BIRMINGHAM Safeguarding Children PARTNERSHIP

Serious Case Review

BSCB 2015-16/03

Independent Lead Reviewer:
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1. Introduction

1.1 This report concerns the serious injury of a 4-month-old baby. Although the baby survived the injury, they will have permanent impairment as a result. The baby had head injuries that were non-accidental and were likely to have been caused by a single event of inappropriate forceful handling. The injuries were consistent with shaking and an impact to the head. The baby was also found to have an older rib fracture. The baby was the second child of two young parents - themselves children. During the process of the investigation the older sibling was found to have old injuries (rib fractures). Initially both parents were arrested; however the mother was later charged and pleaded guilty to causing the injuries to both children. In March 2020 the mother was sentenced to 12 months imprisonment for the first charge of child cruelty in respect of the baby, and a further six months for the second charge of child cruelty in relation to the sibling. Both sentences are to run concurrently and are suspended for 18 months. Both children were adopted in May 2019 where they have settled very well.

1.2 This does not appear to be a case of deliberate mistreatment or abuse but of the inability of a very young parent to cope.

1.3 There had been considerable involvement of agencies with the parents, their families and the two young children prior to the incident.

1.4 The Serious Case Review Sub-Group of the Birmingham Safeguarding Children Board (BSCB) discussed the case on 18th December 2015 and recommended to the Independent Chair of the BSCB that the criteria for a serious case review was met. The Independent Chair, after due consideration and peer review, agreed and decided on 27th March 2016 to commission this Serious Case Review.

1.5 This case fits the national profile of non-fatal physical abuse in that the baby was under a year old, the incident took place within the family, and the perpetrator was the mother. The baby had never had a Child Protection Plan but was known to Children's Social Care.

1.6 These two children suffered harm in spite of all the work professionals were doing to support and protect them. Rather than looking at whether serious harm was predictable or preventable we need to look at the opportunities that arose for prevention and protection and the underlying systems and processes that might get in the way of, or support, such work. What could have been done differently?

1.7 At one of the meetings during this review it was said that as the "Threshold for Care" would not have been met (before the injury), how could it have been prevented? Surely there are more ways to protect children?

1.8 This case highlights learning in managing individual cases, working together as professionals and agency structures, processes and cultures.

1.9 In reviewing this case the author is mindful of the massive amount of organisational change in all agencies before, during and after the events described. Therefore, where changes have been put in place that would mean that practice now would be different, to those referred to within the review.

2. Reasons for a Serious Case Review

2.1 Statement of Working Together Criteria for an SCR

2.1.1 Regulation 5 of the Local Safeguarding Children Board's Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) Abuse or neglect of a child is known or suspected; and
(b) Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. (1)

2.2 Process of Decision Making

2.2.1 When considering the case on the information known at that time the Serious Case Review Sub-Group noted that there was a range of issues in relation to the family. The children's parents were both teenagers with two children under the age of one, each having health concerns. Both parents were known to Children's Social Care and had had intensive interventions in their own right. There was an unreported rib fracture in the sibling, and concerns about domestic abuse as well as the injuries indicative of shaking. There were a significant number of agencies involved with the family. The last assessment completed was in June 2015.

2.2.2 The recommendation from the Serious Case Review Sub-Group was to undertake a serious case review as the sibling had sustained serious non-accidental injuries and there were concerns about how agencies had worked together.

2.2.3 The Independent Chair agreed with the Serious Case Review Sub-Group. The injuries the baby had sustained were likely to result in sustained serious and permanent impairment of health or development. It was clear that agencies had been involved and risk factors identified but that the available information indicated that they had not necessarily worked collectively together to ensure the two children were effectively and fully safeguarded.

2.2.4 The Independent Chair peer reviewed the case and the peer reviewer agreed that the grounds for a serious case review were met.

3. Terms of Reference

3.1 Aim

3.1.1 The focus of the Serious Case Review is on the quality of professional practice and the way in which frontline practitioners worked as professionals within their own agencies and together to best identify the needs of the family, plan to meet those needs and progress those plans.

3.2 Process

3.2.1 This was to be a simple and proportionate review given that care proceedings were also underway, and that there was an outstanding criminal investigation that had not yet concluded.

3.2.2 A Lead Reviewer was identified and commissioned to lead the work.

3.2.3 The Serious Case Review was to use a blended methodological approach, led by the Lead Reviewer reporting to the Serious Case Review Sub-Group.

3.2.4 Both parents and their immediate family members were to be involved.

3.3 Time Period: 1st January 2015 – 18th November 2015

3.3.1 The review began at the point of the confirmation of mother's pregnancy with the baby and concluded at the point of the admission of both children into foster care.

3.3.2 Some events prior to this were considered as they were important to subsequent events.

3.4 Key Issues

3.4.1 The Lead Reviewer was asked to utilise the methodology above and explore in depth:

- The nature of the family's needs, lifestyle and their ability to meet their own and their children's needs themselves;
- The needs of both the baby and the sibling, and the impact of those on both children's lives;
- The vulnerabilities inherent in two young parents caring for two children under one-year-old, both with health needs, and how well these were

identified, recognised and responded to by professionals in contact with the family;

- The quality of interagency information-sharing, joint assessments of need, joint planning and joint interventions to support the family;
- The quality of referrals, assessments and casework by Children's Social Care in relation to both children during the period under review;
- The theoretical casework models utilised, and the research evidence used by practitioners to inform decision making;
- The journey the family experienced in terms of their contact with professionals over the period under review, and why things happened the way they did;
- Those key incidents during that journey where positive learning can be identified and used to improve multi-agency and single agency practice in similar situations;
- The impact of repeat short interventions on the family's relationship with professionals; and
- Any other key matters arising from the involvement of the family and the practitioner events.

The Serious Case Review Report was also to consider relevant research as part of its analysis.

3.5 What was out of scope

3.5.1 The review was not to:

- Consider in detail the baby's birth family or previous agency contact with them unless it was directly pertinent to the terms of reference (e.g. the factors that gave grounds for care proceedings);
- Consider events prior to the pregnancy and birth of the baby;
- Consider the extended family network and agency contact with them except and unless it was pertinent to decision making.

4. Methodology

4.1 Independent Lead Reviewer

4.1.1 Dr Anne Aukett is a retired Consultant Community Paediatrician. She trained in Birmingham and held posts in the West Midlands, Sheffield and The Gambia. Much of her work was in safeguarding children. During her career she was a Named and Designated Doctor and Clinical Lead for Safeguarding at the Strategic Health Authority. She was the Vice Chair of Birmingham Safeguarding Children Board and Chair of the Serious Case Review Sub-Group. She was the author of six serious case reviews prior to the requirement for independence. Leadership posts

included Clinical Director and Medical Director. Since retirement five years ago she has taken on commissioned work including serious case reviews.

4.2 Panel

Head of Service Safeguarding Children - Birmingham Community Healthcare Trust

Detective Chief Inspector – West Midlands Police

Childcare Quality and Sufficiency Manager – Early Years, Childcare and Children Centres Service

Head of Service East - Directorate for People, Birmingham City Council

Head of Safeguarding - Birmingham Women's NHS Foundation Trust

Principal Officer Child Protection – Directorate for People, Birmingham City Council

Neither the author nor the panel had any involvement in the case.

4.3 Participating Agencies

4.3.1 See Appendix 2

4.4 Methodology used.

4.4.1 A blended methodological approach was used based on Root Cause Analysis. (2)

- Key incident chronologies and agency reviews were completed by each agency in contact with the family.
- An initial learning event was held involving all the frontline practitioners and managers in contact with the family. At the event practitioners and managers were open and honest and some insight was gained into why things happened the way they did. It was salutary that some practitioners said that they had learned things about the family at the event that they had not known before.
- Immediate learning and actions required were identified from the reports and at the event, some of which had/have already been implemented.
- A second learning event involving middle and senior managers was held to look at the learning derived from the review and how this could be applied to the wider system especially in the light of changes since the events under review. This was also a helpful meeting given the pace of change. Managers were able to share where there are still difficulties in multi-agency working and where partners can help to address them.

- A final report with learning points and suggested recommendations.

5. Family Involvement

5.1 There is an expectation that families will be involved in case reviews. Working Together 2015[1] includes the following guidance:

"Families, including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process."

5.2 In this case the children were too young to speak for themselves but how they might have felt is considered.

5.3 Family perspectives can add valuable insights and support learning for future protective services but there are inherent tensions in the process.[3] The reality of such participation in this area is under researched and practice varies across the UK. However, it is acknowledged that families may have information about hitherto unknown aspects of a child's life. On the other hand, families may have little understanding of the risks facing the child.

5.4 In this case it was felt that meeting with the family was an essential component of the review and would allow the family to have a voice in the process, contribute to the learning and raise, at an early stage, any concerns or issues that they felt they would like addressed as part of the review.

5.5 At the point the report was written, due to the ongoing criminal investigation, it was not possible to meet with relevant family members. However, subsequent to the conclusion of the criminal proceedings both parents were contacted. The mother has declined to contribute to the review process. The father has not responded.

5.6 During the Family Court proceedings mother admitted to causing the injuries to both children.

5.7 Mother has said that she felt guilty because she was not able to cope and that she did not want anyone thinking she had hurt the children. She did not want to think she had caused the injuries and had never meant to hurt them. She was finding it difficult to deal with the fact that she had hurt her children just like her father hurt her. The difference being that he meant to hurt her, but she never meant to hurt them, but they still got hurt and she has to live with that and feels very bad.

5.8 Father has said very little other than denying that he had anything to do with the injuries.

6. Summary of Family Circumstances

This provides the "Context" as described in the model outlined below.

At the time of the events under review the following was known about the family circumstances. It is to be noted that this family consisted of four "children".

6.1 Mother

6.1.1 Mother was a very young vulnerable mother. She was 16 when this baby was born and 15 when the baby's sibling was born. There was only eight months between the two births.

6.1.2 Mother herself had a troubled childhood and has disclosed that her parents regularly physically abused her as a child.

6.1.3 She has borderline/below average intellectual ability and it has subsequently been stated that she has a cognitive reading age of about 10 years. She attended primary and secondary school, but didn't finish year 10 as she was pregnant. Attendance had been 83% up to that point. She returned to take one GCSE in Year 11 and obtained a grade C. She had behaviour problems at school – abuse to staff, truanting and being defiant.

6.1.4 She has three teenage siblings and a younger half sibling. There was significant police and social care involvement with her family with child protection concerns including domestic violence, poor living conditions, drug and alcohol abuse, unexplained burns to a sibling and anti-social behaviour. She was never in Local Authority care but was required to live with her maternal grandparents for a short period of time when she was 13.

6.1.5 Mother left her family home in July 2014 during her pregnancy with the sibling. Initially she went to live with her maternal grandparents together with her older sibling, but later moved in with her boyfriend and his family. Apparently in October 2014 (after her first baby was born) mother herself made a disclosure to Children's Social Care regarding her own mother. This related to domestic violence and drug abuse. The youngest three children were made subjects of a Child Protection Plan (neglect). Mother was also assessed at that time, but her case was closed as she was said to be in a stable relationship with the father of her child. It was thought that she was supported by the father's family.

6.1.6 As a teenage mother she was recruited to the Family Nurse Partnership (FNP) Programme [4] but left having disengaged. Following her arrest for the injuries to her baby, mother presented to her GP querying whether she had post-natal depression. She was started on anti-depressants. It was not felt she had any significant mental disorder but that this was a mild depressive episode and a fairly normal response to the situation.

6.2 Father

6.2.1 Father was 16 when the older sibling was born and 17 when this baby was born.

6.2.2 Father too had had a troubled childhood. He had been the subject of two Child Protection Plans, one in respect of inappropriate chastisement of himself and his siblings and one relating to his father taking inappropriate photos of a sibling. There were concerns about poor home conditions and presentation of the children. There have been many police contacts with his family. The majority of these incidents relate to neighbour disputes and anti-social behaviour. His mother left home suddenly in 2008/9 following a domestic violence incident when he was 11/12 years old. His father had a new partner (step-grandmother).

6.2.3 Academically he was said to be an able child with the potential to achieve, but during secondary school he had problematic behaviour including disruption, being argumentative and aggression. His behaviour was seen as anti-social and put him at risk of offending. This was mainly due to neighbour disputes. The Youth Offending service was involved, and he engaged with short-term work. His family was seen to be supportive at that time.

6.2.4 In July 2014 following a Section 47 enquiry he and the other children in his family were subject to Child in Need Plans.

6.2.5 Father has been linked to numerous incidents of violence towards others and property (not family members). These have not resulted in a conviction. In February 2015 he is alleged to have assaulted his stepmother's ex-partner with a baseball bat. In July 2015 he was the victim of a minor assault.

6.2.6 Father briefly left the family home on 27th September 2015 but had returned by 7th October 2015. During this time, he fell off a bike and sprained his wrist.

6.2.7 He was in work (apprenticeship).

6.3 Sibling

6.3.1 The baby's older sibling was only a year old at the time of the serious injury. This was the parents' first child who was born at 38 weeks. It would appear that mother was initially pleased to be pregnant with this child, but when she was involved with the FNP worker she seemed to have little attachment to the new-born baby and was disappointed by the sex of the child.

6.3.2 The sibling had had their routine child immunisations and had had other minor health problems for which they were appropriately taken to the GP. They had an Atrial Septal Defect (ASD) which was identified by the GP at the age of 2-months-old. This is a small hole in the heart which usually causes no problems in childhood but requires six-monthly reviews by the hospital. The sibling was otherwise healthy and was meeting their developmental milestones.

6.3.3 The sibling presented as a smiling inquisitive child and was reported to have good interaction with the mother. It was later said that the child could present with challenging behaviour such as screaming and slapping and that they were a poor sleeper.

6.3.4 The sibling had a severe nappy rash at the time of the incident.

6.4 The Baby

6.4.1 The baby and subject of this review was the second child. The birth was not planned. The baby was born at 28 weeks gestation and spent 2 months on the Neonatal Unit (NNU). At the time of discharge the baby was 36 weeks gestation. The baby was ventilated on the NNU and had chronic lung disease as a result of immature lungs which required oxygen at home. On discharge from hospital the baby was tube-fed but by the time of the incident was taking bottles, albeit sometimes with difficulty.

6.4.2 The baby had a Patent Ductus Arteriosus (PDA). This is an extra small channel near the heart common in premature babies, which usually closes in time on its own. The baby was on no treatment for this. Scans whilst on the NNU showed some brain haemorrhages associated with the baby's prematurity. These were without clinical significance.

6.4.3 The evidence seems to be that mother and indeed father did not bond with the baby.

6.5 Home Circumstances

6.5.1 Both parents were living with the paternal grandparents from early in the pregnancy with the first child (June/July 2014). Mother appeared to receive a great deal of support from step-grandmother.

6.5.2 Mother, father and their first baby moved into their current address on 9th March 2015. This was following a homeless application due to overcrowding at the paternal grandparents' home. They seem to have been proactive in requesting repairs to the property, but there was a report of a burglary on 29th March 2015.

6.5.3 In the house at various times there was also a dog, a bird, and a snake. After the move to their own home mother appears to have continued to have considerable support from step-grandmother and spent part of most days in that household.

6.5.4 Father seems to have had little to do with the care of the children especially during the day when he was either at work or out with his friends.

7. Summary of Key Events

7.1 Events prior to the timeframe of the Review

7.1.1 These are included as they are important to the subsequent decision-making in the case.

7.1.2 During her pregnancy with the older sibling mother was enrolled in the Family Nurse Partnership Programme. The FNP worker worked with mother in the summer of 2014. On 15th July 2014 the FNP worker raised a number of concerns with the family's social worker (parenting capacity, attachment and bonding, ability to parent, ability to respond to child's changing needs, overcrowding, limited support from maternal family, domestic violence, mother having been brought up in a cycle of deprivation). This was a social worker who was carrying out an assessment of mother's family following a referral regarding domestic violence. Mother at that time was moving between her own home and that of her boyfriend (father).

7.1.3 The social worker told the FNP worker that he could not open an assessment on the unborn child and gave the number for Information and Support Service (IASS) in order for the FNP worker to make a referral. The social worker also said that he would make sure the information she had given him was recorded on mother's assessment. On 16th July 2014 the FNP worker phoned Children's Social Care and a referral form was sent electronically. There is no trace of this referral on any of the Children's Social Care systems; however, the FNP Nurse received an automated response that it had been received and was to be dealt with by the social worker already working with the family. The case was never opened, and no further action taken. The social worker did not record the concerns on mother's assessment and indeed recorded that there were no concerns regarding the pregnancy having contacted the GP surgery. That assessment was closed on 21st July 2014 with no further action.

7.1.4 As a result of the FNP worker making this referral mother disengaged from FNP. Mother told the FNP worker she did not want her as her worker. She was unhappy about her making the referral. She did not want the FNP Nurse "meddling in her life". She refused input from both this worker and the Programme. The FNP worker was involved for approximately three months. It is not clear when she stopped visiting but the health visitor received a handover on 7th November 2014.

7.1.5 On 4th September 2014, when the community midwife made a referral regarding the unborn child (sibling) she mentioned mother had declined FNP support. Mother apparently consented to this referral. No action seems to have been taken.

7.1.6 This first child was born in October 2014.

7.1.7 In October 2014 Mother made a disclosure to Children's Social Care relating to her own mother and as a result of this all her siblings were made subjects of a Child Protection Plan. No further action was taken in regard to mother as she was no longer in the family home and was seen to be supported by father's family.

7.1.8 On 23rd October 2014 the community midwife did her final post-natal visit. She noted that the home environment was unclean with a strong smell of animal urine. There was underwear on the floor in the hall with human faeces. The baby was discharged into the health visitor's care and the midwife documented that she would contact the health visitor.

7.2 Events leading up to the injury within timeframe of review

7.2.1 On 12th January 2015 mother's pregnancy was confirmed by her GP. The sibling was then three months old.

7.2.2 Mother attended her first antenatal appointment with the community midwife on 2nd February 2015 when she was accompanied by step-grandmother. The following day (3rd February) a homeless application was made. As both mother and father were under 18 a referral form was sent to Children's Social Care. Although clearly recorded by Housing with a copy of the form no trace of this can be found within Children's Social Care.

7.2.3 The first key event occurred on 6th February 2016 when mother's sibling disclosed to the school nurse that mother was experiencing domestic violence and was pregnant. The school nurse made a verbal and written referral to MASH regarding this allegation. She also phoned the health visitor. On the following Monday a Strategy Meeting was held at MASH involving the police, social care and health. An 'amber' rating was given, and a decision made for a single agency assessment. A social worker was not allocated until 17 days later and a home visit not done until 16th March, more than five weeks after the referral.

7.2.4 In the interim, on 9th March the family had moved to their own home.

7.2.5 The assessment was completed and closed on 10th April 2015 with mother referred to a children's centre two months after the referral. This key event is discussed in more detail later.

7.2.6 As the family had moved, a new health visitor was allocated on 13th May 2015 although the old one remained involved up to the point of handover. The new health visitor visited on 26th May 2015. Mother declined children's centre support or a family support worker. The issue of what to do when support is clearly needed but declined is considered later.

7.2.7 On 17th June 2015 mother went into labour at 28 weeks gestation. The baby was born and admitted to the NNU. The sibling was eight months old.

7.2.8 Mother went home two days later.

7.2.9 The midwifery service contacted MASH to check if the family were known as part of the lateral checks for the baby and were told that mother had been previously known and the last assessment had been completed on 3rd June 2015 (*the author remains unclear what this related to*). They also contacted the health visitor and on the same day received information from the health visitor who advised FNP were involved (inaccurate). No concerns were noted. The new family health visitor contacted the NNU on 24th June 2015 with more accurate background information and a "discharge-planning booklet" was commenced on the NNU. Mother was discharged from the midwifery service on 29th June 2015.

7.2.10 On 20th July 2015, the new birth worker visited the home. The baby was still in hospital and the worker had no information about the family. The "assessment" completed relates to the sibling. She contacted the health visitor. This is discussed later.

7.2.11 The baby remained on the NNU for two months. The baby had the usual medical problems of a premature baby and remained oxygen-dependent. Mother visited most days and learnt to care for the baby. There is little recorded about father's visits.

7.2.12 At the first visit of a new HV (previous one had left) on 30th July 2015 mother disclosed that she was struggling to cope with visiting the hospital and caring for the sibling and on 4th August 2015 after another visit the health visitor phoned the NNU about home conditions and was told that a discharge planning meeting would be held. The NNU contacted Children's Social Care for information but were told the baby was not known.

7.2.13 The baby was discharged home on 13th August 2015 on tube feeds and oxygen. No discharge planning meeting was held. The baby was 36 weeks gestation. This key event is discussed later.

7.2.14 The Neonatal Outreach Team visited regularly starting on the day after discharge. The health visitor did the New Birth visit on the 17th August 2015 and mother and baby had a post-natal check at the GP on the 20th August 2015.

7.2.15 Over the following four weeks the baby was admitted three times to the Paediatric Unit (24th August, 9th September and 14th September 2015). On each occasion the baby was discharged within 24 hours.

7.2.16 On Friday 25th September 2015 the health visitor visited. This was another key event and was a follow-up visit to one on the 22nd when the sibling had a severe nappy rash. The health visitor offered to complete a Family Common Assessment Framework (FCAF) but mother refused. Following advice from the Trust Safeguarding Team the health visitor made a phone referral to MASH followed up by a Multi-Agency Referral Form (MARF). The essence of this referral was that

mother was not seeking appropriate medical advice to treat the nappy rash and was not being straightforward with professionals.

7.2.17 Father left the family home on the 27th September 2015.

7.2.18 The following Tuesday (29th) the health visitor went again to the home. She found mother tearful. Father had left. The sibling had a bruise on the forehead. Mother felt she couldn't cope alone and was now accepting of family support. The health visitor didn't pass this new information onto MASH but completed an FCAF with mother and referred to the local children's centre for family support. A multi-agency professional discussion between Children's Social Care and the police was not held at MASH until the 6th October. It was agreed that the case should be allocated to an Assessment and Short-Term Intervention (ASTI) worker and a family/single assessment commenced. This was now 11 days after the referral. The case was allocated on 10th October 2015 (two weeks post referral) and he made an unannounced home visit on the 14th. This sequence of events is discussed later.

7.2.19 The health visitor phoned mother on the 1st October and visited again on the 7th and 13th. Father had returned. The sibling's nappy rash was not improving, and mother had not consulted the GP as advised. She stated she had an appointment that day but when three days later the health visitor checked with the surgery she was told the child and family had not been seen since August. The health visitor then phoned and e-mailed the social worker team manager expressing concern about the family and learned that the social worker had already visited and had also been told that the sibling had been taken to the GP for treatment. It was decided that a joint home visit should be done, and this was scheduled for 20th October 2015

7.2.20 In the meanwhile, a FSW was allocated on 12th October and had made several failed attempts to contact mother and had drawn up a draft Family Support Plan. She had also spoken to the health visitor. It was decided that the FSW should visit after the planned social worker/health visitor visit on the 20th.

7.2.21 On the evening of 17th October, the baby was admitted to hospital with serious injuries.

7.3 Events after the admission to hospital with the serious injury

7.3.1 The baby was admitted to hospital after a 999 call. The baby had difficulty breathing and was treated overnight on the High Dependency Unit. The initial focus was on providing urgent medical care. Seizures were noted in the early hours of the morning and a CT scan later that day showed an extensive subdural haemorrhage. Following discussion with the Children's Hospital, non-accidental injury was suspected. This was discussed with mother and the nursing staff made a safeguarding referral to the Emergency Duty Team (EDT) at approximately 8pm

on the 18th October. Concerns were expressed about the safety of the sibling at home with father overnight. The social worker provided information about past Children's Social Care involvement. The referral was followed up the following morning (Monday) when a MARF form was sent to MASH.

7.3.2 The social worker spoke to the medical staff later that day and confirmed that the sibling was with father and paternal grandparents.

7.3.3 The following day the Safeguarding Nurse from Heart of England Foundation Trust phoned the social worker who stated that a professionals' meeting or strategy meeting would be held depending on the results of the medical investigations and that he would meet with the parents. Later that day the social worker met with the safeguarding nurse and informed her that the paternal grandparents had current involvement with Children's Social Care. She queried the placement of the sibling with them and whether a strategy discussion should be held and the police informed. The social worker said he intended to do that.

7.3.4 On the 21st October the Named Doctor reviewed the x-rays and an old rib fracture was seen. A skeletal survey was done, and a skull fracture seen. The ophthalmologist examined the baby and found retinal haemorrhages. There were several phone calls between the safeguarding nurse and the social worker's team manager relaying the information about the medical findings. Concern was again expressed about the sibling and a strategy meeting requested. The police were informed and a strategy meeting scheduled for the 22nd October 2015. At some time during the day the social worker visited the ward when mother, father and sibling were there. At the end of the afternoon nursing staff were still worried about the safety of the sibling and also how they should supervise the parents with the baby on the ward. These concerns were eventually expressed to EDT who suggested the ward staff should persuade mum to go home and that a "safe and well" check would be done regarding the sibling.

7.3.5 The doctor explained the situation to mother who, after phoning father, went home. It was apparent that the sibling was with father at home. The doctor informed the police who found the sibling at home with father when they visited the family home with a social worker. They were both taken to the paternal grandparents' house. The police and social worker were happy with this arrangement.

7.3.6 On the 22nd October a strategy meeting was held. Both children were placed in Police Protection and Section 47 enquiries started. Parents were arrested and interviewed. Later that day the sibling was placed in foster care. This was four days after concerns had been expressed about the sibling's safety.

7.3.7 The following day during a discussion about the children going into care, mother told the social worker that she had shaken the baby.

7.3.8 On 29th October old rib fractures were found on the skeletal survey of the sibling.

7.3.9 On 18th November Interim Care Orders (ICO) were obtained on the baby and the sibling and on discharge from hospital on 30th November the baby too went into foster care.

7.4 What has happened since

7.4.1 Mother went to the GP on 26th October 2015 expressing concern that she may have postnatal depression. This led to the GP referring her to the Mental Health Trust Single Point of Access. The referral was screened on the same day by a community psychiatric nurse who forwarded it to the Community Mental Health Team who subsequently saw her. On the advice of her GP mother also self-referred to Birmingham Healthy Minds.

7.4.2 The parents separated in November 2015. Mother has said that father "kicked her out". She has gone back to her mother's home.

7.4.3 Father is said to have a new relationship with a 16-year-old girl who is now also pregnant.

7.4.4 There has been a parenting assessment done in which mother engaged and did well. Father did not engage. He has asked to be reassessed with his new partner.

7.4.5 The foster carer had expressed concerns about both children: developmental delay in the baby and worries about poor interaction, developmental delay and poor weight gain in the sibling. These symptoms in the sibling may well relate to poor attachment given the child's experiences in the first year of life.

7.4.6 The baby has been followed up by the neurosurgeon. The baby has developmental delay and hemiplegia as a consequence of the head injury.

8. Key Issues arising from the Review and Author's Analysis of them

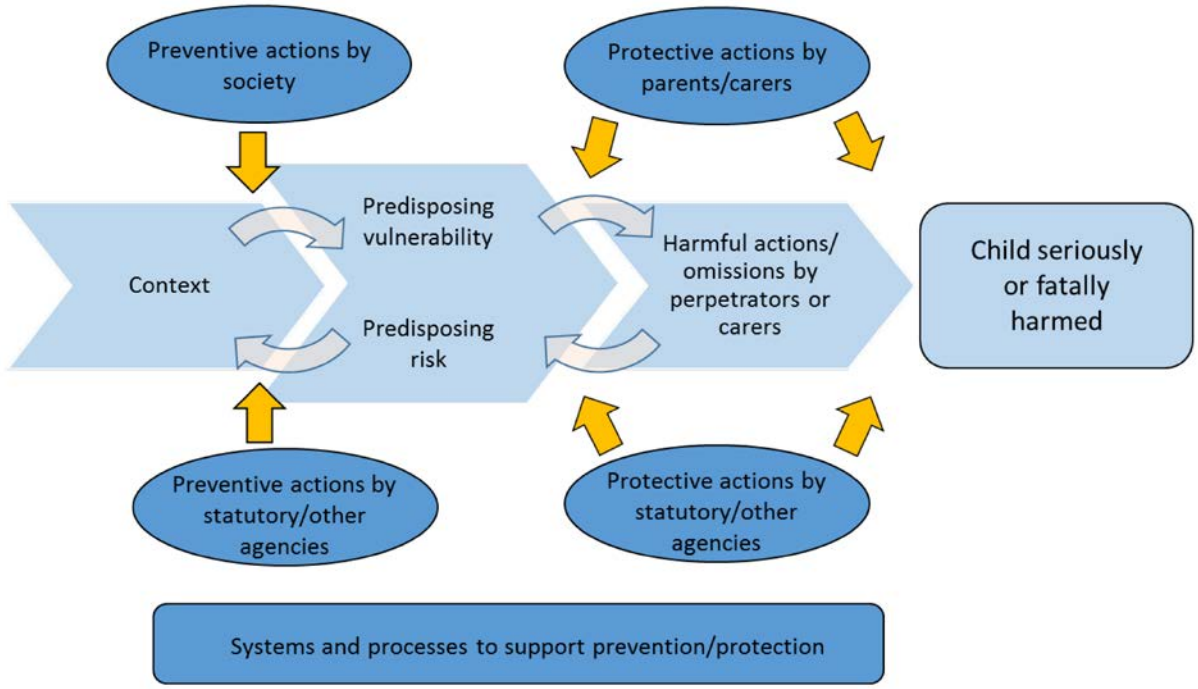
8.1 In reviewing this case the author is mindful of the recent report and triennial analysis of Serious Case Reviews [5] where it is stated:

"We therefore suggest an approach that steers away from whether a death or serious harm could have been predicted or prevented to acknowledging that there is always room for learning and improvement in our systems."

8.2 Also the Wood report [6] where it is stated, "The main purpose of an enquiry into an event is to improve the systems we provide to protect children" and "If we want to achieve a safer system to protect children, we must create an environment in which better skilled practitioners can practice and get on with the work of protecting children."

8.3 The Triennial Review report suggests a model "Pathways to harm, prevention and protection", which is outlined in diagram form below:

Pathways to harm, prevention and protection



From: Sidebotham, Brandon et al. (May 2016) [5]

8.4 This postulates that by looking at cases within a framework that looks for opportunities for prevention/protection within this concept of pathways to harm, there is a shift away from individual blame to opportunities for improvement within the system for safeguarding children.

8.5 The focus of this Serious Case Review is on the quality of professional practice and the way in which frontline practitioners worked as professionals within their own agencies and together to best identify the needs of the family, planned to meet those needs and progress those plans. Therefore, the key issues will be about preventative and protective actions by agencies and the systems and processes to support them. However, the context of the children's and the parent' characteristics, predisposing vulnerabilities and risks will also be discussed as will protective actions that were taken by the family.

8.6 The essence of this case revolves around a struggling young parent, not an intentionally wicked or cruel one. This fits with a national pattern where 44% of maltreatment-related deaths were not intentional [5], and the local picture as reflected in the recent review of Serious Case Reviews. [17] Therefore, in looking at professional practice we are not so much looking at whether professionals identified signs of harm but whether they recognised that mother was struggling to cope and what they did about it.

8.7 The nature of the family's needs, lifestyle and their ability to meet their own and their children's needs themselves

8.7.1 In the pathways model this relates to predisposing risk.

8.7.2 There were four children in this family: both mother and father were children themselves. There is a large body of evidence on adverse outcomes associated with teenage pregnancy. Neither parent had positive parenting models and would have had difficulties in putting their children's needs above their own. There is a general consensus that child maltreatment, particularly physical abuse, may lead to an intergenerational transmission of negative or abusive parenting behaviours. More recently emphasis has been placed on a maternal history of emotional neglect being associated with poor parental outcome. [7] Mother's own childhood, up to the point she left her home, was characterised by physical abuse, domestic violence, drug and alcohol abuse and neglect. On moving to father's home, she moved to another household where violence and anti-social behaviour were commonplace.

8.7.3 Father's childhood was also troubled with concerns about neglect, inappropriate chastisement and possible sexual abuse. Neither parent had a positive experience of intervention by statutory agencies, particularly Children's Social Care, who throughout their childhoods appear to have intervened for short periods with no real change in the children's circumstances.

8.7.4 Apart from these adverse childhood experiences there were other areas of predisposing risk. There was a history of criminality (father) and domestic violence. Whether mother had an underlying mental health problem is unclear. She presented to the GP post the event feeling depressed and she has since revealed that she was exhausted, stressed and cried most days.

8.7.5 Even experienced/mature parents would have had difficulties coping with a premature baby and their needs and there also seems to be evidence that neither parent really bonded with this child. There was certainly maternal ambivalence to this pregnancy and possibly to the previous one when mother expressed disappointment at the sex of her first child. These feelings may well have continued.

8.7.6 It would appear that father had little to do with the care of the children. He was out most of the day at work and once home often went out with his friends leaving mother to cope alone. Whilst the baby was on the NNU he visited rarely. In this he demonstrates his immaturity.

8.7.7 It would appear that mother gained considerable support from the paternal step-grandmother. Whilst living in the same household this would have been practical and hands-on, but once out of this household the support would have been more distant. Mother and the sibling certainly spent time at the paternal grandparents'

house, but this became more difficult once the baby was born and came home. Mother seemed to have accessed some support and advice by phone, but she was isolated having moved to a new area away from what little support she had.

8.7.8 The house move was positive in that it moved the family from an overcrowded and possibly unsafe environment. It did however disrupt any positive social networks and certainly disrupted mother's antenatal care and health care for the sibling as mother failed to register with a new GP until 19th August, 5 months after the move and well after the birth of the baby. This house move added to the family's vulnerability.

8.7.9 There was therefore evidence of cumulative and interrelated risk of harm to these children. All of the above information was available to agencies at the time and this is considered further below.

8.8 The needs of both children and the impact of those on both children's lives

8.8.1 In the pathways model this relates to predisposing vulnerability.

8.8.2 The sibling was only one year old at the time of the incident. It would appear that this child had little in the way of health needs. The heart defect would not have impacted on their life at all and it appears they were taken appropriately to the GP for minor childhood ailments as well as for their immunisations. The sibling was only eight months old when the baby was born. Developmentally the sibling was said to be within normal limits. At this age the sibling would have started to crawl and be inquisitive. The sibling was a poor sleeper and it has since been stated that they would wake up two or three times a night. The sibling would be in need of play and stimulation. It was observed by the health visitor that there were few toys in the house. The health visitor also noted that mother was "short" with the sibling and had to be reminded that they were still very young and needed a lot of care and attention themselves. It was noted that mother did not appear to fully understand these needs. However, it is also observed that the sibling was mostly appropriately dressed and that they had good interactions with mother. Little is observed about the sibling's interactions with father.

8.8.3 From the sibling's point of view the birth of the baby would have had considerable impact as initially they would have had to be cared for by others whilst the mother spent time on the NNU, and later once the baby was home mother's attention would have to be divided between the two, of which the baby required a great deal. The sibling's challenging behaviour (screaming and slapping) may have been their only way of expressing that the mother was ignoring them. The sibling's untreated nappy rash would also have been very uncomfortable. This also indicated that the sibling's physical needs were of lower priority to mother than those of the baby.

8.8.4 The baby had considerable needs.

8.8.5 "Babies and young children are inherently vulnerable and dependent, and features which mark them out as especially fragile place them at higher risk of abuse and neglect. Low birth weight babies and those requiring special care…potentially pose challenges to their parents over and above the considerable demands of any new born infant." [5]

8.8.6 The pregnancy with this baby had not been planned and neither parent really bonded with the baby. Once home the baby required oxygen all the time which would have meant it was difficult for mother to take the baby out of the house. The baby was initially tube fed. Mother and father had been taught to do this. Once fed by bottle the baby remained quite a difficult feeder and frequently vomited. As a premature baby they required frequent regular feeds, which necessitated a night feed. Mother was understandably anxious about the baby and this led to three admissions back to hospital.

8.8.7 It was of concern that mother did not always follow the advice given about the care of the children particularly in terms of getting medical attention for the sibling's nappy rash, but in hindsight it can be seen how difficult this may have been for her with no help from father and a very needy baby. She later admitted how much she was struggling to cope with the children. Her own experiences are likely to have meant that although she could cope with their physical needs, she lacked the empathy to deal with their emotional needs.

8.9 The vulnerabilities inherent for two young parents with two children under one year, both with health needs, and how well these were identified, recognised and responded to by professionals in contact with the family

8.9.1 This relates to both preventative and protective actions by agencies in the above model.

8.9.2 Lord Laming in his 2003 report [8] says "Cases involving vulnerable children do not come with convenient labels attached" but in this case they were pretty obvious.

8.9.3 There was evidence of so-called "cumulative risk of harm" but research indicates that most children living in vulnerable or risky environments are unlikely to be abused. Equally it is difficult, often impossible, for professionals to protect children if their parents are not open and honest with them. Mother did not engage fully with professionals and father not at all.

8.9.4 "There is cumulative risk of harm when different parental and environmental risk factors are present in combination or over periods of time…adverse experiences in the parents own childhoods, a history of violent crime…When presented with any of these risk factors, practitioners should explore whether there may be other cumulative risks of harm to the child, as well as any protective factors." [5]

8.9.5 In working with the families with these risk factors it is often Universal Services that play an important role. Children at the threshold of intervention may be at particular risk. (5) The actions of these services are considered here and the actions of CSC in section 8.11 below.

8.9.6 All agencies failed to engage with father. He never attended antenatal appointments and so the midwives never saw him. The health visitor never saw him either and did not seem to explore his relationship with mother and what role he had in the lives of the children. She and others accepted at face value mother's assertion that the allegation of domestic violence was malicious and didn't seem to explore why he had left the family home and indeed why he had returned. Also not explored were the consequences of the mother's strained relationship with father or the support mother received from his family. The neonatal unit staff also had opportunities to enquire about father. He rarely visited the baby, but when he did so there is little indication that he was engaged in any meaningful way. This lack of effort to find out about the men in children's lives has featured in other serious case reviews.

8.9.7 There is a difficult balance to be struck here in that enquiry about him from mother could have put more pressure on her. Direct contact with him would have been difficult as he was out of the home during the day and most of the professionals work mainly 9-5 Monday to Friday. Having said that, more efforts could have been made by utilising end of day visits and telephone calls. Some social workers do work late and at weekends. The FNP Programme does try to engage young fathers as well as mothers. Although he was registered on the children's centre system this was only as the father of the children and it is unclear what, if any, services could have been offered to him.

8.9.8 "Although families are usually a supportive and protective element in a child's life, for some the wider family context can instead present additional risks." (5)

8.9.9 Mother repeatedly stated to professionals that the extended (paternal) family were supportive, indeed this is given as a reason for not engaging in the offered Family Support Services. This support from the paternal family was therefore assumed. Evidence gathering or further assessment did not test the assumptions. There was over optimism about this given the history of that family.

8.9.10 The FNP worker whilst working with mother did identify vulnerabilities both in mother's attitude to her unborn child and the risks in both households. Unfortunately, although she appears to have acted on these concerns this was not followed through and led to mother's disengagement with this service, which would probably have been the most appropriate intervention to support her. During the first pregnancy the Midwifery Service had similar concerns and responded by making a referral to Children's Social Care. The support from the extended family was again given as a reason for no further action regarding the

unborn child. The recognition by these professionals of these vulnerabilities are cited, although out of scope, as it is clear that there were concerns about mother's ability to parent from mid-2014 onwards, but nothing was logged about this until February 2015.

8.9.11 When mother's pregnancy with the baby was confirmed there was no record as to whether there were questions asked by GP or Midwife as to how mother, who was still a child herself, would cope with two babies under the age of one. The midwife did not ask the usual question about domestic violence, as the paternal step-grandmother was present. She did however refer to the Teenage Pregnancy Midwifery Service even though mother had declined this service. The GP did not enquire further at the postnatal check either. This is highlighted in the report from the Clinical Commissioning Group.

8.9.12 It is not clear whether the issue of mother's mental health was explored at all. The health visitor should have enquired routinely using the Whooley Questions [12] but this was not recorded although it is recorded that she responded to enquiries about how she was managing with "fine". She gave similar answers with the previous baby. The GP did not enquire about her mental health.

8.9.13 The Health Visiting Service did offer an enhanced service Universal Plus. This is offered to families with additional and complex needs. The health visitor visited on a regular basis and was persistent in offering further Early Help through FCAF and Family Support Services. When these services were declined frequent contacts and support were maintained.

8.9.14 The school nurse in her referral to MASH in February 2015 recognised the vulnerabilities of both mother and child and responded appropriately (see 8.5 below). However the main focus of the subsequent assessment was on the sibling and not on mother's own needs as a child herself.

8.9.15 When the baby was born the midwives were aware of the social concerns highlighted in the pregnancy, but this did not feature in their handover to the NNU. When mother requested to go home, they did recognise the vulnerabilities of the mother with two young babies and contacted the Maternity Safeguarding Team. They erroneously thought that FNP was still involved and were informed by MASH that there was no current Children's Social Care intervention. They also contacted the health visitor and this prompted her to phone the NNU and share the information she had. The NNU documentation lists quite a comprehensive list of vulnerabilities. Although a discharge planning booklet was commenced the identification of the factors did not lead to an enhanced assessment regarding the additional support the parents would need, and no discharge planning meeting was held (see later).

8.9.16 Whilst on the Unit the staff clearly monitored mother's visits and observed her interaction with the baby. They were generally positive about her provision of

care for the baby although there were some indications of her difficulty in managing to visit and care for the sibling. At the point of discharge mother was deemed to be competent in the physical care of the baby but there was no evidence that they considered the family as a whole, the young age of the parents, their own experiences of childhood, the emotional impact of caring for the baby and another child or parental access to support. This is acknowledged in the Heart of England Foundation Trust's own report. Further support was however given by the Neonatal Community Outreach Team who visited regularly.

8.9.17 Following the birth of the baby there was a New Birth visit by a new birth worker from the children's centre. The worker did not know anything about the baby who was still in hospital. The visit instead focused on his older sibling and did not record any concerns. Mother was told of support groups available at the centre. The new birth worker did contact the health visitor on her return from the visit as she was concerned that both parents were very young and had two babies under the age of one. This raises questions about the current process of new birth visits and is discussed later as well as in the report from the Early Years Service.

8.9.18 The only other professional involved was a housing officer who interviewed the parents when they requested rehousing from the parental parents' home. A referral was made to Children's Social Care due to the age of the parents as well as the fact that mother was expecting her second child. Although it is commendable that the officer recognised the vulnerabilities this referral does not seem to have been acted upon and it was not followed up.

8.10 The quality of interagency information sharing, joint assessments of need, joint planning and joint interventions to support the family

8.10.1 This relates to the systems and processes to support prevention/protection in the above model.

8.10.2 **"**Effective communication requires practitioner skills and a culture that promotes information sharing as well as clear systems and guidance that enables information to be critically appraised and used to guide decision making and planning. Information received must be triangulated and verified and child protection agencies must provide prompt feedback to referrers and others participating in safeguarding." (5)

8.10.3 The importance of information sharing features in nearly all Serious Case Reviews.

8.10.4 There are instances of poor information sharing throughout this case both within and between agencies. This applies not only to recorded information sharing but also to the lack of informal professional conversations.

8.10.5 To look at this chronologically:

- During mother's pregnancy with the sibling the FNP worker shared important information with the social worker. This was not recorded on mother's assessment and so was not available to the next worker who assessed mother. There was no mechanism to record this on the unborn child either and so it was not available when she first came to the notice of Children's Social Care in February 2015.
- There were four children in this family. There seemed to be no linkage between them so that when an enquiry was made on one of them information known about the others was not shared. When the school nurse made a referral about domestic violence this was recorded on the sibling's file not mother's, although she was a child herself. When an enquiry was made to MASH about the baby, they were told the baby was "not known" although mother, father and the sibling were.
- Consent seems to be a huge barrier to information sharing in MASH, particularly if a case does not meet the threshold.
- The community midwife did not pass information on to the health visitor. Although this is agreed practice, the midwife was newly qualified and the service was under pressure at that time. There are systems and processes in place to ensure this should happen.
- The Midwifery Service did not pass information on to the NNU.
- The new birth worker had no information about the family when she visited. This would seem to be the norm. It is said that with approximately 120 new births per month and three workers there is not enough time to make contact with health visitors prior to the visit. Staff often have difficulty knowing who the health visitor is, although there is apparently a health visitor directory on the Birmingham Community Healthcare website. New birth workers do not have access to the Children's Social Care IT recording system Carefirst.
- There was no feedback on referrals (see later 8.11)
- Strategy meetings in MASH were delayed.
- The GP seems to have been totally "out of the loop" with no discussions held within the practice about this vulnerable family. Although the health visitor did communicate with the GP this does not seem to have generated any discussion. This may be because the regular meetings (six-weekly) that are held in GP surgeries about vulnerable families are with the "linked health visitor". This was a Solihull GP and the family health visitor was from Birmingham. There may therefore be a cross border issue.
- There was no NNU discharge planning meeting. At the time of this case the threshold to hold a discharge planning meeting was that Children's Social Care knew the family or that an FCAF was being initiated. There was no current involvement. The family's vulnerability warranted an FCAF but mother had refused. This is highlighted in the Heart of England Foundation Trust's report

and subsequent actions to address this are considered later. This is also an issue in another current Serious Case Review.

- When the baby had three admissions in quick succession this was another opportunity for a professional discussion.
- The health visitor did not inform the Neonatal Community Outreach Team (NCOT) that she had referred to MASH. This was probably because the referral was made quite late on a Friday.
- New information the health visitor had about mother's inability to cope was not conveyed to MASH. This may have been because the health visitor was accustomed to delay in the system and felt she should refer directly to family support herself to save time.
- Information was not triangulated. Mother's words were taken at face value especially in relation to the allegation of domestic violence. The health visitor did do this in contacting the GP to check whether mother had taken the sibling or not but when the social worker visited and mother repeated the same information, he accepted it.
- Several opportunities existed for professional conversations. A Team Around the Family (TAF) meeting could have been held.
- The hospital's communication with Children's Social Care did not convey the level of concern they had about the safety of the sibling nor did Children's Social Care appreciate that it was not necessary to await the result of medical tests before acting. Dealing with such "medical uncertainty" has been a feature of other Serious Case Reviews.

8.10.6 There were some examples of good practice in information sharing and joint work:

- When the school nurse made the referral about mother and alleged domestic violence she also informed the health visitor who was able to explore this further with mother. She also informed the GP.
- There was good handover of information from the FNP nurse to the health visitor and from one health visitor to another.
- At the first strategy meeting (6th February 2015) all three agencies were present and information was obtained from the health visitor by phone. The police had a great deal of information about father and his family, which they shared.
- There was good joint work and liaison between the NCOT and the health visitor.
- There was a joint visit by the social worker and health visitor planned. This was to be followed up by a visit from the family support worker. Unfortunately, the baby was injured before this took place.

8.10.7 Other than these there is little evidence of any joint assessment, planning or intervention.

8.11 The quality of referrals, assessments and casework by Children's Social Care in relation to both children during the period under review

8.11.1 This relates to Protective Actions by statutory agencies in the above model.

8.11.2 Referrals need to be clearly identified as referrals and document risks and concerns.

8.11.3 There were a number of referrals to Children's Social Care:

- The referral made by the FNP Nurse in July 2014. Although she did send a Multi-Agency Referral Form electronically this seems to have been treated as "information only" and no assessment opened on the unborn child (sibling) this was just pre-MASH. The form identifies many risks and vulnerabilities.
- The referral made by the midwife in September 2014 to which mother apparently consented. This referral does not outline the risks and vulnerabilities and indeed states that mother is well supported. It is not surprising that no further action was taken.
- The referral by Housing in February 2015. This referral seems to have been "lost". It is assumed it was made on the basis of the "Southwark Judgment".(9)
- The referral by the school nurse in February 2015 after mother's sister had alleged domestic violence being perpetrated by father. The case was only opened on the sibling and not on mother who was herself a child.
- The referral by the health visitor on 25th September 2015 did not convey the level of her concern. And she did not follow this up with the further information she received on 29th September that father had left, and mother couldn't cope.
- The hospital referral on 18th October 2015 which was received following the injury to the baby did not immediately proceed along a "red" MASH pathway, as the case was already open to Children's Social Care.

8.11.4 The need for redesign of the MARF form is discussed in Section 9.

8.11.5 For some of these referrals there was no feedback to the referrer. This should be standard practice. There is however a duty of the referrer to follow up the outcome as this will inform their future work with the family. A system is in place to inform referrers at the point of decision making in MASH.

8.11.6 Assessments contribute to decision-making and action to protect children. They also provide a picture of the child, family functioning and information about them that can be used in future work with the family. Too often, as in this case, assessment is seen as a one-off event often relying on a single visit.

8.11.7 They need to be timely and comprehensive and although Children's Social Care is the lead agency, they should include information from other professionals working with the family. There should not be overreliance on what is said and

there should be critical analysis of the information gathered. Lateral checks or information from other agencies should be followed through. The focus should not be just on a single issue but also on other relevant issues. A manager should not sign off an assessment before all identified risks are addressed.

8.11.8 If concerns are not substantiated the family may still have on-going needs and there may still be risks to the child. There needs to be a mechanism to address these.

8.11.9 The importance of robust assessments is emphasised in the triennial review. (5) "To be effective, assessments must incorporate both information gathering and appropriate appraisal of that information to understand risk and formulate appropriate plans."

8.11.10 In this case there were a number of opportunities for assessment. Two assessments were done. Of these only one was completed before the serious injury.

8.11.11 The first of these was following the referral of the school nurse on 6th February 2015 regarding an allegation from mother's sibling that mother was experiencing domestic violence. Mother was pregnant with her second baby. A timely strategy meeting was held at MASH and it was agreed that a single agency assessment should be undertaken. There was then a delay of 17 days before the case was allocated. The expectation is that a case should be allocated within 24 hours. Even if there was a backlog the case should have been allocated within 2-3 days. The allocated worker did not contact the referrer at all and there was no contact with mother's sibling who had made the allegation. A home visit to mother was not made for a further two weeks. It was by then five weeks after referral. By any standards this is not timely.

8.11.12 The manager's instructions were:

- To read all the historical information
- Contact mother
- Explore extended family support
- Lateral checks with other professionals
- Speak to father
- Assess home environment
- Ensure a suitable risk assessment is completed

8.11.13 When the visit was undertaken mother was alone in the house with the sibling. Father was not there and there was no was contact with him afterwards. Mother stated that this was a malicious and fictitious act by her sibling. She stated she knew the effect of domestic violence on children having experienced it herself. Everything was fine. The social worker accepted this.

8.11.14 As far as lateral checks are concerned it is assumed that the detailed information provided by the police would have been available to the social worker. It is not clear whether or not the worker read all the historical information available but if she did there doesn't appear to be any critical appraisal of that information in relation to risk and vulnerability. It is stated that "Health have raised no safeguarding concerns in relation to (the sibling)." This seems odd in that the health visitor was in possession of considerable worrying information passed on to her by the FNP nurse and the school nurse had made the referral in the first place. The GP was not contacted nor is there any record of a contact with mother's midwife. Mother had a pregnancy outreach worker and although the social worker mentions this there is no recorded contact with her.

8.11.15 There is no recorded contact with the extended family and the historical information if read would have raised considerable concerns.

8.11.16 We can assume the home environment was assessed. The visit took place in the new family home.

8.11.17 As far as risk assessment is concerned, the tools used are listed as interviews, observations and lateral checks with health.

8.11.18 The protective factors are listed as:

- New home
- Child happy
- Mother has good understanding of DV and its impact
- No evidence of domestic violence
- Good support from paternal family
- No concerns raised by other agencies
- No concerns by the police

8.11.19 The risk factors are listed as:

- Young parent known to Children's Social Care
- Father known to the police
- Allegation of domestic violence
- Isolation

8.11.20 This risk assessment is at best extremely superficial and shows no insight into the vulnerabilities and risks in this family. The majority of the protective factors are not protective at all e.g. "child happy" and the list of risk factors shows no indication of any analysis of the available information.

8.11.21 What is even more surprising is that three weeks later the manager signed off this assessment when hardly any of her original instructions had been followed.

No further action was taken except that mother was to access support from the Children's Centre. There is no indication that this was followed up.

8.11.22 This referral and assessment was not recorded on mother's Carefirst records but on that of her older child, even though mother herself was still a child and the referral had been made about her.

8.11.23 By any standards this was a poor quality assessment. It was both superficial and inaccurate.

8.11.24 The referrer was not informed of the outcome of the assessment.

8.11.25 The second assessment was not completed until after the serious injury. The health visitor made the original referral with concerns regarding both children. She felt that the parents needed support, that mum lacked the maturity to understand the needs of the children and had not been honest in relation to whether she had sought advice regarding health needs. There was considerable delay in allocation of the case (12 days) and the reason for this delay is not clear. It could be argued that the nature of the information did not warrant an urgent response. The team manager requested that a family support worker should undertake a visit with the social worker to consider the support required. Although this assumes that the outcome of the assessment would be family support this is a reasonable assumption given the nature of the referral. The expectation was that the assessment would be completed in 10 days. This doesn't indicate that the manager felt this would go further than an offer of family support and therefore "set the tone" for the assessment.

8.11.26 The social worker did what he regarded as an initial visit four days later and took mother's words at face value that she had sought advice about the nappy rash. He felt there were no immediate concerns especially as mother said she would welcome support and was open about her relationship problems. No risk analysis was done at this stage and he had no understanding of the case history when he did this first unannounced visit. He contacted the family support team the following day and the health visitor contacted him two days later. Joint visits were arranged. This plan for joint working was a good one but the baby was admitted in the meantime.

8.11.27 This changed the whole nature of this assessment. The events over the next few days are detailed above. This is covered in the analysis contained in the Children's Social Care report and I would agree with them that the decision to undertake Section 47 investigations should have been taken when the hospital first referred on the 18th October expressing concerns that the injuries may have been caused non-accidentally. There should have been consideration at that point of the safety of the sibling. In the event they did not commence until four days later. This delay seems to have been partly because there was already an allocated worker and it did not therefore follow the "red" MASH process. It is

recognised by Children's Social Care that there are still delays in Strategy discussions in cases that are "open", and they are liaising with the police as to how to improve the response in these situations

8.11.28 The police and a social worker did a so-called "safe and well" check on the evening of 21st October. This was precipitated by the hospital's increased concern for the safety of the sibling expressed throughout that day but not done until late in the evening. The sibling was left in the care of the father and paternal grandparents. It is doubtful that the workers concerned had any of the information known about that family but as it was by then late and the sibling was already asleep it was perhaps not unreasonable to leave them there especially as a strategy meeting was planned for the following day. Concern has been expressed in another Serious Case Review about these checks, which are often done by uniformed officers and only provide a snapshot at that moment in time. As there was a social worker present, they would normally have taken the lead with the police only intervening if to them the sibling was obviously not safe.

8.11.29 The remaining casework by Children's Social Care was carried out after the sibling had been taken into care. Mother and father were interviewed and at this interview mother admitted she had shaken the baby. The social worker responded appropriately to this. The authorising manager lists the elements of the assessment, which includes assessment of paternal family

8.11.30 The assessment subsequently completed appears to be thorough covering all the relevant issues.

8.12 The theoretical casework models utilised, and the research evidence used by practitioners to inform decision-making

8.12.1 This relates to systems and processes to support prevention/protection in the above model.

8.12.2 "Professionals need training and support in analysis and decision making and appropriate supportive tools need to be developed." [5]

8.12.3 Most agency reports cite "Right Service, Right Time" [10] as the model they are using and both the Community Trust and the Hospital state that this was used to inform decision making in relation to the referrals they made. This model was not known by the GP practice as they fall within Solihull CCG although they were familiar with a similar model used in Solihull but had not had a reason to utilise it in this case.

8.12.4 The Mental Health Trust whose only involvement was "after the event" refer to the "Think Family" approach [11] and health visitors also use the "Whooley Questions" [12] to assess maternal mental health although it is not clear they were used in this case.

8.12.5 The hospital used the "Strengthening Families" [13] model to support safeguarding supervision and analysis with staff following the baby's admission with injuries. Clinical decision-making was supported by PEWS, the Paediatric Early Warning Scores. [14] Almost every hospital in the UK uses this.

8.12.6 In Maternity Services, the green booking notes and accompanying guidance provide a framework for practitioners and will help decision-making.

8.12.7 Health visitors use a variety of tools depending on what level of service is being offered but Right Service, Right Time is the main one used for decision making in safeguarding.

8.12.8 The new birth worker used the "Pre-Assessment checklist" which is part of the FCAF paperwork. This clearly failed to identify the vulnerabilities of this family so was no aid to decision making. The CAF provides a theoretical framework for Early Help and both TAF and Team Around the Child (TAC) meetings could have been utilised but were not as mother failed to give her consent until a very late stage.

8.12.9 The theoretical model, which has been used for the longest time and provides the basis for many others, is the Framework for Assessment for Children in Need. [15] More recently has been the introduction of the "Signs of Safety" approach [16] but this was not in use at the time of this case. The one assessment done by Children's Social Care uses the paperwork being used at the time and cites the tools used as interviews, observations and lateral checks with Health. It is therefore impossible to know what theoretical models the worker drew on and what informed their approach. It seems doubtful that they were "evidence informed". The so-called Risk Assessment was based on the person's own perspective.

8.12.10 Practitioner decision-making will ultimately depend on what they think. But what they think is coloured by learning, supervision, asking for advice, empathy, experience and confidence to challenge amongst other things.

8.13 The journey the family experienced in terms of their contact with professionals over the period under review and why things happened the way they did

8.13.1 This relates to the whole pathway.

8.13.2 The family's journey is outlined in Section 7 and took place in the wider social, physical and cultural environment in which they lived. This changed over time, as did the vulnerabilities of the children and the risks posed to them by their parents and others. The harmful actions causing the injuries and omissions e.g. the untreated nappy rash were the end point of their journey. The contact with professionals and why things happened in the way they did has been explored as far as is possible in the sections above and below. There were opportunities to explore further with mother what life was like for her, particularly during the

baby's stay on the neonatal unit and subsequent admissions but when this was attempted, she always asserted that father's family would support her, and staff accepted this without exploring further.

8.14 Those key incidents during that journey where positive learning can be identified and used to improve multi-agency and single agency practice in similar situations

8.14.1 This relates to the whole pathway and in particular to identifying opportunities for prevention and protection.

8.14.2 Key incidents or events are indicated in Section 7. Many issues are raised in the course of a review, which, in some ways, is an audit of practice using the case as the "sample". Issues will be identified which although important to recognise and act upon are not necessarily pertinent to the outcome of this case. Some will be particular to this case. Others will clearly be generalised to wider practice and not particular to just this case. These are the issues that generate the learning points that are outlined in Section 9.

8.14.3 There are some issues that agencies have already recognised, and actions have been put in place to address them.

8.14.4 The GP practice missed two opportunities to enquire from mother how she was coping. The first when she attended the GP to confirm this pregnancy and the second when she attended with the baby for her postnatal check. The GP practice in Solihull has now implemented holistic postnatal assessments to assist in the recognition and response to early identification of needs. This learning should be shared with other practices.

8.14.5 The Mental Health Trust have identified that the Think Family approach was not applied when mum attended after the incident and that there was a lack of multi-agency liaison between internal and external partner agencies. Two recommendations are made to address these areas.

8.14.6 The Birmingham Community Healthcare Trust have recognised that the house move was a trigger point for increased vulnerability and that this could have provoked the health visitor to explore this further with mother. There is no certainty however that mother would have agreed to further support at this point. The Birmingham Community Healthcare Trust is to continue to maintain a practice focus on Early Help in responding to neglect to improve workforce understanding and support for families and children.

8.14.7 The Heart of England Foundation Trust recognised that the Teenage Pregnancy Midwifery Service could have provided support to this mother. Mother had refused this. There were capacity issues in this service, but these have been recognised and recruitment is underway. They have also noted that mother was placed on a "low risk" midwifery-led pathway as she was not under 16 at the

time. The policy has since been amended to include mothers under 17. There is no indication that this would have provided further opportunities for protection or prevention. They identified that there was a missed opportunity when baby was transferred to the NNU. The specialist midwife looking after the baby did not discuss their concerns with the NNU staff, but in the event the health visitor gave them the information a few days later and this was recorded on the appropriate documentation. However no specific action was taken, and the family were not discussed with the Safeguarding Team. No discharge-planning meeting was held. This would have been an opportunity for prevention. This has now been recognised and the NNU Team now have weekly meetings where babies who have social and safeguarding issues are discussed and there is closer liaison with the Safeguarding Team. There have been increased resources to enable this.

8.14.8 There was certainly delay in action to protect the sibling once the baby was admitted to hospital with non-accidental injuries and this considered above. (8.11)

8.15 The impact of repeat short interventions on the family's relationship with professionals

8.15.1 This will affect protective actions by parents in the above pathway.

8.15.2 "There is a need for a shift in emphasis from incident or episodic service provision to a culture of long term and continuous support." (5)

8.15.3 The history of repeated short interventions in mother's life would have led her to the view that Children's Social Care were of no help. Her experience during childhood was that they intervened when not needed and did not intervene when they were. This led to mistrust of those services and a lack of trust in professionals. This was probably reinforced by father and his family who themselves had been in receipt of repeated short interventions.

8.15.4 Effective safeguarding of children relies on good collaborative working between professionals and families. This requires longer-term relationships and trust. Equally it requires professional curiosity and challenge.

8.15.5 The only service to have a regular input was the Health Visiting Service but even this was interrupted by changes of worker. In spite of this they did establish a relationship with mother that enabled her to talk about her childhood. This would seem to indicate that if mother did establish a relationship with a professional, she would trust them.

8.15.6 Mother and baby spent lengthy periods engaged with the hospital services. Access to the same professional is difficult to achieve in these circumstances and a significant number were involved. This would have militated against establishment of relationships, but some conversations did take place, which touched on her troubled background.

8.15.7 Both Children's Social Care interventions consisted of one home visit with no follow up. This would just have reinforced mother's view that "they come, they go, they do nothing." She was able to reassure both workers that she was ok and could cope.

8.15.8 It is surprising that mother disengaged from FNP. These events are outside the timescale of this review, but this service is long term and would have seemed ideally suited to this mother. It would seem that she felt acceptance of support from outside the family was an admission of defeat on her part and there must have been an underlying worry that her children would be removed.

8.16 Other key matters arising from the involvement of the family and practitioner events

8.16.1 As yet there has been no family involvement.

8.16.2 Three matters arose at the practitioner and managers' events:

8.16.3 **The role of the pregnancy outreach worker.** It was thought this was a school-based professional. Information has subsequently been obtained from Birmingham City Council's Education School Age Parent Coordinator.

8.16.4 Contact with the social worker was made in December 2014 *(Author unclear which social worker this was)* who stated that school was working and supporting mother in returning to school and that the service was not required. Mother had apparently indicated that she did not want the team's service. In February 2015 the school notified the service that mother was pregnant for a second time. The worker then worked closely with the school to ensure appropriate support was offered. This included:

- Improving school/home liaison
- Maternity school uniform supplied by school
- Exam dates and times provided
- Revision resources provided by school for exams
- Transport funded
- Details of Careers Service to ensure post-16 options explored

There is no indication that this worker was in contact with any of the other professionals involved.

8.16.5 **The Birmingham Safeguarding Children Board's 'Never Shake a Baby' campaign.** The 'Never Shake a Baby' campaign was a direct result of the tragic death of a baby and the subsequent Serious Case Review. The campaign formed part of a wider range of 'Safer Parenting Guidance', providing advice on the correct sleeping position for a baby, how to bath a child and never shake a baby. All three sets of guidance were incorporated in three NHS leaflets, which were disseminated across the city targeted at parents through GP surgeries,

libraries, health centres and children's centres during 2012. Unfortunately, the NHS campaign evaluation lacked sufficient detail to assess tangible outcomes.

8.16.6 The dangers of shaking a baby have also featured in other Serious Case Reviews: a 4-year-old old shaken and battered in 2009/10 and a baby aged 22 months who was shaken and thrown 2011/12.

8.16.7 **The BSCB's 'Safer Sleeping' campaign** commenced 1st April 2016 and had a far more rigorous evaluation process in place to measure outcomes, with the findings scheduled to be presented to the Executive Group 22nd November 2016.

8.16.8 The campaign was built around health visitors at the 28-week antenatal visits where all mothers are provided with a 'Safer Sleeping' resource pack. The resource pack includes guidance on safe handling. The health visitors repeat this advice at the new birth visit and this reaches those who, for whatever reason, have not had the 28-week visit. The 2012 leaflets are part of the resource pack. It was stated that the midwife gives advice to the mother at discharge and that the teenage pregnancy midwife looks with parents more specifically at handling. There is also information in the 'Red Book'. The NNU staff and Neonatal Community Outreach Team were not aware of the campaign. As pre-term babies are particularly vulnerable and mothers may miss the 28-week visit, if their baby is already on the NNU, it seems particularly important that the packs are available on the NNU.

8.16.9 It was clearly evident at both the practitioner and manager events that the pace of change at the moment is immense and that practitioners in all agencies are finding it difficult to keep up with the changes. This produces a potential disconnect between the strategic policy makers and the front line.

8.17 Consideration should also be given to the racial, cultural, linguistic and religious background to this case and any impact that may have had on decision making by professionals

8.17.1 There is no indication that this had any impact on the decision making in this case.

9. Conclusions, Key Learning Points and Comments

9.1 Of the 50 cases of non-fatal physical abuse looked at by the Triennial Review, three-quarters were under a year old and all the incidents took place within the family. The majority had never had a Child Protection Plan, but three-quarters were known to Children's Social Care. The perpetrator, where this was identified, was more likely to be the mother, domestic abuse was a characteristic and there was evidence of neglect in almost half of cases. This case therefore fits the national profile of non-fatal physical abuse.

9.2 The review in its conclusion states that "If we are going to further reduce serious and fatal maltreatment, we need to identify family risk and vulnerability and look for opportunities for prevention and protection". It goes on to say that there will be such opportunities even when you can't predict which children will be harmed or die and that professionals should do their best in the way they know works best.

9.3 These two children suffered harm in spite of all the work professionals were doing to support and protect them, particularly the health visitor and the Neonatal Community Outreach Team. Rather than looking at whether serious harm was predictable or preventable we need to look at the opportunities that arose for prevention and protection and the underlying systems and processes that might get in the way of or support such work. What could have been done differently?

9.4 At one of the meetings during this review it was said that as the "threshold for care" would not have been met (before the injury) how could it have been prevented? Surely there are more ways to protect children? The recent review of Serious Case Reviews in Birmingham [17] states that cultural changes and social work/professional tools should emphasise needs and support over threshold concerns.

9.5 This case highlights learning in managing individual cases, working together as professionals and agency structures, processes and cultures.

9.6 There seem to be six general areas that generate learning. Since the events of this case there have been major changes and there are more to come. Therefore, where changes have been put in place that would mean that practice would have been different, these are referred to. The impact of changes needs to be evaluated. The pace of change is alluded to above.

9.7 The provision of Early Help

9.7.1 The importance of Early Help as described by Allen [18], Field [19] and Munro [20] is accepted by all agencies, and this family from any perspective was 'crying out for it'. Both mother's and father's childhood experiences meant that they were likely to have difficulties in effective parenting themselves, they were very young, and they had two very young children, one with significant needs. There were many risk factors and an absence of protective ones.

9.7.2 The Family Nurse Partnership [4] is a voluntary, preventative programme for vulnerable, young, first-time mothers. It is evidence-based and the worker stays involved for two years after the birth of the child. It would also have engaged father and looked at positive relationships. The FNP Nurse has the capacity to complete intensive work with young parents. This would have been the ideal intervention. Mother disengaged from this and this non-engagement in offered

support formed the pattern from then on and professionals accepted mother's assurances that she would seek help if she needed it.

9.7.3 The crucial question therefore is **what to do if parents who clearly need 'early help' don't want it or refuse it?** There needs to be a clear easy pathway to help and support and parents need their 'hands held' to access it. This can be reinforced at contacts that 'happen anyway' such as the New Birth Visit, GP visits etc. Practitioners can talk to and engage the help of other agencies in working out who the best person is to engage the family. They also need to explore why families are refusing help.

9.7.4 If families do not engage professionals, they need support to escalate if the vulnerabilities and risks warrant it as they did in this case, rather than give up. This in turn requires confident, tenacious practitioners with good supervision and practice support. The **Signs of Safety approach** may help this and could have explored with mother the sort of support she needed and would accept. It would have given her the opportunity to say, "I can't do this". Parents respond better when they understand what we are worrying about and the impact on their children. The FCAF was meant to be the framework but there is a view that this is not robust enough and consent remains an issue. Other mechanisms include the TAF and the TAC.

9.7.5 There seem to be two separate family support teams with different modes of access. These workers have the same name but different roles and provide a different level of intervention. If a professional was to be informed that a Family Support Worker was involved, they may assume a higher level of intervention than the reality if it was a "Family Centre FSW" rather than a "Local Authority FSW".

9.8 The pathway needs to be clearer

9.8.1 Consideration also needs to be given to what sort of interventions would have prevented the harm to these children. In addition to FNP there are other parenting programmes such as Incredible Years and Triple P. Childcare that could have been offered for the sibling whilst the baby was in hospital and after the baby came home. Home Start would have been another option. There is no guarantee that mother would have accepted any of these.

Changes in Practice

9.8.2 "Signs of Safety" has not been adopted per se as a model but some of the tools from it are being used as part of Relationship Based Practice. However only social work staff have had any training in this approach. Other agencies have not been engaged in this. If this is to be the model a common language and understanding is needed across agencies and this will require some coordination.

9.8.3 Children's Social Care has initiated changes in supervision and practice support but the impact of this is yet to be evaluated. Similarly, with Health Visiting.

9.8.4 The FNP programme has been decommissioned. The reasons for this are unclear but apparently based on a report published in the Lancet [21] looking at short term outcomes such as smoking cessation and admission to hospital. The research did not look at long-term benefits particularly those relating to safeguarding. As a response to this the Community Trust have developed a Vulnerable Parents Pathway. Whether this will replicate the therapeutic relationship that was the basis of FNP is still to be seen.

9.8.5 FCAF is no longer used and instead there is to be a new Early Help Assessment tool.

9.8.6 Right Service, Right Time is to be re-launched in November 2016.

9.8.7 See also below regarding Consent

9.9 New Birth Visits and how they are carried out

9.9.1 It is essential that the worker who does these visits has full access to all the information about the family before they do the visit. Currently they only have a list of new births without any other information. Access to Children's Social Care information via Carefirst and contact with the health visitor seem to be prerequisites. It also seems dangerous for the workers that they "go in cold". There is no "single view of the child" that is easily accessible. The paperwork used for these visits (pre-CAF Checklist) does not lend itself to showing a true picture of a family's needs and should be reviewed and revised. It is understood that there may be changes to this service, but the learning is still pertinent. There is currently duplication with both Children's Centre Staff and health visitors doing New Birth Visits often within days of each other. There are also differences across different settings and no links between them.

Changes in practice

9.9.2 The Local Authority, who now commissions Health Visiting Services as well as Children's Centres and other more specialist early years provision currently provided by both the Local Authority and the Voluntary Sector, has drawn up a new integrated service specification. This was out to tender with a start date for the new service set for September 2017. It is understood that there would be collaborative bids to deliver this service but that in the future it is likely that there will only be one "New Birth Visit" and that the health visitor will do this. The budget for this new integrated service is likely to be less than that of the current parts.

9.9.3 The pre-CAF checklist is to be replaced by an Early Help Assessment tool.

9.9.4 The data warehouse (Sentinel) could conceivably provide a link of information between Children's Social Care and Children's centre staff but at the moment this seems unlikely

9.10 Remaining focused on the child and family

9.10.1 There were **four children in this family** all with their own needs and vulnerabilities. This was not always apparent in the work with this family where the focus was often on one only. Father was never engaged by anyone and his lack of visibility should have been a warning sign in itself. Mother was viewed in her role as mother and not as the subject of concern, for instance in the response to the domestic violence referral, and the needs of the sibling seem to have been mainly overwhelmed by those of the baby.

9.10.2 There was **no linkage of information** so that when enquiries were made about one, information that was held on the file of another was not linked. Records should have been opened for all four children including the two who were parents with cross-linking of information. It is apparently standard practice in some Authorities that there are separate social workers for young parents who are children themselves. The parents' own childhood experiences and the likely effect on their ability to parent would then have been highlighted.

9.10.3 Losing focus on the whole family is also highlighted in other Serious Case Reviews. [17]

Changes in practice

9.10.4 Since July 2016 Children's Social Care have been recording all contacts made to the service. This will mean that there will be a record of all referrals made even if the decision has been made that the threshold for statutory intervention has not been met. The system will record contacts as well as referrals and assessments. Guidance for Pre-Birth assessment was subsequently updated, and Early Help assessments now take a whole family approach.

9.11 Information Sharing

9.11.1 This was an issue at both a formal and informal level and features in nearly all Serious Case Reviews both national [5] and local [17] It is covered in 8.10 above. Lack of professional conversations led to a situation where each incident was treated separately without taking into account the whole history and context.

9.11.2 The main Learning Points from this are:

- Within MASH, consent is a huge barrier to the sharing of information on a family if the threshold of referral is not met. Hence pieces of information are not put together that could together mean that the threshold for intervention would be met.
- The TAF/TAC meetings were apparently not being used to their fullest extent. Even without consent families could be discussed and a joint plan made that would support the involved practitioner in their work with the family and in managing risk and uncertainty. It would have been a forum where all of the information on risks and vulnerabilities could have been put together
- Discussions within GP practices about vulnerable families need to be embedded. This may have been hampered in this case by cross border issues. There will always be these issues and there is an expectation that practitioners should recognise the problem and resolve it by practitioner-to-practitioner conversations. GPs already have a list of health visitors and their catchment areas.
- The criteria for holding multi-agency hospital discharge planning meetings should be reviewed especially for the neonatal units.
- The information access for family support teams in children's centres should be reviewed.

Changes in practice

9.11.3 MASH has changed. (see below)

9.11.4 There have been considerable discussions about consent and a very useful paper compiled for the EHSP Conference in June 2016 on Consent, Information Sharing and Thresholds. This should address some of the current uncertainties of practitioners and ensure that information shared is proportionate and well recorded.

9.11.5 TAF meetings have ceased and have now been replaced by the "Early Help Panel". Practitioners could take cases here anonymously to get advice and guidance and the "Early Help Desk" could collate information. TAC meetings will continue as currently, with the focus on children with Special Educational Needs. There is some evidence that the Early Help Panels are not being utilised to their full extent. There needs to be enough flexibility in the system to allow professional conversations to take place

9.11.6 Within this NNU the discharge planning process has changed and there is now a Discharge Planning Nurse in post. There is a new Discharge Planning booklet to be introduced within the next few months. This will be based on Strengthening

Families [13] and aims to recognise vulnerable families early and put a plan in place prior to discharge.

9.11.7 The CQC inspection was critical of interaction between health visitors and midwives. An inter-agency group was set up to take forward the CQC recommendations.

9.12 Quality of assessments in Children's Social Care

9.12.1 This is covered in detail above in 8.11 above. It is understood that the framework for these assessments has changed since the case under review. However whatever forms are used the quality of assessment and casework will still be reliant on the individual and their manager's ability to analyse and challenge. Changing paperwork and forms does not necessarily change practice and although checks and balances can be built-in it will always be a "judgement call".

9.12.2 The focus should be on fully identifying risks and vulnerabilities as well as positive factors. It seems obvious to point out that all risks identified both by the referrer and the social worker should be addressed (or there should be a monitored plan to address them) before an assessment is signed off and closed by a manager.

9.12.3 In this case there were also issues of speed of decision-making allocation and completion. Systems have now changed, and it is unlikely these delays would occur now.

Changes in Practice

9.12.4 A new assessment proforma has been introduced for Section 17 and Section 47 Family Assessments in May 2016 and a new "Early Help Assessment" is being developed. Both of these will provide further guidance for social workers and managers.

9.12.5 Practice evaluation has now been introduced within Children's Social Care. This consists of two evaluations. The learning from them is fed back to the practitioner and their manager.

9.12.6 A Practice Evaluation Bulletin has been introduced. Circulated quarterly it has already included some of the learning points from this Serious Case Review.

9.12.7 The expected speed of decision-making has changed. For all cases coming to the front door a decision should be made that day. A family support worker and a manager should be allocated that day. If the case is referred from CASS to Children's Social Care a decision should be made within 24 hours whether to

proceed to a Section 17 assessment in which case the child should be seen within 3 days, or a Section 47 where there should be a same day response.

9.12.8 It is acknowledged that there are still issues at the front door. A Front Door Reference Group reports to the Board (via Quality and Assurance). This should monitor the quality and progress of decision-making. There is also an audit of the Front Door within MASH daily.

9.13 The operation of MASH

9.13.1 It is understood that the operation of MASH changed during the period under review and that it has changed at least once since. There is a view that MASH is vulnerable especially in terms of resources and that the MARF form needs revision. This should reflect the need to record context, risks and vulnerabilities as well as harmful actions/omissions by parents/carers. It may need adaptation if the "Signs of Safety" approach is embedded in practice particularly of Health and Children's Social Care. In this case there was delay in holding Strategy meetings and not all partners were present. It is assumed that this was a resource issue. The front door decision seems to be made without background information and in this case a change in circumstances meant the case was escalated, as the case was already open to Children's Social Care. This issue of response when new concerns are raised about open cases is recognised both by referrers and Children's Social Care.

9.13.2 The referrals made for this family were all seen in isolation and therefore even when there had been a number within quite a short timescale this did not trigger further action.

Changes in practice

9.13.3 The MARF has been replaced. Since the beginning of October 2016 there is now a "Request for Support Form" which incorporates some of the aspects and tools within the "Signs of Safety" approach. It includes sections on "What is going well?" "What are your concerns?" and "What needs to happen next?"

9.13.4 MASH has changed. From 4th September 2016 there is now CASS (Children's Advice and Support Service). MASH will only be used for Section 17 and Section 47 enquiries. The pathway through the front door has changed and all enquiries including requests for information will go to the Early Help Desk. There will no longer be the option of "No Further Action"; there will always be an Early Help offer.

9.13.5 The changes made in July 2016 whereby all contacts with Children's Social Care are recorded should assist workers within CASS/MASH to consider previous referrals made to the service.

10. Recommendations to Address the Key Learning Points

These are suggestions only and open to amendment. They will be considered by the Serious Case Sub-Group who will identify the key action required to embed the learning from this case for endorsement by the Executive Board.

10.1 The provision of Early Help and what to do when parents refuse it

10.1.1 Mindful of the changes already made over the past year the following recommendations were made in November 2016:

Recommendation 1

The Learning and Development Sub-Group of BSCB together with the Workforce Development Workstream of the Early Help and Safeguarding Partnership consider how to disseminate to all frontline practitioners the changes in the pathway to Early Help. This to encompass:

- The re-launch of Right Service Right Time
- Referral process for Early Help and how to make good referrals
- CASS and MASH
- Signs of Safety
- Consent guidelines
- The use and functioning of the Early Help Panels and Desk
- Effective use of the Early Help Assessment tool

Recommendation 2

The Local Authority and CCG commissioners consider the effect of the decommissioning of FNP and how they will evaluate any replacement programme.

Recommendation 3

BSCB through its Quality, Impact and Outcomes Sub-Group evaluate the effect of changes to supervision and practice support.

Recommendation 4

The utilisation and functioning of the Early Help Panels to be monitored and evaluated. In particular the ease of access and whether or not they are creating a further barrier to professional conversations.

Recommendation 5

The Early Help and Safeguarding Partnership should consider renaming the two teams of "Family Support Workers" to better reflect the differing roles of these two teams of workers.

10.2 New Birth Visits and how they are carried out

It is recognised that these will change in less than a year. In the meantime:

Recommendation 6

The means of access to background information about families for family support workers from the health visitor, Children's Social Care and other children's centres to be resolved by the Early Years Childcare and Children's Centres Service with the help of partners.

10.3 Remaining focussed on the child and family

This is an issue for supervision and practice support and therefore no further recommendation is made other than that in Recommendation 3 above.

10.4 Information Sharing

The issues regarding Consent and are covered in Recommendation 1 above.
The use of TAF now Early Help Panels is covered in Recommendation 4 above.
Information access for family support teams is covered in Recommendation 6 above.

Recommendation 7

As part of the Sustainable Transformation Plans, the Birmingham Midwifery Partnership should ensure that the improvements in discharge planning for babies being discharged from Neonatal Units are implemented across the city and also consider whether any other parenting support should be available for this particularly vulnerable group of babies and their families.

10.5 Quality of assessments in Children's Social Care

It is recognised that many changes have been made over the last year, therefore no recommendation is made in relation to this. However, BSCB needs to have an assurance that these changes do improve the quality and timeliness of assessments.

10.6 The operation of MASH

Many changes have been made in the last year, some of which address the learning from this case. BSCB needs to be assured that these changes simplify rather than complicate the access to help and support for families and that all workers understand the changes. This is covered in Recommendation 1 above.

Recommendation 8

CASS/MASH to develop operational guidance to enable "triggers" where there are multiple referrals/contacts and use of chronologies.

Recommendation 9

A specific recommendation around fast decision making when cases are already open to Children's Social Care and another referral is made.

11. Embedding the Learning from this Case

11.1 Serious Cases Sub-Group has overseen implementation of the emerging learning during the review process. Whilst the SCR involved ten agencies, only four of those agencies identified areas for improvement in their own safeguarding arrangements. All ten learning points have been fully implemented.

11.2 The final SCR reports makes nine multi-agency recommendations. These recommendations have helped shape and inform the development of multi-agency safeguarding arrangements within Birmingham. Serious Cases Sub-group have monitored the timely implementation of these recommendations and all are now complete.

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Appendix 1

Abbreviations

ASD	Atrial Septal Defect
ASTI	Assessment and Short-Term Intervention
BCHC	Birmingham Community Healthcare NHS Trust
CAF	Common Assessment Framework
FCAF	Family Common Assessment Framework
CASS	Children's Advice and Support Service
CCG	Clinical Commissioning Group
CSC	Children's Social Care
CQC	Care Quality Commission
EDT	Emergency Duty Team
EHSP	Early Help and Safeguarding Partnership
FNP	Family Nurse Practitioner
FSW	Family Support Worker
GP	General Practitioner
HV	Health Visitor
IASS	Information and Support Service
MARF	Multi Agency Referral Form
MASH	Multi Agency Safeguarding Hub
NCOT	Neonatal Community Outreach Team
NNU	Neonatal Unit
PDA	Patent Ductus Arteriosus
SCR	Serious Case Review
SW	Social Worker
TAF	Team Around the Family
TAC	Team Around the Child

Appendix 2

Agencies who participated in the SCR process by submitting an Information Summary Report and Chronology**:**

Birmingham Children's Hospital

Birmingham Community Health Care

Birmingham & Solihull Mental Health Foundation Trust

Birmingham Children's Social Care

Birmingham Early Years

Heart of England NHS Foundation Trust

Sandwell and West Birmingham Hospitals

Solihull Clinical Commissioning Group

West Midlands Ambulance Service

West Midlands Police

Nil Returns:

Birmingham & Solihull Women's Aid

Birmingham Women's Hospital

Change Grow Live

Community Rehabilitation Company

Family Action

National Probation Service

NSPCC

Royal Orthopaedic Hospital

Sandwell and West Birmingham Clinical Commissioning Group