 2014 although one was not available immediately after the child's birth. Difficulties were recorded in communicating with parents twice and hospital staff also tried to contact English speaking friends of the parents.

The health visitor reported using a family relative and then an English-speaking neighbour during visits in the days before the child's discharge.

The police and housing service engaged Arabic interpreters during home visits or telephone calls and the health visitor made a new birth visit with an Arabic interpreter.

West Midlands Ambulance Service noted difficulties in obtaining a history due to a language barrier in the three call outs to the child and the need to focus on time critical clinical interventions.

Most agencies made use of the national Language Line service.

It is not possible to determine the impact of these language barriers. During the first three years of the child's life mother missed a large number of appointments. This

may have reflected a lack of communication and/or comprehension rather than a lack of engagement but this was not explored further at the time.

4.6 Housing and multiple moves

The family lived in ten different addresses between 2014 and 2017 and, as a result, moved outside of Birmingham for brief periods. They had only two periods of stable tenancy during this period and the hotels provided did not always have essential items. For example, the social worker had to ask hotel staff to provide a cot for the child in September 2017, two weeks after the family moved there and a week after the child had been discharged from hospital.

The multiple housing moves and use of hotels to accommodate families is unsatisfactory but reflects the reality, both nationally and locally, that there is insufficient suitable accommodation for vulnerable families. This negatively impacted this family including limiting the consistency of, and access to, services and support.

Information about the family address was frequently out of date. Different professionals had different addresses for mother. For example, the health visitor's attempt to visit in March 2015 failed as they had the wrong address. The first Children's Centre to which mother was referred also spent four weeks unsuccessfully trying to engage, including a failed home visit, and as a result closed the case. In response to a separate referral, a family support worker attempted to visit mother in hotel accommodation in November 2017 but mother was not there. Health visitor records also record a failed home visit around the same time.

It appears that mother chose to stay with relatives and/or friends rather than spend time in the hotel accommodation for periods between September and November 2017. This is, perhaps, not surprising given this temporary accommodation was ten miles from mother's key support (the child's aunt) and seven miles from the child's father.

This meant that community health, early years and social care professionals all lost contact with the family from late September 2017 (child aged 3 years one month) after mother was placed in this temporary accommodation. There was little understanding of how mother was living day to day and therefore what the child's life was like.

4.7 Considering the impact of experiences on mental health

Asylum seekers may have fled war and persecution in their countries of origin and may have experienced trauma and abuse at home and on their migration journeys which impact on their mental health. This needs careful consideration and recording by professionals. There is little evidence of such practice with this family.

There is limited reference to father in agency records or reports. He was seen for six consultations for general illness. He was also seen in July 2015 for reported anxiety when he spoke of difficult experiences before coming to England. There is no record of a mental health assessment or a referral for counselling and no reference to his

mental or emotional welfare at his next GP appointment. This is significant given the impact mental health can have on parenting capacity.

Father presented at an Emergency Department in May 2016 with shortness of breath and 'personal stress' which he did not wish to discuss. He was advised to see his GP if his symptoms persisted and offered appropriate advice. He was not asked by staff if he had any children or caring responsibilities.

4.8 Experience of racism

In February 2017, mother reported to the Police that she had been a victim of racial abuse and made reference to being a victim of this on previous occasions. Police officers responded appropriately to this report. Nothing more is known about any experiences of racism.

4.9 Good Practice

Staff at the second GP Practice were very responsive to the health and language needs of mother. She was seen without an appointment and given support with letters and appointments when she attended the Practice seeking help. Interpreters were provided on every occasion by telephone or in person.

Learning

Learning Point 1: Professionals undertaking assessments of parenting capacity need to fully consider the impact of the experiences of asylum seekers in their countries of origin/on their journeys to this country and the potential for post-traumatic stress disorder alongside their lived experience in the UK and potential isolation.

Learning Point 2: Professionals need to understand national and local asylum seeking systems and processes, the role of the Home Office and contracted services, and local arrangements for support, or at least have access to specialist knowledge.

5. Assessment and support for vulnerable families

5.1 Considerable resources were provided to the child and parents by local agencies in Birmingham between the child's birth in August 2014 and the serious incident in November 2017 (phase one of this review). However, during this entire period of the child's life there was no detailed assessment of needs or coordinated early help to support these first time parents and promote the child's development.

5.2 Overview: agency involvement and the child's experience during phase one

Born 14 weeks prematurely with low birthweight, the child remained a vulnerable child throughout the period considered in phase one of this review.

The health needs of the child were met by specialist hospital inpatient services for the first three months[4], before discharge in November 2014.

On leaving hospital, child and mother were registered at three different GP practices and five health visiting teams were involved with the family up to November 2017.

The child had five unplanned hospital attendances between April 2015 and September 2017. Three of these were because the child had sustained significant injuries. (These unplanned hospital attendances are examined in section 6).

The child was not brought to medical appointments on multiple occasions between 2015 and 2017.

Six safeguarding referrals were made about the child between November 2014 and September 2017. This review also identified at least one instance where a referral should have been made.

Two attempts were made to offer family support in response to these referrals but the frequency of moves meant, in one instance, it was not possible to locate mother and, when mother was contacted, she was reluctant to engage.

The child did not attend any early years setting or Children's Centre in Birmingham in three years, despite being included on the list of children eligible for a funded place.[5]

By age two, the child was assessed as having global developmental delay.

5.3 Through the child's eyes

It is difficult to perceive the child's daily life from the information available to this review.

The child was frequently referred to as active and was observed to roll around, smile and babble.

Initial records report the child making good developmental progress and thriving. The child was taken to a cardiac clinic in March 2015 (aged 7 months) where professionals noted that two holes in the heart had closed and the child's growth was progressing on the 9th centile. At a neonatal clinic in August 2015 (aged one year) no concerns were raised.

[4] Child was born at Birmingham City Hospital and transferred to the Level 3 Neonatal Intensive Care Unit at Birmingham Women's Hospital the following day. The child transferred back to Birmingham City Hospital's Level 2 Local Neonatal Unit in October 2014 and discharged from there in November 2014.

[5] The child's family's name was included seven times on the termly list sent from the Department of Work and Pensions to the Early Years' Service of parents who appear to have an eligible child for a funded two-year Early Education Entitlement place.

When presented at City Hospital in December 2015, the child had significant developmental delay and was unable to sit unsupported or stand alone at 16 months old (corrected to 13 months due to prematurity).

In April 2017 (age 2 years 8 months), the child was described by two nurses from the Nurses at Home Team as being upset during their three daily home visits.

The child was not talking or walking in September 2017 (aged 3 years 1 month).

Mother reported that the child had a poor appetite and diet. The child did not attend any nursery or playgroup and mother said that the child hit other children.

5.4 Recognising mother as a child in her own right

Limited consideration appears to have been given to the age and inexperience of both the child's parents. At age 17, mother was still a child but this was not widely recognised.

Support and parentcraft training throughout the child's period in neonatal care would have assisted the family. A health visitor recorded contact in September 2014 with a community midwife, who confirmed they had made a referral to a pregnancy outreach worker, but there is no further reference to any additional support.

A health visitor did seek advice from the Birmingham Community Healthcare Safeguarding Children Team and liaised with children's social care in September 2014 about the fact that mother was 17 years old.

However, when a referral was made about the child in November 2014, the social work team did not consider mother as a child in her own right.

5.5 Missed opportunities to complete holistic assessments

Comprehensive and holistic assessments need to be completed without delay and should lead to effective planned help for children. This did not happen in this case. Instead, multiple opportunities to complete assessments were missed. Indeed, there is no evidence that agency knowledge of, and involvement with, the child and parents was ever collated.

5.5.1 Opportunity missed for holistic assessment in first three months

There was an opportunity for a comprehensive holistic family assessment during the three months the child spent in hospital after birth. The Specialist Health Visiting Team for asylum seekers identified Level 3 needs requiring a multi-agency service shortly after birth but there is no evidence of action being taken to progress this while the child was in hospital. There is reference in the Birmingham Women's Hospital records to a meeting being planned in September 2014 but no evidence that it went ahead or what was intended.

When the child transferred back to Birmingham City Hospital in October a referral was made to children's social care with mother's consent. Unfortunately, there was

considerable delay and drift and the case was closed in March 2015 without an assessment being completed (see section 5.6.1 below).

5.5.2 Advice to complete a Common Assessment Framework not actioned

There was good contact made with the family by the health visitor in the lead up to, and following, the child's initial discharge from hospital in November 2014. However, the advice given to the health visitor to complete a Common Assessment Framework assessment was not actioned, possibly because the Specialist Health Visiting Team had three part-time staff and limited capacity.

5.5.3 Team Around the Family

There are references in health visiting records to a 'Team Around the Family' meeting in February 2015 which agreed the allocation of a family integrated support worker. However, there are no records of this meeting in the files of other agencies and no evidence of action being taken.

5.5.4 Response to safeguarding referrals

Six safeguarding referrals were made about the child between November 2014 and September 2017. None of these resulted in any multi-agency meetings or plans to co-ordinate support.

Each referral is considered in more detail below.

5.6 Safeguarding Referrals

5.6.1 Referral 1 (November 2014)

The child was transferred from the Level 3 Neonatal Intensive Care Unit at Birmingham Women's Hospital to the Level 2 Local Neonatal Unit at Birmingham City Hospital in October 2014.

Staff at Birmingham City Hospital had concerns that both parents, who were young and asylum seekers, were experiencing financial and housing difficulties. The parents were living in a Bed and Breakfast Hostel at that time and had made no preparations for the birth of the baby. A referral to Children's Social Care was completed with mother's consent. A social worker was allocated before the child was discharged from hospital in November 2014 and a Team Manager recommended a family assessment. There was significant drift and four different Team Managers were involved in managing this single referral. The proposed assessment had not progressed by February 2015. A decision was made that the family's issues were in relation to parenting capacity rather than safeguarding, and the family assessment was abandoned. A referral was made to a Children's Centre for family support and the social care referral was closed in March 2015.

This decision to close the case was reached without an assessment to consider the multiple concerns raised in the original referral.

5.6.2 Referrals 2 and 3 (March 2015)

Two anonymous referrals were made to the NSPCC in March 2015 alleging that mother was ill-treating the child (aged 7 months).

The Police were informed and responded promptly to these. Police officers visited the family and visually checked the child to confirm no signs of bruising and they found the child to be 'happy and content'.

The referrals were shared with Children's Services. Social workers accepted a statement by the health visitor that premature babies cry more than other babies as an explanation for the referrals to the NSPCC. The Biennial Analysis of Serious Case Reviews 2005 - 2007 highlights that babies born prematurely with low birth weight are harder to look after, more difficult to feed and may cry more. However, it goes on to state: 'This may in turn prompt angry reactions from a parent'.

Managers judged that the involvement of the health visitor, whose recorded view was that the second referral in March was malicious, was sufficient to close the case. There should have been greater consideration and exploration of alternative explanations and the child's specific circumstances.

5.6.3 Referral 4 (April 2015)

A third anonymous referral was made direct to both the NSPCC and the Police by a member of the public in April 2015. The anonymous referral related to concerns about alleged physical and emotional abuse of the baby, who was then 1 year old.

There is no evidence of liaison between the police and children's social care over this referral.

NSPCC records indicate they did pass this referral on and were told that a worker or manager in the MASH (multi-agency safeguarding hub) would store the referral on the Children's Services' system for future reference. This did not happen.

5.6.4 Referral 5 (July 2017)

A doctor, from the second GP Practice mother and child had registered with, made a referral to Children's Services in July 2017 following confirmation from the hospital that the child had not been brought to medical appointments.

A social work team manager requested that the GP request parental consent. This should not have been necessary for a referral raising concerns about long-term neglect of a child's needs. It should have been challenged by the GP Practice, enlisting the support of the Clinical Commissioning Group's safeguarding lead.

5.6.5 Referral 6 (September 2017)

In September 2017, the child attended the Emergency Department at Birmingham Children's Hospital with injuries attributed to a fall from a tricycle (see section 6.3.3 for an analysis of this incident).

Staff from the hospital alerted the MASH that the child's x-ray results looked abnormal. An Orthopaedic doctor stated it was an unusual fracture likely to have been caused by a twisting mechanism.

An initial telephone strategy discussion took place involving the Child Protection Nurse Specialist, a Ward Junior Sister and a Manager in the MASH. It noted the lack of clarity around the injury and the wider concerns around non-attendance at community health appointments, a potential lack of parental supervision, missed health appointments and developmental delay.

The child was discharged in September 2017 and the plan agreed with Children's Services was to complete a Child in Need assessment.

A social worker and Team Manager completed a family assessment in early November 2017. This concluded that there were no safeguarding concerns identified, only support needs and made a decision to step the child's case down to Children's Centre involvement. The social worker for the child submitted a referral to the Children's Centre (the sixth Children's Centre that mother had been encouraged to attend) where staff gave the referral a red priority rating based on its complexity and urgency.

The social work manager's decision to close the child's case in November 2017 (child aged 3 years 2 months) was premature given the limited progress made in addressing the needs identified for the child and mother. Again, no multi-agency meeting was held to plan agencies' involvement, to set out expectations of both parents, and no contingency plan was put in place. There was no acknowledgement that the child's parents had not accessed family support in three years and had regularly missed health appointments. Father was not consulted until October 2017 and was not involved in the safety plan. There is no evidence that any support network available to mother was considered.

5.6.6 Missed Safeguarding Referral (December 2015)

This review identified at least one instance where a safeguarding referral should have been made. In December 2015 the child was taken to hospital with a swollen arm and a fractured elbow was later confirmed by x-ray (see section 6.3.1 below). There was no adequate explanation for this fractured arm and a full safeguarding assessment should have been undertaken and specialist advice sought.

5.7 Missed medical appointments

The child was not brought to medical appointments on multiple occasions between 2015 and 2017, including the first neonatal appointment in February 2015. Responses to these missed appointments were inconsistent and did not try to establish the rationale for why the child wasn't brought to the appointment.

The child was not brought to five appointments at Birmingham City Hospital between 2015 and 2017. The child was followed up at three clinics – a developmental clinic, a clinic for immunisations and a cardiac clinic.

The child was discharged from a baby clinic in August 2015 and again in April 2016 when they were not booked into an appointment with the community paediatric service. In December 2016 the child was not brought to see a consultant and a letter was sent to the GP and Health Visitor.

The child was discharged from the hearing clinic when parents did not make an appointment in July 2017: the GP made a safeguarding referral to Children's Services due to parents' recurrent failure to bring the child to appointments (see section 5.6.5 above).

The child was not brought to appointments in August 2017 or September 2017. The child was discharged by community paediatrics when it would have been appropriate to escalate concerns. The community paediatrician did write to the GP and requested a copy letter be sent to the health visitor with a request for contact with the child and monitoring.

In September and October 2017, the child (aged 3 years) was also not brought to orthopaedic follow up appointments. A letter was later sent to the local GP practice but there was no contact with Children's Services despite mother's lack of compliance with the intervention safety plan.

It is worth noting that, in June 2015 (child aged 10 months), mother shared concerns with the health visitor that hospital outpatients were changing appointments too often, but there is no other information about why the mother missed so many appointments.

5.8 Discharge Planning

This case also demonstrates a need for strengthened discharge planning for premature babies and children with complex needs.

Planning for the child's discharge in 2014 should have begun much earlier. The discharge planning coordinator was not in work for four weeks due to illness in 2014 but there should still have been multi-agency discharge planning and a clear discharge plan. Both could usefully have involved a representative from G4S and closer involvement of the health visitor and GP.

Discharge planning practice after the child's presentations with unexplained injuries (see section 6) was not robust. In April 2017, a nurse did not include information about the delayed presentation with the child's head injury in the letter for the health visitor. In September 2017, a discharge letter for the health visitor did not include details regarding the safeguarding process or the fact that there was an allocated social worker.

The safety and discharge plan put in place in September 2017 was not effective. It stated that mother should supervise the child at all times and use her support network to translate letters for appointments but did not identify any network. It did not include any actions for father or attendance at a children's centre. The safety plan did

not include a contingency plan if a fracture was confirmed or if mother did not cooperate or achieve or maintain change.

When mother did not take the child to a community paediatric review in September 2017 or to orthopaedic appointments to review the fracture in September and October, this information was not shared with, or sought by, the social worker.

5.9 Good Practice

- In July 2017 (child aged 2 years and 11 months), doctors at the second GP Practice that mother registered with were proactive and made a referral to the Child Development Centre following the child's two-year developmental review and made a referral to Children's Services following confirmation from hospital that the child had not been brought to medical appointments.
- The sixth Children's Centre that mother was referred to screened the referral as 'red' recognising the complexity of the child's circumstances, and identified the need for an urgent response. Unfortunately, contact was not achieved before the child's admission to hospital with the injuries leading to this review.
- A Consultant Paediatrician's assessment of the child's developmental progress in April 2017 (child aged 2 years 8 months) resulted in a referral to a range of appropriate specialist services to assess the child and coordinate services to meet their health needs. Further referrals were made by a Consultant Community Paediatrician in Autumn 2017.

Learning

Learning Point 3: Despite the complex challenges faced by the family in this case and the multiple agencies involved, there was no detailed assessment of need or co-ordinated early help to support these first-time parents and promote the child's development. Comprehensive and holistic assessments need to be completed without delay and should lead to effective planned help for children.

Learning Point 4: Health professionals need to consistently follow the 'Was not Bought' policy and inform social workers involved with the child concerned.

Learning Point 5: Discharge planning for premature babies and children with complex needs should be robust. It is important to identify a lead health professional to ensure effective communication and continuity of care between health professionals and hospital trusts.

6. Unexplained, suspicious and non-accidental injuries

6.1 This review has highlighted the need for robust practice when children attend hospital with unexplained or suspicious injuries.

6.2 Overview: unplanned attendances at hospital in phase one

The child was taken to hospital on five occasions between April 2015 and September 2017. Three of these were because the child had sustained significant injuries:

- *December 2015:* aged 16 months, child was taken to hospital with a swollen arm – a fractured elbow was later confirmed by x-ray. The child remained in hospital for two days.
- *April 2017:* aged 2 years 9 months, child was admitted to hospital with a head injury (boggy skull swelling) alongside unusual bruising on the child's body.
- *September 2017:* aged 3 years, child was admitted to hospital with swelling to the left arm, fading bruising to the right cheek and a scratch on the left cheek. A fracture of the left humerus (the bone in the upper arm) was identified after discharge.

These three injuries, and the serious incident that prompted this review, have since been established as non-accidental injuries in a Finding of Fact Court hearing.

6.3 Professional response to incidents when child had been injured

6.3.1 December 2015 - swollen arm / fractured elbow

This attendance was appropriately investigated. A CT scan, skeletal survey and retinal examination were all normal and this appears to have reassured professionals wrongly that the child was safe to be discharged. There was no adequate explanation for a fractured arm and no investigation of potential bruising. A full safeguarding assessment should have been undertaken and orthopaedic advice sought. Lateral checks were made with children's services and previous hospital admissions were considered. The health visitor reported no concerns about home conditions or the care of the child. Children's services consulted with Police and both agencies appear to have concluded that the medical opinion that the injuries might be accidental was definitive.

Further training has been undertaken within the City Hospital paediatric department to highlight the developmental abilities of babies when assessing injuries.

6.3.2 April 2017 - head injury

A lumbar puncture was performed, and an urgent CT head scan did not show any underlying skull fracture or internal injuries. However, the history of a head injury, a significantly delayed presentation and a changed account given by mother should have been explored further as a possible non-accidental injury. Mother's explanation of the reason for child's bruising was also unlikely but there is no evidence of this being explored.

Lateral checks were not undertaken, and the previous unexplained fracture of the elbow in December 2015 was not known. If a referral had been made to children's social care, this would have triggered an alert on the electronic record and engagement of the safeguarding team.

6.3.3 September 2017 - swelling to arm, fading bruising, facial scratch, fracture of the left humerus bone in upper arm

Hospital staff appropriately checked with children's social care, made a new referral and an initial telephone strategy meeting took place with a MASH manager.

The consultant paediatrician did not attend the strategy meetings despite the lack of clarity around a medical explanation for the child's injury. Information from the GP, health visitor and other hospitals was collated. The safeguarding nurse contacted City Hospital for information and City Hospital's Emergency Department administrative officer had informed them of three attendances there.

The degree of the child's developmental delay was significant and the plausibility of the child sitting on a small tricycle and either falling or being pushed required further explanation and professional curiosity.

There was no contingency plan drawn up in case a fracture was confirmed, further communication and planning were required, and/or mother did not cooperate. Such a plan should have been countersigned by a qualified nurse. This was a missed opportunity to ensure appropriate follow up.

6.4 Learning identified from the analysis of the professional response to incidents when the child had been injured

6.4.1 The importance of multi-agency communication and information sharing

The child's case illustrates the importance of effective communication in complex cases when a child is seen at a number of different hospitals and requires the coordination of a wide range of specialist services. Rather than prompting joint working and assessment, unplanned hospital attendances appear to have been considered in isolation.

There was also inconsistent sharing of information with non-NHS organisations such as the police and children's social care.

A thorough holistic assessment, if undertaken, would have highlighted vulnerabilities and any accumulation of concerns much earlier.

6.4.2 Sharing information between hospitals

The NHS Health Trusts have different IT record systems which cannot be viewed by the other hospitals. Staff should consult with other Trusts to ask about any attendances when a possible non-accidental injury is being considered. Paediatric liaison with health visitors and GPs should also take place.

In attendance 3 and attendance 4, it appears that medical staff were not aware of the previous presentation at City Hospital in attendance 2 with a fractured elbow. Enquiries made in attendance 5 established three previous hospital attendances but details about them were either not requested or provided and again the previous fracture was not identified.

6.4.3 Over-reliance on medical opinion

There appears to have been an over-reliance on medical opinion in both attendance 2 (December 2015) and attendance 5 (September 2017). Social workers and police appear to have concluded that the medical opinion that the injuries might be accidental was definitive rather than one of a range of possible explanations. For example, there was no adequate explanation for a fractured arm in December 2015 and a full safeguarding assessment should have been undertaken and specialist advice sought.

A practice issue identified by the Social Care Institute for Excellence (SCIE) and the NSPCC review of Serious Case Reviews in 2015/16 found the interpretation of medical information on the cause of injury to a child and a tendency for agencies to interpret health input about possible causes of injuries as definitive, rather than one of a range of possibilities amongst professionals. It identified a 'clash' between social care and police's pursuit of categorical explanations from medical professionals with a norm among medical professionals of giving differential diagnoses in which anything is possible until it is ruled out. It also highlighted the fact that risk assessment became more difficult if doctors could not attend meetings and there had to be a reliance on written information.

It is important that social workers avoid an overreliance on medical opinion. The Victoria Climbie Inquiry report (2003) recommended that social workers be trained to have 'the confidence to question the opinion of professionals in other agencies when conducting their own assessment of the needs of children'.

Learning

Learning Point 6: When children present with unexplained or suspicious injuries, professionals need to exercise:

- **professional curiosity:** consulting with other Trusts to ask about hospital attendances and the nature of these; paediatric liaison with health visitors and GPs to clarify information; and timely holistic assessments informed by a chronology of agency knowledge of, and involvement with, the child and both parents.
- **healthy scepticism:** non-accidental injury should be considered until there is definitive evidence for another cause of injury; and viewing injuries in the context of the child's history rather than as isolated incidents.
- **respectful uncertainty:** including managing anonymous referrals the same as other referrals; and considering injuries and how they are said to have occurred in the context of the child's development; and avoiding over reliance on medical opinion.
- work to **avoid assumptions** and the **rule of optimism:** requiring regular review of plans and progress for the child and development of contingency plans.

The above should be aided by regular reflective supervision and peer review to challenge and develop assessment practice and inform professional judgement.

7. PHASE TWO - Identifying the factors that led to the child's lengthy stay in hospital

7.1 Overview of events: November 2017 – March 2020

Following the serious incident that prompted this review, the child received medical care from Birmingham Children's Hospital which is a neurosurgical centre and has considerable expertise and experience in managing complex and serious injuries.

In the two years and four months the child subsequently spent in hospital, significant resources were deployed in a number of linked and parallel processes:

- **Initial palliative care pathway:** the child's early prognosis was poor due to the severity of the injuries and a palliative care pathway was followed. This changed in January 2018 when a neurosurgeon judged the child should have more time to respond.
- **Specialist medical care:** medical care was provided to the child in hospital by a variety of specialisms. Multi-disciplinary meetings were held in the hospital to coordinate this care.
- **Police investigation and criminal proceedings:** a criminal investigation was launched in response to the incident. There was a police homicide team presence in the hospital for twenty-four hours a day from the time of the incident until 5 February 2018 (removed in response to the move away from a palliative care pathway). There was a delay in allocating a CPS solicitor and a decision was made in January 2019 to charge mother with neglect[6] of the child.
- **Assessments and placement search:** the child was pronounced medically fit for discharge in April 2018. However, suitable arrangements were not in place for the child to be discharged. Assessments of the child and parents were completed by social workers and searches undertaken to find the child a suitable placement to facilitate discharge.
- **Care proceedings:** Birmingham Children's Trust had concerns about returning the child to the care of mother and initiated care proceedings in October 2018.

The Family Court decided in March 2020 that the child should be discharged to parents and this took place.

Mother was found guilty in criminal court of child neglect in July 2020.

7.2 The importance of following Child Protection processes

On admission to hospital, it was clear that the child had suffered significant harm.

However, in late November 2017, there was an understandable focus by professionals on the critical and palliative care of the child. The decisions not to convene a child protection conference or to begin care proceedings in respect of the child appear to

[6] Defined as 'failing to attend to the child's medical and health needs and failing to obtain medical attention'.

have been influenced by the severity of the child's injuries and a wish to be sensitive to the situation of the child's young parents.

The need for a contingency plan in case the child's health condition improved or parents withdrew their cooperation with treatment does not appear to have been considered. Indeed, the child continued to be subject to Child In Need rather than child protection processes throughout the protracted stay in hospital.

Only two formal Child In Need meetings were held (December 2018 and January 2019). Instead, the focus appears to have been on providing assessments and paperwork for the care proceedings.

With hindsight, it would have been appropriate and helpful if an Initial Child Protection Conference had been held in 2017 or at least in January 2018 when the child's prognosis and care plan changed and if an earlier application to court had been made to alert them to the child's complex situation. The threshold for holding an initial conference was met and this would have ensured independent oversight by an Independent Chairperson, and it may have resulted in a more robust plan for the child. There were several other occasions when a further Strategy meeting could have been convened and the decision not to initiate section 47 enquiries or proceed to an Initial Child Protection Conference could have been revisited:

- When the court did not make an interim care order in October 2018 (see section 7.4 below);
- When another patient alleged that there had been a concerning incident between parents on the hospital ward in April 2019;
- When mother reported allegations of domestic abuse in September/October 2019;
- In advance of the signalled court decision that the child would be discharged into the care of parents which took place in March 2020, a multi-agency planning meeting would have been appropriate to consider the discharge in detail.

7.3 Risk and needs assessment

The Assessment and Short-Term Intervention (ASTI) Team managed the child's case for nearly 11 months. The transfer of the case to the Disabled Children's Social Care Team was only agreed in June 2018 and effected in October 2018. The Disabled Children's Social Care Team could have offered at least advice and support from the outset or have jointly worked the case.[7]

Contingency planning for changes in a child's circumstances or new perspectives on situations should be routine. A parallel planning approach to end-of-life care is recommended to help families to plan with professionals for hopes and wishes for life as well as to advance plans for the end-of-life care. It is not clear that the ASTI social workers or the police were aware of this approach and the specialist knowledge of a

[7] In 2017/2018, ASTI teams could only transfer a child's case when a placement and a care plan were in place. This is no longer the case.

Disabled Children Social Care worker might have assisted at this critical time. It is not clear to what extent health colleagues contributed to discussions around the potential range of options for the child's care around this time.

There was a significant delay in completing parenting assessments of mother and father given their importance in overall assessment and planning.

Birmingham Children's Hospital have reported that changes of social worker contributed in delays to assessment, planning and progress for the child. The child had two different social workers whilst their case was open to the ASTI Team. The child had only one social worker following transfer to the Disabled Children Social Care Team.

The Review Team concluded that assessment and planning should have been more pro-active, co-ordinated, and multi-agency in nature.

7.4 Care Planning and Court Processes

A decision was made not to issue care proceedings in respect of the child in November or December 2017: the medical opinion at this time was that the child was not likely to survive the injuries.

Although this prognosis was revised in January 2018, an application for care proceedings was not made until October. (A decision to apply for an Interim Care Order was made in March 2018. However, Birmingham Children's Trust attempted to search for a placement and reach a voluntary agreement with the parents before submitting an application.)

This delay was heavily criticised by the Family Court and the application for an Interim Care Order was refused at the first court hearing. It was acknowledged during the court proceedings that the grounds for an order would have been met if proceedings had gone ahead after the child's admission to hospital in late 2017 or early 2018.

However, by the time of the application, the Court felt that the need for 'immediate separation' was not met.[8] The child's situation was complicated in that they were in hospital but parents, particularly mother, spent considerable time with the child there. Managers in Birmingham Children's Trust stated that this delay appears to have influenced the judge's view of the local authority's proposed planning and their view, approach, and decision-making throughout the care proceedings.

In November 2018, the local authority filed an Interim Care Plan. At the judge's request, the primary plan was to find a mother and child foster placement.

[8] The Complexity and Challenge report notes that *'courts have a high threshold for ordering the removal of a child from his/her parents. For example, for an interim care order it was deemed that separation was only to be contemplated if his/her safety demanded 'immediate separation' (Re H (a child) (Interim Care Order) [2003] 1FCR 350)'*.

In December 2018, the Court again refused to make an Interim Care Order and asked the local authority to update their Interim Care Plan to include the planned level of supervision of mother in placement and the access arrangements for father.

At a court hearing in May 2019, the Judge stated that Birmingham Children's Hospital needed to urgently facilitate the child's safe discharge into the community with mother.

A Finding of Fact hearing began in July 2019 and the Judge was satisfied, on the balance of probabilities, that each of the four injuries the child sustained were inflicted by mother in '*a temporary and uncharacteristic loss of self-control*' and that she did not intend to harm the child. The Court also found that mother had provided the child with consistent care in hospital and that separation of the child from parents would result in a significant impact on the child.

In December, the Judge made it clear that he would not sanction any plan that would separate the child from parents. It has been recorded that the Children's Guardian took a similar view of the child's case to that of the Judge.

Professionals in both Birmingham Children's Hospital and Birmingham Children's Trust continued to have concerns about the potential for the child to return to the care of mother who was in the process of being prosecuted for child neglect. In February 2020, Birmingham Children's Hospital became an Intervener in the care proceedings. This was supported by Birmingham Children's Trust and enabled Birmingham Children's Hospital to have access to papers within the proceedings and to present their position to the court regarding their care and involvement with the child. The hospital's chief medical officer and head of safeguarding provided statements and attended court to share their concerns about the child returning to parents' care when mother was being prosecuted for child neglect. These concerns had also been put forward by the Children's Trust. The Judge's view did not change.

7.5 Multi-agency communication and agreement

7.5.1 There were several occasions during the time the child was in hospital when there was a lack of shared understanding between social workers and hospital staff about the plans in place for the child, the progress of those plans, and what information and reports were required to inform planning and be presented to court. More robust multi-agency planning and updating of the child's assessment could have provided more clarity.

7.5.2 Missed opportunity to adopt a collaborative approach

In late December 2017, the hospital asked the Children's Trust for approval for their plans around end of life care for the child. This could not be given as the Trust did not hold parental responsibility. Staff from the Trust have acknowledged that this was a missed opportunity to adopt a more collaborative approach around care proceedings to provide a legal basis to make decisions with the child's parents.

When parents decided not to give permission for the removal of the child's breathing tube in January 2018, the hospital informed the Trust they would have to put an application into court and also asked whether children's social care would apply for an Interim Care Order. The social worker confirmed that the Trust would not be making an application to the court and that decisions about the child's end of life care should remain with parents or be presented by the Hospital Trust to the High Court. This was another missed opportunity for the two agencies to adopt a more collaborative approach.

7.5.3 Tensions around report requests

By June 2018 it was clear that planning for the child was complex and drifting. Children's social care stated that they were waiting for hospital statements requested in March 2018. However, the hospital's Children with Medical Complexities Team reported they had tried unsuccessfully to contact the social worker in June regarding the reports requested from the hospital.[9]

Tensions regarding requests for information were evident in September of the same year when the hospital's Safeguarding Officer advised the social worker to seek information from them and/or hospital consultants rather than directly from nursing staff.

The following year there was at least one example of a request for significant information from hospital staff with short notice. In April 2019 an extensive report was requested covering disability, medication, general health and immunisations, role of healthcare, health, behavioural issues, concerns and support for parents, impact of parents physical and mental health and impact on parenting capacity, observation of relationship and care from parents, observation of parental relationship, and missed appointments. The request was for this to be returned within 5 days.

7.5.4 Lack of a shared understanding of care proceedings

In 2019 hospital staff and management formally shared their concerns about the potential for the child to return to the care of mother on at least three occasions.[10] This had little effect and did not lead to a shared understanding or purpose. Birmingham Children's Trust felt that they had made hospital staff aware of the critical view that the Court held about the child. Birmingham Children's Hospital staff have reflected that there was a lack of clarity in information shared by the Trust about the progress of the care proceedings and consequently their realisation that the likely outcome was for the child to return to parents' care came late in the proceedings.

[9] The hospital records indicate that the child was unallocated, but the Head of Service (ASTI) informed the review that the case was always held by a social worker and continuous management oversight was provided.

[10] In January, the head of safeguarding at Birmingham Children's Hospital raised this with the social worker and with the Head of Service in Birmingham Children's Trust, in June the hospital's legal services manager spoke to the Local Authority solicitor about these concerns, and in December 2019, the concerns were raised again at a multi-disciplinary team meeting.

7.5.5 Agreeing arrangements for supervised contact by parents

Both parents had bail conditions to report to a Police station on fixed days/times, and not to have unsupervised contact with persons under 16 years old, including the child. Police describe discussing the supervision of the child's parents on the ward with hospital staff in November 2017. However, when Police withdrew their presence from the hospital in February 2018, no alternative plan for supervision of the parents' contact was put in place. Neither Birmingham Children's Hospital, Birmingham Children's Trust or Police appear to have considered the changes required in the arrangements for supervised contact for the child's parents.

Parental visiting fluctuated during the child's time in hospital and mother became increasingly involved in the child's care on the ward. In April 2018, hospital staff stated that mother was coming to the ward but not staying for long periods of time. In October 2018, hospital staff reported that mother visited regularly and father only sporadically. By June 2019, the ward manager confirmed to the social worker that mother was always resident in the hospital.

There should have been greater clarity about the supervision and contact arrangements for parents to see the child in hospital. By the time the matter reached court, the judge viewed mother as the child's main carer.

7.6 Placement Planning

The child's parents initially agreed to voluntary accommodation under section 20 of the Children Act 1989 for the child, but this was later withdrawn in September 2018.

Birmingham Children's Trust struggled to identify a suitable placement for the child. Searches for foster carers at times appeared to be making progress and there was also consideration of residential and hospice placements. These appear to have been unsuccessful due to limited availability (particularly in the availability of places in mother and child units and foster placements) and because of the complexity of the child's circumstances.

It appears that the lack of clarity around plans for the child's future care (which could have been provided by an application/interim order and court direction) presented an obstacle to finding a placement. The court's expectation that the parents would have significant contact with their child, if not full-time care, further added to the complexity.

7.7 Good Practice

- In 2019 there was effective joint working between Birmingham Children's Trust and Education Services to identify a suitable school for the child and with Housing Services to provide parents with a new home to assist them to be involved in the child's care.
- A comprehensive health and social care package of support was put in place for the child's discharge in 2020 involving community carers who had been trained to care for the child.

- In 2019 and 2020, a Barnardo's worker commissioned by Birmingham Children's Trust offered a high level of support to both parents. The worker provided effective intensive family support to the parents to establish a new home, prepare for the child's return to their care and subsequently to parent the child. There was good communication and joint working between the Barnardo's worker, the social worker and hospital staff.

Learning

Learning Point 7: In circumstances such as this (child in hospital with a non-accidental injury), Child Protection procedures must be followed with an Initial Child Protection Conference being held where necessary.

Learning Point 8: The Assessment and Short-Term Intervention Team should consult at an early stage, if not at the outset, with the Disabled Children Social Care Team for advice and support to effect early joint working or case transfer where appropriate.

Early consultation with Legal Services should take place and there should be timely progress of plans to initiate care proceedings.

Learning Point 9: Effective multi-agency communication and agreement is crucial, particularly between children's social care and hospital providers. This should include:

- the appropriate level of supervised contact for parents with their child in hospital. This should be compliant with any bail conditions for parents.
- consultation in respect of the need for any legal action.
- clarity about the reports required from hospital staff by children's social care in complex cases to assist in finding placements and in making legal applications to the court.

8. Changes and Service Developments since the Review was Commissioned

8.1 This review has covered a significant time period and there have been many changes and service developments since the events considered in this review. This section briefly summarises those most relevant to this case.

8.2 Responding to the needs of migrant families

8.2.1 National changes

Safeguarding and Trafficking Officers at port terminals of entry are now called Safeguarding and Modern Slavery officers and provide specialist knowledge and advice for port officers when dealing with minors and passengers of all ages where there are trafficking or vulnerability concerns.

Medical certificates which provide access to free medical healthcare are now given to applicants via the NHS and no longer issued by Asylum Support caseworkers on behalf of the Home Office.

A Department of Work and Placement team in UK Visa and Immigration established in 2018 now contacts asylum seekers granted asylum and liaises with Job Centres to set up appointments to begin the transfer process when leave to remain is granted.

The Home Office reported that the backlog of post in 2014 which contributed to delays in updating records and financial payments has been addressed and that letters such as that notifying the Home Office of the child's birth would now be processed within 24 hours.

The Home Office awarded new ten-year regional Asylum Accommodation and Support Services Contracts (AASC) which commenced fully in September 2019. The contracts require accommodation providers to develop and maintain close working relationships with local authorities. They were intended to provide a range of improvements to ensure access to support for vulnerable asylum seekers and set clear requirements on the standard and condition of accommodation. Serco was appointed as the new provider of these services in the Midlands and East of England. This provided an opportunity to require better recording of any contact, advice, and support to enable monitoring to take place.

Migrant Help was awarded a national contract for the Advice, Issue Reporting and Eligibility Assistance services (AIRE), for asylum seekers. The plan was for higher practice standards, face to face advice and support for vulnerable service users and more intensive move on support.

8.2.2 Local changes

Birmingham and Solihull United Maternity and Newborn Partnership (BUMP) was established by the relevant local NHS Trusts and developed a Local Maternity System Plan in 2017. The Partnership recognised that it has *'more work to do to achieve the best outcomes for our seldom heard communities, including asylum seekers, refugees and women newly arrived in the UK. These groups of women can present specific challenges including requiring a wide range of interpreting services and additional support navigating NHS services.'* Six Link Support Workers were funded to help women whose first language is not English to access personalised care, improve safety and provide continuity of care and clear communication routes in the main languages. A single maternity record that spans Birmingham and Solihull was also developed with plans for access to be made available for other health professionals, in particular GPs and Health Visitors.

Birmingham introduced new 'Right Help, Right Time' (RHRT) threshold guidance in January 2018. The guidance has been further reviewed and updated in February 2020 and December 2021, specifically to take account of the new Early Help Offer across the City. It highlights that families seeking asylum or who are refugees, families new to area, and children born to teenage parents may have universal plus needs and

require a coordinated approach through an Early Help Assessment or Family Plan. In its recent inspection of children's services in Birmingham, Ofsted recognised the progress that partners had been made in developing and implementing "strong early help services for children and families." A further refresh of the RHRT guidance is currently taking place.

Birmingham Safeguarding Children Partnership now delivers a multi-agency training course *'Safeguarding Children and Cultural Awareness'* which includes information about migration and cultural competence in practice. It is important that agencies also cover these areas within their internal training programmes given the size of the children's workforce in the city.

8.3 Assessment and support for vulnerable families

8.3.1 National Changes: the NSPCC

The NSPCC reviewed its national Helpline's referral tracking system in 2016 to ensure that all feedback from receiving agencies is subject to management review.

8.3.2 Changes to how social care services are delivered in Birmingham

Since April 2018, children's social care services in Birmingham have been delivered by Birmingham Children's Trust. The Trust is owned by, but operationally independent from, Birmingham City Council. A multi-agency Children's Advice and Support Service (CASS) was introduced in 2017/18 to provide a single point of contact for professionals and members of the public who want to seek support or raise concerns about a child. It also signposts professionals to appropriate services and coordinates effective action in Child Protection cases.

Work has taken place to continually strengthen arrangements and practice in the CASS and Multi Agency Safeguarding Hub (MASH). An internal self-assessment was conducted in March 2022 leading to strengthened arrangements in respect of resourcing, governance, quality assurance and performance management. Ofsted found that 'concerns about children who need help and protection receive a timely and effective response from the Children's Advice and Support Service (CASS)."

8.3.3 Management of children's centres and changes to health visiting services

The Health Visiting Service in Birmingham changed to a district configuration in 2015 and became part of the Birmingham Forward Steps Service. Electronic Trust records were introduced in January 2016 for health visitors.

Following a review of Early Years Services, Birmingham Community Healthcare NHS Foundation Trust were commissioned to manage Children's Centre services in January 2018. This contract also includes Health Visiting Services and Birmingham Forward Steps. The Birmingham Children's Partnership have overseen the continued development of a locality based early help and support across the city.

8.3.4 Confirming appointments

The Central Booking Service for the Child Health Medical Service changed its appointment process at the end of 2018. Parents are now sent an appointment following an acknowledgement letter without having to contact the Central Booking Service themselves.

8.4 Unexplained, suspicious and non-accidental injuries

8.4.1 Child Protection Guidance, including bruising in non-mobile babies

Birmingham Safeguarding Children Partnership replaced the former Local Safeguarding Children Board in April 2019. The new partnership is part of a regional consortium which has provided front-line practitioners with access to online Safeguarding Policy, Procedures and Guidance since March 2017.

In February 2023 a new safeguarding toolkit aimed at supporting professionals working with children to take the appropriate action when identifying worrying marks, bruises or injuries was published. This includes guidance on bruising in non-mobile babies and is available via the Partnership's website.

8.5 Identifying the factors that led to the child's lengthy stay in hospital

8.5.1 Child Protection and Child In Need processes

In 2020/2021, Birmingham Children's Trust conducted an internal audit and have rewritten policies and procedures around Child In Need assessment and planning.

8.5.2 Risk and needs assessment

The Child with Medical Complexities Team within Birmingham Children's Hospital now become involved at a much earlier stage with a child after admission, regardless of any poor prognosis.

Birmingham Children's Trust have confirmed that the Children with Disabilities Team would now either lead or be invited to a strategy meeting at the outset if a child presented with such significant injuries.

Birmingham Children's Trust also undertook a full review of the Children with Disabilities Service (CWD) between October 2020 and March 2021. It has taken account of a range of sources of information, including the learning from this serious case review. Following this review, CWD restructured into three area based safeguarding teams, the aim of which is to ensure consistency of allocated social worker, timely assessment and specialist safeguarding as well as support for area based colleagues with advice and guidance. In February 2023, Ofsted found that disabled children who receive help and protection mostly receive an effective service. The report states that "social workers and staff from partner agencies understand the needs and risks…assessments and plans are detailed and purposeful, with the views of children and families consistently recorded. Children's plans are progressed through meetings that are well attended by partner agencies."

8.5.3 Multi-agency communication and agreement

Birmingham Safeguarding Children Partnership revised its Resolution and Escalation Protocol in March 2019 and continues to highlight the importance of implementing the protocol where there are professional differences about responses to safeguarding issues.

Birmingham Children's Hospital have reviewed the information sharing process with Birmingham Children's Trust. They have implemented internal legal planning meetings for complex cases and a more robust process for continuity of safeguarding case management for long term complex patients. Requests for information and reports are now made through the Hospital's legal inbox to ensure a single point of contact and to ensure that appropriate scrutiny, advice, and quality assurance of information to be shared is provided in the process. A more robust escalation procedure is now in place at the Hospital and any concerns around case management and discharge planning would be raised much quicker and at a more senior level. A Hospital safeguarding database provides improved visibility of safeguarding record keeping and escalation of cases.

As part of Birmingham and Solihull's development of an Integrated Care Service, there is a digital workstream to develop shared care electronic patient records accessible between hospitals and across services including GP practices.

8.5.4 Discharge and Placement Planning

Birmingham Safeguarding Children Partnership's Quality Impact and Outcomes Sub-Group undertook a multi-agency audit and review in 2019 of eight cases that involved a child being discharged from hospital. The audit found that some children with complex needs were staying in hospital too long when they had been deemed medically fit. This was mainly due to a lack of suitable beds/placements and a lack of multi-agency agreement about what was needed for the child. The audit findings have been taken forward and a briefing note on discharge planning highlighting good practice, and the importance of early intervention, was circulated to front-line practitioners and managers in Birmingham in 2019.

In 2020 Birmingham Safeguarding Health Partnership updated the discharge planning documentation and guidance in line with the *Right Help Right Time* documents to ensure that the layers of need are assessed to determine what action is needed to support a family to improve the quality of practice and to standardise practice across NHS Trusts in the City.

9. Conclusion

9.1 This is an extremely complex review, which examines partnership intervention over a long period. The review has two distinct phases to maximise the opportunity to identify important learning.

9.2 Phase One

Learning from Phase One is largely focused on how agencies identified and responded to the vulnerability of both the parents and the child.
The parents' circumstances included all the factors outlined in NICE guidance as indicating vulnerability[11]:

- recent arrival as migrants
- difficulties in understanding English
- homelessness
- asylum seeker or refugee status
- parents under 20 years of age
- poverty

As a young migrant couple, English was not the parents' first language and neither had any experience of the health, benefits or housing systems in this country and very limited support. Professionals could have done more to understand these challenges.

The findings from this phase also echo the learning identified in previous Serious Case Reviews in Birmingham and nationally. It highlights well-known challenges for agencies working with children and families around the need to embed and monitor timely, robust practice regarding multi-agency assessment, planning, intervention, and review.

This review identifies several potential missed opportunities for holistic assessment, emphasises the importance of health professionals following the 'Was not Brought' policy, and highlights the need for a lead professional to co-ordinate care for children with complex needs.

It also underlines the importance of professional curiosity and healthy scepticism, particularly when children present with unexplained or suspicious injuries. Non-accidental injury should be considered until there is definitive evidence for another cause of injury.

In April 2019, Birmingham Safeguarding Children Partnership developed a plan to ensure that learning from Phase One was disseminated, referenced in relevant training, and put into practice. Birmingham Safeguarding Children Partnership has confirmed that all 33 actions have been completed.

9.3 Phase Two

The circumstances which led to Phase Two are extremely unusual. A unique combination of factors made the multi-agency management of the child's health and safety particularly difficult.

This was in part due to the unanticipated change in the child's original prognosis. The initial adoption of a palliative care pathway meant child protection processes were not instigated early enough, which could have led to a more integrated partnership approach to the child's safeguarding needs and long-term care and support.

[11] NICE guidance model for service provision for pregnant women with complex social factors.

The lack of shared vision and agreed multi-agency plan for the child complicated communication between agencies. There were too many occasions between November 2017 and March 2020 when there was a lack of clarity between social workers, hospital staff, police, and legal teams about the plans in place for the child, the progress of those plans, and what information and reports were required to inform planning and the family court proceedings.

Multi-agency assessment and planning should have been more pro-active in bringing together the key professionals involved in managing safeguarding issues and responding to the child's complex health needs. While this would not have prevented the significant challenges finding a suitable placement, a shared understanding could have minimised delays and enabled professionals from different agencies to better explain their concerns about the child's safety to the Family Court. This case has also highlighted the shortage of specialist placements nationally, which can delay the discharge of children with complex care needs from hospital.

The learning from this Review reinforces the importance of early information sharing and engagement by agencies in discharge planning, particularly for the most vulnerable children and families with complex health needs requiring integrated long-term care and support.