Serious Case Review

SCR Child P

REVIEW REPORT

Independent Reviewer: Alex Walters

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1. Introduction

1.1. Hampshire County Council notified Ofsted/Department for Education (DfE) of a serious incident in February 2019 and a Rapid Review process was undertaken as required by Working Together 2018. This was submitted to the National Child Safeguarding Practice Review Panel with the recommendation that the Serious Case Review (SCR) criteria, a child had died and abuse/neglect were suspected, were met. The Panel confirmed their agreement on 7 March 2019.

1.2. In the case, a child, aged five weeks was admitted to hospital in February 2019 in an unresponsive state and was subsequently found to have a severe, widespread and irreversible brain injury which sadly caused their death three days later. For the purpose of this review the child shall be known as Child P.

1.3. Both parents were arrested and subject to criminal investigations. Mother was subsequently convicted of manslaughter.

1.4. Child P's Siblings 1 and 2 were made subject to care proceedings.

1.5. The purpose of a SCR, as confirmed in the current statutory guidance,
"Working Together to Safeguard Children 2018": Chapter 4, is clear that the focus is on learning and not holding individuals or agencies to account.

> "*The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.*
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> *Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings*"

2. Process for conducting the SCR

2.1. Hampshire Safeguarding Children Partnership (HSCP) recognised the criteria for undertaking a SCR were fully met and there was potential to learn lessons from this review regarding the way that agencies work together in Hampshire to safeguard children.

2.2. A meeting of the HSCP Learning and Improvement subgroup met on 5 June 2019 and agreed draft Terms of Reference for the SCR. These are attached at Appendix A. An Independent Reviewer, Alex Walters, was commissioned on 5 June 2019. She is an independent safeguarding consultant, experienced Local Safeguarding Children Partnership (LSCP) and SCR Panel chair, SCR author and fully independent of HSCP and its partner agencies.

2.3. It was agreed that the timeframe under review would be from April 2018 - February 2019. Relevant information prior to these dates was also considered, particularly historical involvement with the family by agencies.

2.4. Full agency reports were completed by seven agencies, providing the opportunity to consider and analyse their practice and identify any systemic issues. The reports provide details of the learning from the case within their agency and provided agencies the opportunity to reflect on effective practice and make recommendations for improving their own practice.

2.5. An SCR Panel was established and met together to consider the learning from these reports in July 2019. Further information and clarification were subsequently sought by the Independent Reviewer. A Practitioners workshop was then held in 2020 involving representatives from Midwifery, Health Visiting, GP and the Neonatal Unit. The Practitioners workshop considered key themes identified by the Independent Reviewer, and the perspectives and opinions of all those practitioners involved at the time were discussed at the event and have informed the SCR report.

2.6. The contribution of family members is an important part of the review, but it was agreed that any contact by the Independent Reviewer or the Independent Chair for the Hampshire Safeguarding Children Partnership (HSCP) would take place at the conclusion of the criminal and care proceedings. Mother and father were both informed of the SCR process. The Independent Chair for HSCP met with mother and explained the purpose of this review and the themes and recommendations that had been identified. Mother made no material contribution that would alter the substance of this report.

2.7. This review has been undertaken in a proportionate way to ensure the key learning is identified to support improvements in practice. It is, therefore, deliberately not detailed but provides a summary of the family and key agencies' engagement with the family.

3. Family structure

The relevant family members in this review are:

Family member	To be known as:
Subject child	Child P
Father to subject child	Father
Mother to subject child	Mother
Sibling 1 to subject child	Sibling 1
Sibling 2 to subject child	Sibling 2
Half Sibling to subject child	Half sibling 1
Half sibling to subject child	Half sibling 2

4. Relevant background information on parents prior to the timeframe under review

4.1. Mother became known to Children's Services in 2013 when Child P's older half sibling 1, who was six months old at the time, was referred. The baby was seen with three bruises on the curve of his forehead, one on his cheek, and several small scratches on his hand, back, and right ankle, and slightly bigger scratches on his rib and left calf. Half sibling 1 was made subject to a Child Protection Plan (CPP) and Hampshire Police made mother subject to a community resolution, which required her to comply with the direction of Children's Services.

4.2. Care proceedings were initiated in May 2013, but this was stepped down in June 2013 following assessment and parents' engagement. Mother was suffering with postnatal depression at this time and admitted causing injuries to half sibling 1, reporting she had pushed his head to stop him crying. The paediatric assessment noted other issues which had not been medically treated prior to the child protection medical - eczema, constipation and that half sibling 1was underweight/percentile had reduced for length and head circumference.

4.3. Half sibling 1 then moved to live with father and paternal grandfather in July 2013 by agreement and the CPP ended in December 2013. The case was closed to Children's Services in March 2014. It is not clear if ongoing contact was to be supervised between half sibling 1 and mother. Mother also came off anti-depressant medication in 2014.

4.4. On 15 October 2015 a referral to Children's Services was made from Midwifery advising that mother was pregnant with sibling 1. A pre-birth assessment was undertaken by Children's Services to assess risks to the unborn baby in view of the concerning history. The assessment was completed and sibling 1 was made subject to a Child in Need (CIN) plan. No concerns were raised during CIN planning and the case closed to Children's Services in May 2016.

4.5. Mother subsequently became pregnant with twins in 2018 and from June 2018 received universal care services from the GP, Midwifery, the Neonatal Unit and Health Visiting. She gave birth to twins prematurely at 33 weeks in December 2018 - Child P and sibling 2. Child P was diagnosed with talipes (clubfoot) in utero. The twins were discharged home on 9 January 2019 from the Neonatal Unit and followed up by the Neonatal Home Visiting Team until 15 January 2019. Midwifery visited two times and the Health Visitor 1 undertook an antenatal visit in December 2018 and Health Visitor 2 undertook two visits in January 2019. On the first of these, 16 January 2019, sibling 2's weight was just below the 25th centile and the baby had gained 330 gms since discharge. Child P's weight was just below the 9th centile and the baby had gained 260 gms since discharge. Both twins were reported to be taking the same volumes and number of feeds but there was a small but notable difference between weight gains.

4.6. The father of sibling 1 and the twins has an older child, half sibling 2 who lives with his mother. Both parents of Child P were known to the police for minor incidents of previous domestic incidents with their partners and have no convictions. There were a number of reports from the Neonatal Unit, the Neonatal Home Visiting Team and Midwifery of the house and parents smelling of cannabis.

5. June 2018 – February 2019 and the involvement of agencies:

5.1. During this period, which covered the pregnancy and birth of Child P, the family received universal health services from the GP, Midwifery, the hospital Neonatal Unit and Neonatal Home Visiting Team and Health Visiting.

MIDWIFERY and NEONATAL SERVICES

5.2. Midwifery became involved in July 2018 at the maternity booking in appointment and undertook all antenatal care. The midwife noted that there had been a history of safeguarding with half sibling 1 and read the historical information. She noted that the case was referred in second pregnancy to Children's Services but was subsequently closed and made the decision

that as she felt there were no new risk factors, she did not need to share information with Children's Services or the hospital's Maternity Safeguarding Team (who provide safeguarding advice) as she felt sufficiently reassured by the case closure and by mother's presentation and explanation of the historical safeguarding issues. The midwife was not aware of the LSCP's Unborn Baby Safeguarding Protocol and the requirement to refer the case automatically to Children's Services as the criteria for a previous child subject to Child Protection Plan involvement had been met.

5.3. In October 2018 mother did not attend (DNA) a 22-week antenatal appointment with the obstetrician and it was noted that mother had not attended a previous appointment. A week later, the Fetal Medicine Midwife emailed the midwife regarding safeguarding concerns voiced by the sonographer who saw mother and noted that there were historical safeguarding concerns, recent DNA and mother had declined support for stop smoking. The Maternity Safeguarding Team were not copied into the email trail.

5.4. However, both parents and sibling 1 attended the routine 24-week appointment with the midwife. Mother reported to continue to smoke and declined a referral to stop smoking. Mother reported her mood was good. The midwife noted good interaction between family members and the family appeared clean and well kempt and were preparing for the birth appropriately. Mental health "Whooley" questions were revisited with mother as per the protocol. She answered 'no' to all but did report feeling tired, as she had been unwell for two weeks.

5.5. In addition, the midwife took mother out of the room and asked if everything was alright at home following concerns expressed during the visit to Fetal Medicine and the two rearranged appointments. Mother replied all was well at home, but the couple found attending lots of appointments at the hospital stressful, as her partner was self-employed and would not be paid for time off. There was however no documentation of discussion regarding the concerns raised by Fetal Medicine. The midwife did consider referring to the Maternity Safeguarding Team regarding the missed appointments as per the Missed Appointment Policy but decided that this would be triggered after three missed appointments, and she considered it had not reached this level. It is noted that mother would ring and request rescheduled appointments.

5.6. During the stay in the Neonatal Unit staff reported both parents visited regularly and, if unable to visit, made contact with staff for an update on the twins' progress. Parents were noted to handle the babies well and interacted with their children and staff. Parents acted on advice, for example purchasing suitable car seats for discharge. However, the parents were noted to have arrived on the Neonatal Unit smelling of cannabis. The parents were not spoken to, and the concern was not followed up and shared with the Maternity Safeguarding Team. Substance misuse with both parents if understood would have triggered a red risk factor on the LSCP Unborn Safeguarding Baby Protocol.

5.7. The Neonatal Home Team contacted the Maternity Safeguarding Team on 31 December 2018 to enquire if there were any current safeguarding concerns as they had noted previous 'Yellow Pages' (these are maternity safeguarding concerns form). It was noted there were no current concerns, but they were advised to speak to the health visitor as she was reported to have a good rapport with the family. On 8 January 2019 the family were discussed at the Neonatal Unit/Health Visitor Liaison Meeting but there is no documentation regarding the discussion of previous safeguarding concerns or concerns regarding parental cannabis use.

5.8. The twins were discharged on 9 January 2019 and on 11 January 2019 they were seen at home by both the midwife in the morning and the Neonatal Home Team. The midwife challenged

mother that she could smell cannabis in the house and mother denied this. A home visit was undertaken by the Neonatal Home Team - an assistant practitioner and a newly qualified nurse. Both twins were reported to be well and had gained weight. They also reported a mild smell of cannabis but were unsure whether it was in the flat or whether from surrounding flats.

5.9. The Neonatal Team contacted the health visitor following the visit and discussed the above incident and previous reports from Neonatal Unit staff about parental cannabis use on the Neonatal Unit. The health visitor had no recollection of previous concerns regarding cannabis smoking with the family.

5.10. On 16 January 2019 there was a telephone discussion between the health visitor and Neonatal Home Team assistant practitioner. The health visitor, who was at the home, reported no concerns with health, feeding or weight of the babies. Sibling 2's weight was documented as being just below 25th centile and she had gained 330 gms since discharge. Child P's weight was documented as just being below 9th centile and he had gained 260 gms since discharge. Both agreed with the plan for no further visits from the Neonatal Home Team. There was no discussion documented regarding issues around financial problems or previous cannabis use concerns and no exploration around the fact that both twins were reported to be taking the same volumes and number of feeds and there was a small but notable difference between weight gains.

5.11. On 18 January 2019 a telephone call was made by a dietician to mother, after two previous failed attempts. Mother reported that the twins were taking 100 mls of preterm formula six times a day. The dietician recorded that it was unlikely they were taking this volume and would review in clinic in four to six weeks. Child P's weight had been reported as suboptimal just plotting below 9th centile. A plan was made to review feeding and weight in a dietician clinic. There is no evidence this concern was shared with the health visitor or Home Team or discussion around weight as the visit on 16 January 2019 weight was reported as no concern.

Analysis and learning identified by the Agency Author

5.12. The historical risk factors were known to maternity services as there were previous 'Yellow Pages' (Midwifery Liaison forms) in 2015/2016. There was a disclosure at the booking appointment that mother had postnatal depression and as a result of her mood caused a non-accidental injury to half sibling 1. Mother had reported half sibling 1was living with her but there is no record of this being confirmed with Children's Services or Health Visiting.

5.13. The risk factors were considered by the midwife at the 2018 booking but she was reassured by mother's report that there was no Children's Services involvement and sibling 1 was currently in her care. The midwife felt there were no new risk factors and decided a referral to Maternity Safeguarding for advice was not necessary. There was a lack of professional curiosity regarding older half sibling's safeguarding history and no request for oversight by the hospital Safeguarding Team. There appears to be limited exploration and consideration given to the impact of twin pregnancy on mother's mental health or social circumstances despite signs of financial challenges in the postnatal period.

5.14. Concerns emerged in pregnancy regarding missed appointments, which were identified as a risk factor. However, as mother had rung and rearranged/cancelled appointments this allowed a pattern of disguised/unhelpful compliance to persist. Although identified as being a risk and discussed with mother, the midwife felt the explanations given were plausible and this meant other historical risk factors were not considered. The family presented well to staff whilst on the

Neonatal Unit and were compliant with advice and engaged well. Staff noted historical risk factors, but they were given reassurance that there were no current concerns. However, following staff being given reassurance new risk factors emerged regarding parental substance misuse and further advice was not sought from the hospital Safeguarding Team.

5.15. Information was shared with the Health Visiting Service regarding concerns around parental substance misuse in the postnatal period. However, there did not appear to be a discussion and oversight with Neonatal Home Team Qualified Nurses regarding the reasons why both infants were reported to be taking the same volumes and number of feeds but sibling 2 had gained more weight than Child P and the potential reason for this explored or captured in documentation.

5.16. There is a Health Visitor/Midwife Liaison Meeting that occurs monthly in the locality. It is understood that the family were discussed and information shared, but there is no documentation of this. This is co-ordinated by one midwife for each area, who shares information from booking paperwork and any updates for the families. It does rely on the woman's allocated midwife being able to update the midwife prior to attending the meeting so information shared may not always be up to date.

5.17. The UHS Trust Safeguarding Children in Maternity Policy, although similar, does not directly refer to the LSCP Unborn Baby Safeguarding Protocol and this may have contributed to the Protocol not being used correctly.

5.18. Risk factors were identified by staff members but not always acted upon or discussed with the family or other professionals. Midwifery and nursing staff should be aware of changes in family circumstances (in this case a twin pregnancy) and how this may impact on maternal mental health, the family finances, previous risk factors, environment and parenting capacity.

Subsequent changes/improvements in practice for Midwifery/Neonatal services identified by the Agency Author:

5.19. The LSCP Unborn Baby Safeguarding Protocol should be used as the primary guideline/protocol within UHS Trust to assess/plan actions to safeguard the unborn/new-born baby. The current trust Safeguarding Children in Maternity policy should be reviewed to compliment the protocol.

5.20. The Missed Appointment Policy in Maternity should be reviewed to add guidance around recognising disguised/unhelpful compliance and action that should be taken.

5.21. The Safeguarding Supervision Policy in the UHS Trust has recently been reviewed. Midwives/neonatal practitioners holding caseloads within a community practice should have access to a model of safeguarding supervision as a minimum of one session per quarter and monitored annually.

5.22. If visits are undertaken by staff who do not hold a nursing qualification, there needs to be documentation that the case has been discussed and has had oversight by a qualified nurse/midwife within UHS.

5.23. Postnatal Patient Contact Document by Midwifery should be reviewed to ensure they capture qualitative information, for example, concerns regarding neglect, parental substance misuse and that this has been shared with relevant professionals.

5.24. A strategy that babies most at risk from traumatic head injury are identified and that the ICON programme is continued to be promoted and discussed with all families on discharge and highlighted to professionals through training and supervision.

6. HEALTH VISITING

6.1. Mother received an antenatal visit from a health visitor (HV) in December 2018 and a new birth visit from a health visitor (HV 2) on 16 January 2019 and a follow-up visit on the 25 January 2019. The HV put the twins on universal pathway due to their prematurity so their feeding and weight could be reviewed and to monitor mother's mental health/wellbeing. The HV identified the risks in the electronic records, which included the historical Children's Services involvement due to half sibling 1 being removed from mother's care due to non-accidental injury. The HV recorded on the Family and Child Assessment form that mother received a conviction for this assault. The HV also included a risk that mother had a previous mental health history. It is recorded that the health visitor was also aware that sibling 1 was previously on a CIN plan, which closed in May 2016.

6.2. The new birth contact was completed on the 16 January 2019 by HV (2) who had known mother since the birth of sibling 1. The Neonatal Home Care Team informed the Health Visiting team by telephone on the 14 January 2019 that they thought they had smelt cannabis at their contact. The HV did discuss this with mother who reported that she did not smoke cannabis, but others did in the surrounding flats. The HV did not take this action any further or report to the Neonatal Home Care Team that they should raise their concerns through the appropriate channels. It is documented in sibling 1's electronic record that she was present during the new birth visit and that no concerns were identified or reported. It is recorded that she had good speech despite dummy use and her mother had two-year funding to sort out with the local preschool. The HV (2) opened a universal plus pathway for sibling 1 due to her sibling's prematurity but did not complete a Family and Child assessment form for her, which is recommended when there is a change in health visiting service offer from a universal to universal plus service. This would have allowed for consideration and assessment of sibling 1 of the impact of having twin siblings who were premature and a previous history of maternal physical abuse of an older sibling and of the potential negative impact of maternal mental health on the whole family. The Family and Child Assessment form was also not completed at the new birth visit for the twins but was completed at the next contact on the 25 January 2019.

6.3. Mother cancelled the planned postnatal contact with the HV on the 22 January 2019. She reported to the HV that she was going to her mother's home with the twins for some sleep, so her mother looked after them as she had had a very disturbed night. The HV completed a rearranged postnatal home visit on the 25 January 2019. The HV documented that there were no concerns for the twins' health or welfare. The HV appropriately discussed safety around sibling 1 being supervised with the twins. The cancellation of the planned visit by mother could have promoted a meaningful conversation between the mother and the HV exploring how she was coping with her toddler and twin babies. This shows a potential lack of professional curiosity by HV in considering the previous history of maternal mental health, postnatal depression and physical assault of a young baby in assessing how mother was coping. However, the HV did write in her analysis on the Family and Child Assessment form that the extra HV support should help to minimise any reoccurrence of mother's rough handling of her older son, demonstrating that she had considered the historical risks and the possible impact the risks could have had on the twins.

Analysis and learning identified by the Agency Author

6.4. There appears to have been a degree of professional optimism by the health visitors who assessed the family. HV felt that the family should receive a universal pathway as the Child in Need plan for sibling 1 had been closed in April 2016 and there had not been any further concerns regarding mother's care of sibling 1 recorded. There did not appear to be an analysis of the historical risk of mother previously causing injury to her first child and how the demands of a twin pregnancy and prematurity could put a strain on mother, placing the children at potential risk of harm.

6.5. The LSCP Unborn Baby Safeguarding Protocol was not followed by health visitors.

6.6. Limited information was known about father, who was not included in any of the risk analysis. No consideration was given to him being an unidentified adult in that household.

Subsequent changes/improvements in practice for Health Visiting identified by the Agency Author:

6.7. The need to raise awareness of the LSCP Unborn Baby Safeguarding Protocol with all the Trust staff including those providing adult mental health services. Health visitors need to ensure at liaison with midwives, GPs and other professional staff that the LSCP Unborn Baby Safeguarding Protocol is considered.

6.8. To raise awareness amongst the Trust staff of the need to direct other professionals to communicate their evidence of concerns to Children's Services directly and to inform families themselves that they are doing this.

6.9. To develop further training for staff around the analysis of historical risk and resilience factors and the potential for these to have an impact on current or future behaviours.

7. **GP**

7.1. There was minimal contact with mother during the pregnancy other than the initial contact to confirm the pregnancy and the GP referred her to the midwifery service. She did see the GP in April 2018 with mood swings but did not attend her follow up appointment. She was not seen again by primary care as all further antenatal care was undertaken by the midwifery service. Although neither mother or the twins were seen following the referral to midwifery services, information was received and entered into the patient notes from secondary care regarding:

- Multiple pregnancy
- Child P's physical health problem (talipes)

Analysis and learning identified by the Agency Author

7.2. The risks to the unborn baby and postnatally do not appear to have been considered and there appears to be a lack of awareness of the LSCP Unborn Baby Safeguarding Protocol. The sharing of information between primary care and midwifery services could have been done in a clearer, more explicit manner at the time of referral and throughout the antenatal and postnatal period. A safeguarding risk assessment and decision making could have been improved by

increased awareness of the significance of lack of engagement with antenatal care, previous Children's Services involvement, multiple pregnancy and a child with a physical health problem. The need to understand that safeguarding risk assessment is an evolving process and may change with time needs to be understood by agencies.

Improvements in practice identified for GP services by the agency author:

7.3. Training on the LSCP Unborn Baby Safeguarding Protocol to increase awareness and an understanding of assessing safeguarding risk as a situation evolves.

7.4. Improved information sharing between midwifery services and primary care to be addressed by development and roll out of guidance for Primary Care Vulnerable Family Meetings.

7.5. Development of standardised referral form to midwifery services from primary care that explicitly outlines safeguarding risks and plans to help information sharing between these agencies.

8. CHILDREN'S SERVICES

8.1. The family had been known to Children's Services since March 2013 when half sibling 1, who was approximately six months old at the time, was referred. A Section 47 investigation was initiated as half sibling 1 was seen with three bruises on the curve of his forehead, one on his cheek, and several small scratches on his hand, back, and right ankle, and slightly bigger scratches on his rib and left calf. Half sibling 1 was made subject to a Child Protection Plan (CPP). Care proceedings were initiated in May 2013. This was stepped down in June following parents' engagement. Mother was suffering with postnatal depression at this time and admitted causing injuries to half sibling 1, reporting she had pushed his head to stop him crying. Half sibling 1 moved to live with father in July 2013. CP Planning ended in December 2013 and the case closed in March 2014 with mother having contact supervised by the extended family.

8.2. In October 2015 a referral came in from the midwife advising that mother was pregnant (with sibling 1). A pre-birth assessment was undertaken by Children's Services to assess risks to the unborn baby in view of the concerning history. The assessment was completed and sibling 1 was made subject to a Child in Need Plan (CIN). No concerns were raised during the CIN planning and the case closed in May 2016.

8.3. There was no further involvement with the family from Children's Services until the referral after Child P was injured. All of the risk factors above were known to Children's Services and were included on agency records. They would have been shared with the wider professional network had Children's Services been aware of the pregnancy with the twins.

8.4. There are no improvements or learning identified by the Agency Author.

9 HAMPSHIRE POLICE

9.1. Hampshire Constabulary had limited contact with the family during the review period. Between April 2018 and February 2019 (excluding the date of the incident) police had been contacted by mother on four occasions. Two of these contacts were neighbour disputes between mother and her neighbours regarding the use of parking bays. This had resulted in complaints of anti-social

behaviour. The other two of the four reports related to mother as an aggrieved in an assault (without injury) by an employer (no further action taken) and mother reporting that an associate of her partner was growing cannabis plants at another address.

9.2. Historically in 2017, police recorded a domestic incident involving mother. This was reported by her ex-partner. The informant advised police that mother had sent him 17 text messages threatening to remove their child (half sibling 1) out of school. This was due to a disagreement regarding mother paying maintenance to her ex-partner who had custody of their child. A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment was completed and assessed as standard risk. A CYPR safeguarding notification (now referred to as a PPN1) was submitted to Children's Services in line with force policy and procedure (FPP).

9.3. Police were primarily involved with father during the period of 2013-2014. There were six reports made to police regarding domestic disputes between father and two ex-partners. Most were verbal domestics, with the exception of one, whereby a member of the public reported that the male involved had grabbed the female by the neck. On all occasions police completed the required DASH risk assessment and CYPR safeguarding notifications for children linked to the adults involved.

9.4. There was no learning or improvements identified by the Agency Author.

10. HOUSING

10.1. The District Council first became involved in September 2015 when mother presented as pregnant and initiated a homelessness application, which was agreed. Mother was placed in temporary bed and breakfast accommodation in April 2016 and a tenancy in May 2016. During the tenancy there were regular disagreements between mother and another neighbour with allegations/counter allegations around car parking, noise and the smell of cannabis. There were however no concerns about the tenancy, or any safeguarding concerns identified.

Learning identified by the Agency Author

10.2. The Agency Author has identified the need for improved liaison between the different district council functions and the need for enhanced training for frontline staff on professional curiosity and problem solving.

11. OTHER AGENCIES:

11.1. There was minimal involvement from South Coast Ambulance Service. CAFCASS had been involved in historical private law proceedings with half sibling 1 and half sibling 2 in 2013 and 2015. Neither parent had involvement with mental health, probation or substance misuse services.

12. FINDINGS and ANALYSIS

12.1. As with any review, the process of refection has identified some areas where the current systems and processes could be improved. However, it is unknown whether, if any of these changes had been implemented, this would have led to a different outcome for Child P. All the agencies involved in Child P's family have identified their own learning and have captured a number of single agency recommendations into action plans. The themes identified below capture additional learning identified by the Independent Reviewer for all practitioners and has resulted in six recommendations.

Theme One - Information sharing and assessment of risk

12.2. There were no current safeguarding concerns identified by any practitioners from the universal services involved with the family including the two midwives, the two health visitors (one who had been involved since the birth of Sibling 1), the GP and the Neonatal Unit practitioners. The midwives and health visitors who had contact with the family were assured by the involvement of Hampshire Children's Services statutory services and the decision to close the case in April 2016. In addition, through their contact with the parents no significant safeguarding concerns were identified and the mental health and substance misuse issues were seen as historical for both parents, although vulnerabilities were recognised.

12.3. However, none of these agencies who had involvement through the mother's pregnancy and first six weeks of Child P's life considered or undertook a referral to Children's Services under the multi-agency Unborn Baby Safeguarding Protocol which had been in existence since 2012 and reviewed and published by Hampshire LSCP in February 2017. This protocol requires an automatic referral to Children's Services by any agency when there is a family history of an older sibling being subject to Child Protection Plan or legal care proceedings. Despite this, the GP, midwifery, Neonatal Unit practitioners and health visitors did not undertake a referral. Awareness of, and compliance with, this LSCP Protocol has been a learning theme identified in SCR U published in February 2018 and SCR N published in July 2019.

12.4. This resulted in an opportunity to undertake a multi-agency process to share information and consider any potential risks to this child not being afforded. Given the level of vulnerabilities that were identified at the time and subsequently through the SCR process, a pre-birth assessment would have allowed information to be shared between partners and any risk to be identified. **(Recommendation 1)**

12.5. The UHS Health Trust confirmed that it had a Safeguarding Children in Maternity Policy, which does not mention or cross reference to the LSCP Unborn Baby Safeguarding Protocol, so even if practitioners accessed this policy, it would not have provided the accurate guidance. **(Recommendation 2)**

12.6. Vulnerable Families Meetings exist to share information between GPs, midwifery, health visitors and school nurses. There was some discussion of this family, but no concerns identified and there are no minutes of these meetings. The purpose and function of these meetings needs to be clarified to ensure consistency across Hampshire and guidance developed. (**Recommendation 3)**

Theme Two - Professional over optimism and professional curiosity

12.7. Although the case had been closed to Hampshire Children's Services in 2016, there were clearly still vulnerabilities identified in this family. These risks can be summarised as:

- Mother's history of inflicting non-accidental injury on half sibling 1 and them becoming subject to CPP.
- Historical maternal depression.
- Low levels of domestic abuse between both parents and previous partners.
- Cannabis use by both parents.
- Mother's non-attendance at antenatal appointments.
- The twin pregnancy and that the babies were premature requiring treatment in the Neonatal Unit for 15 days.
- Child P had also been identified with talipes and that there was a 2-year-old sibling.
- Financial difficulties and father working away.
- Child P's apparent reduced weight gain. This issue had also been noted historically with half sibling 1.

12.8. The professionals involved with the family rightly saw the strengths and had no concerns about either parent's presentation or approach to sibling 1 or the twin babies. However, there were signs of stress within the family - mother talked of having no money to buy baby milk and no internet access and that father was self-employed and away. There was clearly cannabis use by the parents, which although challenged by professionals did not lead to any further questioning or action. There was additionally no exploration around the fact that both twins were reported to be taking the same volumes and number of feeds and there was a small but notable difference between weight gains**.** Professional optimism and the need for professional curiosity is raised frequently in SCRs. This issue needs to be continually reinforced through training and promotion by single agency safeguarding leads. (**Recommendation 4)**

12.9. In addition, neither the midwives nor the health visitors made use of safeguarding supervision or consultation with the named Safeguarding Team, which might have enabled greater reflection on the vulnerabilities of the parents. However, even when the issue of the previous safeguarding concerns was raised by the Neonatal Unit on 31 December 2018 with the Safeguarding Team at UHS, the LSCP Unborn Baby Safeguarding Protocol was not flagged or initiated, and the advice was to discuss with the health visitor. This issue is reflected in their single agency action plans.

12.10. Mother missed a number of antenatal appointments and appointments with the GP in relation to the medical issue of talipes for Child P. Although she frequently made contact to cancel and re-arrange the appointments, this issue needed to be reviewed and considered as a potential risk indicator. **(Recommendation 5)**

Theme Three - Substance misuse

12.11. The midwives and neonatal nurses both at the hospital when the parents visited the twins and at home visits had identified a strong smell of cannabis and the housing provider had received complaints around the smell of cannabis. Although this was discussed with the health visitor who had not historically noticed the smell, and discussed with mother who denied it, no further action was taken by any professionals. It would be helpful for the Hampshire Safeguarding Children Partnership (HSCP) to undertake a review on the impact of cannabis use on parenting capacity

and to provide training, support and guidance to practitioners when they encounter the issue in a family**. (Recommendation 6)**

13. Good effective practice

13.1. The focus of this Review is to learn and improve services. As such, it is important to learn from practice that is considered effective and supports good outcomes for children. Good practice from professionals has been acknowledged and this includes:

- Midwifery talked with mother separately about concerns raised by Fetal midwifery.
- The Neonatal Team shared information with the Health Visiting Service regarding concerns around parental substance misuse in the postnatal period.
- The health visitor discussed safe sleep and ICON with mother at the antenatal contact and New Birth Visit.
- The health visitor recognised that due to prematurity and past depression a care plan was required.
- The focus and assessment by both midwives and health visitors on mother's mental health.
- There was evidence of liaison between health professionals.
- There was open discussion between mother and health visitor around cannabis use.

14. Recommendations

14.1. The Review concludes with recommendations to the Hampshire Safeguarding Children Partnership (HSCP), which build on the recommendations and actions already identified for learning by single agencies during the process of researching their involvement in this case. In a number of cases, actions have already been taken to improve arrangements/systems.

The following additional recommendations are provided to ensure that HSCP and its partner agencies are confident that any other areas are addressed, and that HSCP is able to monitor progress.

1. HSCP to review actions taken in previous SCRs and any barriers to promote awareness of the LSCP Unborn Baby Safeguarding Protocol to all practitioners particularly in universal health services to ensure mandatory reporting is understood and undertake relevant and proportionate auditing activity to ensure compliance.

2. HSCP to ensure all single agency protocols and procedures are compliant with the Safeguarding Partnership's protocols and procedures and audit through the existing Section 11 processes.

3. HSCP to request health partner agencies across Hampshire to review and develop guidance on the use of Vulnerable Families Meetings to share information and assess risk.

4. HSCP to promote awareness and undertake training on the themes of professional over optimism and professional curiosity identified in Serious Case Reviews.

5. HSCP to request that health agencies review their missed appointments policies to ensure they identify this issue where these occur but there is apparent compliance as a potential risk factor.

6. HSCP to consider developing best practice guidance and training for universal services on responding to potential risk issues of substance misuse by parents.

Alex Walters

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Appendix A – Terms of Reference for 'Child P' Serious Case Review

Timescale for review

April 2018 to February 2019

Key areas of focus

- What were the factors known to agencies about this child and their family? Were these factors identified, understood and acted on by professionals? Were they used to accurately assess risk to the child?
- What key information about the family was included on agency records? Was this information available to professionals? Was it shared across agencies and how was it used to assess risk factors?
- How was historical information about the family used to inform assessments and engagement with the family?
- Was the LSCP Unborn Baby Safeguarding Protocol understood and correctly implemented by multi-agency professionals? If not, what were the barriers to professionals' use of the protocol?