

**Serious Case Review undertaken under previous**

**Local Safeguarding Children Board (LSCB) arrangements**

**REPORT OF THE SERIOUS CASE REVIEW REGARDING**

**Child V**

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**1 INTRODUCTION**

**1.1 Background to the review**

1.1.1 This review was commissioned by East Sussex Local Safeguarding Children Board (LSCB) as a Serious Case Review (SCR) following recommendations to the Board’s Independent Chair that the circumstances met the statutory criteria for an SCR because a child had been injured, and the circumstances of these injuries indicated it to be the result of abuse or neglect. The criteria being: “abuse or neglect of a child is known or suspected; and the child has died or been seriously harmed” [[1]](#footnote-1) Child V was examined by a paediatrician and was found to have bruising that was considered non-accidental and subsequent investigations identified a number of fractures of different ages. The parents have been arrested and there is an ongoing criminal investigation into the cause of the injuries. This recommendation was confirmed by the Chair of the LSCB 4th October 2018 and was reported to the Child Safeguarding Practice Review Panel on the same date, with a response received on 5th November 2018.

**1.2 The Terms of Reference**

1.2.1 All agencies were asked to provide individual agency reports on their work using the following headings: -

* How was life for the child in this family?
* What was the impact of Single-Agency and Multi-Agency working?
* How were assessments, including risk assessments, undertaken?
* Were individual agency policy and procedures followed?
* To what extent were professionals aware of domestic abuse and were appropriate actions taken?
* To what extent were professionals aware of substance misuse by the parents and what action was taken?
* How aware were professionals of the legal processes concerning possible care proceedings regarding Child V and what was their involvement in them

1.2.2 The time frame of the review was from 1st June 2017 to 17th June 2018. In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of Child V’s immediate family that fell outside the timeframe if agencies considered that it would add value and learning to the serious case review.

**1.3 Review process**

1.3.1 The review was conducted using a systems methodology that: -

* recognises the complex circumstances in which professionals work together to safeguard children;
* seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
* seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
* is transparent about the way data is collected and analysed; and
* makes use of relevant research and case evidence to inform the findings. [[2]](#footnote-2)

1.3.2 Individual agency reports were received from the following sources: -

* Sussex Police;
* East Sussex County Council - Children’s Social Care;
* East Sussex County Council – Legal Services;
* East Sussex Healthcare Trust (ESHT) Acute Services;
* East Sussex Healthcare Trust (ESHT) Community Services (health visiting);
* SWIFT Adult Mental Health Team
* A local Borough Council;
* Primary Care GP Services.

1.3.3 A key part of the methodology was contact with frontline professionals who had been involved with the family. There were two meetings: a workshop where frontline practitioners and their managers examined inter-agency working; and a recall day, where the same professionals discussed the first draft of the report.

1.3.4 The lead reviewer was Fiona Johnson, an independent social work consultant who was Head of Children’s Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010. Fiona qualified as a social worker in 1982 and has been a senior manager in children’s services since 1997, contributing to the development of strategy and operational services with a focus on safeguarding and child protection. She is independent of East Sussex LSCB and its partner agencies, although she was the Chair of the East Sussex and Brighton & Hove Child Death Overview Panel at the time this review was conducted.

**1.4 Parallel Processes**

1.4.1 There were ongoing criminal proceedings during the review which have not yet been concluded, at the time of this report being presented to the LSCB.

1.4.2 There were also civil proceedings that were concluded during the review. The outcome of these proceedings was that Child V was made the subject of a care order and plans for permanence are being made by the Local Authority.

**1.5 Family Input to the Review**

1.5.1 At the time of this report being presented to the LSCB, it has not been possible to involve family members because of the ongoing criminal proceedings. Parents have been advised, in writing, of the review.

**2 SUMMARY OF FACTS**

#### 2.1 Family composition

|  |  |
| --- | --- |
| **Family member**  | **Age at the time of the injury to the child** |
| Mother | 20 years |
| Father | 22 years |
| Child V | 7 months |
| Sibling1 | 2 years 2 months |
| Paternal grandmother | 43 |
| Maternal great-aunt | 39 |

This was a white British family who were living in temporary accommodation for much of the review period. Neither parent was in employment and they were dependent on benefits. Both parents had difficult childhoods with domestic abuse a feature in relationships within their family homes.

**2.2 Background history**

2.2.1 In 2016 when Mother was 31 weeks pregnant there was a significant domestic abuse incident where Mother alleged that Father had held her prisoner. Soon after Mother was admitted to hospital in premature labour and Sibling1 was born via an emergency caesarean section. The baby was in a poor condition and required special care because of Mother’s substance misuse. There is a lack of clarity regarding this domestic abuse incident as during the period when Mother alleged that she was held prisoner, professionals visited the home and met with Mother alone and she did not report any problems. The couple had a conflictual relationship and professionals working directly with the couple considered that Mother could be abusive to Father as well as vice versa. Mother was also arrested for an assault on paternal grandmother when living within her home.

2.2.2 After the birth Sibling1 spent 8 weeks in the Special Care Baby Unit (SCBU) where it was observed that Mother required constant supervision and prompting. As a result, Mother and Sibling1 were placed in a Mother and Baby foster home to enable a Family Assessment to be completed with twice weekly support from a Family Keyworker to help with bonding, attachment and parenting. Cognitive and psychological assessments of Mother were also commissioned. Mother spent four weeks with Sibling1 in the foster placement; she struggled to wake for night feeds, did not respond to advice, did not interact with or feed the baby properly resulting in Sibling1 losing weight. Soon after this Mother relinquished the care of Sibling1 who was placed in a baby only foster placement. Father had not engaged with Childrens Social Care staff and was not involved in any way with the care of Sibling1. Following legal intervention Sibling1 was made the subject of a care order and in 2017 Sibling1 was placed in an Adoptive Placement.

**2.3 Key episode 1: Work before birth of Child V**

2.3.1 In August 2017 Mother booked in late for ante-natal care, she was 16 weeks pregnant. Following the booking Midwifery informed CSC of mother’s pregnancy as she had reported that a previous child had been adopted. Two weeks later, in early September the couple presented as homeless to the Housing Department but although they were provided emergency accommodation, they failed to attend the address. A few days later Mother attended hospital with abdominal pain and reported that she was homeless following a domestic abuse incident and that her partner had been arrested. She was offered, but refused, a social admission to the hospital. In October 2017 the couple’s homeless application was accepted and they moved into temporary accommodation.

2.3.2 A social worker (SW1) was allocated to the family at the end of September 2017, the same social worker who worked with Mother and Sibling1. There was no contact with the family until November, partly because the parents did not attend appointments, but additionally there was confusion about the expected due date. In November 2017 a health visitor (HV1) did an ante-natal visit and the parents told her about CSC involvement and expressed concern that the same social worker who had previously been involved was undertaking their assessment. The parents told HV1 that there were no on-going risks in respect of their parenting, and she noted that the couple did not appear to have any insight into why Children’s Social Care were involved. SW1 visited the family the next day where the parents agreed to work with her, despite having previously asked for a change in social worker. The couple also engaged with two assessment sessions conducted by the MASH[[3]](#footnote-3) Health Visitor in November 2017. The parents did not co-operate with any further visits from SW1 in December 2017 and she was still attempting to visit to complete her assessment in early January 2018. It is noteworthy that the adoption process regarding Sibling1 was being completed in December 2017 meaning that the parents were receiving letters regarding the adoption which may have affected their willingness to engage with the assessment process. SW1 was unaware that this was happening as once a child is placed for adoption access to their records is strictly limited.

2.3.3 Early in January 2018 SW1 presented her assessment to the Care Planning Forum[[4]](#footnote-4) (CPF), her recommendation was for a Parent and Baby Assessment placement. The rationale for this was that the couple ‘appeared brighter in mood and less negative about further assessment’ and most importantly they had not been assessed as a couple previously meaning that Father’s capacity was largely unknown. When SW1 started her assessment, based on previous knowledge of the couple, she had expected to be recommending immediate removal of the child at birth. The CPF did not agree this plan and instead recommended a robust Community Parenting Assessment alongside a Child Protection Plan. Following this the social worker convened an Initial Child Protection Conference (ICPC)[[5]](#footnote-5). The GP was not invited to this meeting and did not receive minutes. Agency opinion at the meeting was divided; Health reported significantly improved engagement and commitment particularly with midwifery services, however the Police report detailed five call outs regarding domestic disputes and a day of multiple shoplifting offences where the couple identified having no money for food. The Chair of the ICPC had prior knowledge of Mother’s history and felt that Child V would be at significant risk of harm and that more robust planning was needed. The Chair drafted the Initial Child Protection Plan setting out that a return to CPF was needed however this was resisted by the social work team as they had very recently been to the CPF.

2.3.4 In January Swift Specialist Family Service [[6]](#footnote-6) became involved and undertook a mental health triage assessment of father and a cognitive assessment of Mother. The assessment of Father concluded that there was no evidence he was suffering from a mental illness but recognised that he did struggle at times to relinquish control and could become frustrated with others around him when they asserted themselves. They recommended a programme of work on relationships and anger control which was started after the birth of Child V. The cognitive assessment of Mother provided a comprehensive report of her level of functioning and the support required to aid her learning. Additional issues highlighted included her low mood and a lack of consistency between her self-report and actual circumstances. This report was shared with those professionals working with her.

**2.4 Key episode 2: Early days – multi-agency input to end of March 2018**

2.4.1 Child V was born in early February 2018, a normal healthy baby. Initially there were no concerns about the care provided by the parents, and they appeared to engage well with the midwife and HV1, who provided an intensive support package. The parents were sharing the care of Child V, with Father providing night feeds, it was noted that when professionals visited Father was usually in bed, and in mid-February, he told the GP that he was struggling to sleep and was using cannabis to relieve stress. Mother was also diagnosed with post-natal depression and prescribed fluoxetine. This information was not shared with other professionals as the GP was unaware that Child V was the subject of a child protection plan.

2.4.2 At the beginning of March there was a Core Group[[7]](#footnote-7) Meeting attended by the parents with Child V. At the meeting Parents reported that two days previously Child V had been hurt on the mouth by the sharp collar of the feeding bottle. SW1 and the HV1 saw no evidence of bruising to the mouth, but a scab was noted which fell off when father wiped the baby’s mouth. SW1 sought advice from a paediatrician who reportedly advised that the injury could have been caused as described or by the bottle being forced into the baby’s mouth. There was no follow-up to this injury as the paediatrician stated that as there was no longer physical evidence of the injury nothing further would be gained by a paediatric examination. There is no recording of this conversation in the hospital records.

2.4.3 A week later HV1 saw Child V and noted that the baby had dropped one percentile, had redness to the armpits, and had a cough. She advised that the parents take Child V to the GP. The next day the parents took Child V to the GP but were told there were no appointments available and were advised to return the next day; Child V was taken to a walk-in clinic the next day and had a chest examination which did not identify any issues. There was no direct contact between the GP and HV1 so they were unaware of the family history, including that the child was the subject of a child protection plan.

2.4.4 During the last week of March 2018 the Parents argued and Father told the Housing Department that they had split up. There was no contact with the family by CSC staff or HV1 however Mother attended the GP for her 7-week post-natal check. At the end of the month HV1 and SW2 had telephone contact with the parents who confirmed they were back together. There was a further discussion at the Care Planning Forum (CPF) about the deteriorating level of engagement with the family and agreement was given to progress to ‘meeting before action’[[8]](#footnote-8) and a recommendation that a ‘viability assessment’ of maternal aunt be completed as a potential family carer for Child V if one was needed.

**2.5 Key episode 3: Improvements identified April 2018**

2.5.1 During April 2018 some improvements were noted; the family were allocated a flat and their universal credit came through. The parents were more co-operative with professionals and Child V was weighed and showed a moderate weight gain; the baby had not regained the birth weight centile but was noted to have had three consecutive weights on the 9th centile[[9]](#footnote-9). Child V was observed as alert, cooing and trying to engage in eye contact with Mother when she was handling him. Mother observed to handle the baby with care and attention.

2.5.2 The Review Child Protection Conference (RCPC) was held mid-April and it was decided that Child V should remain the subject of a child protection plan as despite some improvements there were still concerns regarding domestic abuse between the parents. The parents struggled with the meeting and left early. The GP was not invited to the RCPC and did not receive minutes from this meeting.

2.5.3 During April SWIFT undertook a mental health triage assessment of Mother. This assessment was purposefully delayed until the Mother was at least 6 weeks post-partum and was completed over 2 sessions, 2 weeks apart. The assessment did not identify that the Mother’s mental health was currently having a negative impact on her ability to parent and the Mother declined to receive any ongoing support or intervention from the SWIFT mental health staff. Father also attended two sessions with SWIFT staff however he did not attend any further appointments offered despite assertive attempts to engage him. He was subsequently discharged from the service on 20th June 2018. The allocated social worker was advised regarding the Father’s lack of engagement and subsequent discharge.

**2.6 Key episode 4: Deteriorating care May-June 2018**

2.6.1 During May 2018 there was a change in health visitor because the family had moved. There were also concerns regarding further weight loss and by the beginning of June Child V’s weight had dropped to between the 2nd and 9th centile. The family were allocated a community nursery nurse to provide additional support, but the family failed the appointment.On 4th June Child V wasweighed and was found to be two centiles below the birth centile. Child V was reported by parents to feed 3-4 hourly during the day. The baby was observed to smile and vocalise and was seen wearing clean clothes appropriate for the weather. Child V was seen a week later when HV2 undertook a home visit at midday and Mother reported having just woken up; the parents also appeared to be ignoring advice regarding feeding the baby and had not kept a diary of feeds given.

2.6.2 During June 2018 the family disengaged from professionals and were not available for visits. Visiting by CSC staff was increased but this coincided with SW1 having three weeks’ leave and planned management cover was lost due to the Practice Manager having to take unexpected leave and so the team had to cover the work during this period. Mother eventually responded to the Family Key Worker (FKW) acknowledging high levels of anxiety and avoidance. SW2 and the FKW observed a significant dip in Mother’s mental health, issues in the couple’s relationship, continued difficulties with SW1 due to associations with the previous proceedings and the impact of anniversaries / correspondence relating to their first child. In mid-June there was an anonymous report of regular violent domestic disputes. A duty worker visited and followed-up with the FKW. The couple denied regular arguments but acknowledged the previous night’s dispute and confirmed police attendance

2.6.3 In late June 2018 HV2 undertook an unplanned visit to the family home at the request of the FKW to weigh Child V. On arrival the Mother and Father were in a heated argument, they were observed to be shouting and swearing at each other. Child V was observed being formula fed whilst on a changing mat. Both parties expressed concerns about each other. Child V was weighed and noted to have lost weight, he presented as quiet and watchful during the parental argument. HV2 did not feel that Child V should be left in the parents’ care while they were arguing and so called the FKW who arrived with SW2 (who was the duty social worker). When they arrived, Father became jovial and acted as if nothing had happened. That evening it was arranged for Child V to stay with a friend, after checks were made by CSC.

**2.7 Key episode 5: Continued concerns July 2018**

2.7.1 During early July 2018 concerns escalated across the professional network because the parents were avoiding contact meaning that professionals were unable to monitor Child V’s faltering growth and there was evidence of increased police involvement in domestic disputes. The ‘Meeting Before Action’ (MBA) process had been delayed because the family had moved and SW1 was slow to complete the ‘letter before action’ because of sickness. In July, as concerns about the parents’ co-operation grew, the Practice Manager in CSC considered whether to move straight to issuing Care Proceedings and discussed this option with the Legal Department. The Legal Department advised that on the available evidence the threshold to issue care proceedings was met but that the court would be unlikely to find that the high legal test required to meet threshold for separation was also met and that an attempt should be made to engage the parents with assessment under the MBA whilst further information and evidence was obtained from other professionals.

2.7.2 In Mid-July 2018 a Welfare Medical was requested due to concerns around faltering growth and neglect. During the medical Child V was seen to have red marks on the neck which were reported to be insect bites. The medical was a very difficult experience for the parents who were very distressed as they feared that Child V would be removed from their care. They had only expected to be at the hospital for an hour so were not prepared for the five hours that they ultimately spent there. They had brought enough supplies for Child V but not for themselves; neither had eaten or had a cigarette and they had no money with them. The parents became agitated once they understood that safeguarding concerns had been raised. There was a lot of verbal altercation between the parents and both parents were aggressive and difficult with professionals which raised concerns for hospital staff about their capacity to care for the baby safely. The perspective of the CSC staff was that the Parents were observed to have been agitated with each other and professionals but not towards Child V.

2.7.3 Child V was noted during the initial medical to have a chest wheeze and there was discussion with the social worker (a duty worker) and the parents about possible causes which included a suggestion it could indicate a possible historic injury. This was eventually discounted after observation on the ward when the symptoms resolved. It is now known that this was caused by a ‘floppy larynx’ (Laryngomalacia)[[10]](#footnote-10) that was worse when the baby was distressed. At the time of transfer to the ward it was suggested that the child should be admitted to the hospital and a skeletal survey be undertaken. It was eventually decided by the paediatrician on the ward that the skeletal survey was not needed as there was no obvious sign of an injury and the wheeze had resolved. This was not effectively shared with the social worker however as at the time of discharge it was thought that Child V would be returning to the hospital on Monday for a skeletal survey. It was therefore agreed that Child V would stay with a family friend over the weekend, who had cared for the baby previously, providing some respite. It was noted that Child V was not distressed on separation from the parents and was content to be left in the care of a stranger.

2.7.4 At this point there was a change in social worker and SW2 formally became the new social worker, she had previously worked with the family as a duty social worker because of absences by SW1 because of planned and unplanned leave. On 25th July Mother attended Accident & Emergency with a fracture to a finger. The explanation she gave for the injury was that she trapped it in the flat door. There is no evidence that domestic abuse was considered or discussed with Mother as a cause of the injury and it is probable that the staff were unaware of the child protection plan and the previous history of domestic abuse.

2.7.5 The next day Child V was not brought to a scheduled growth review with HV2 who telephoned the family. Father responded and was very irate saying they could not get hold of FKW and had no electricity or formula for Child V. HV2 offered support and requested they attend the children’s centre, but father refused and proceeded to swear at HV2. She contacted CSC and spoke to a duty social worker who attempted to visit but was unable to gain access. The next day SW2 visited. Home conditions were poor, and mother was noted to have a badly bruised and bandaged hand which she reported having shut in a door. SW2 facilitated getting Child V weighed and returned to check that the property had been cleaned as agreed.

2.7.6 At the end of the month there was the ‘Meeting Before Action’ (MBA), both parents attended, only Mother was represented by a solicitor.

**2.8 Key episode 6:** **Further injuries August 2018**

2.8.1 At the start of the month Child V was seen at the clinic by a nursery nurse, the baby’s weight was still not following the centile chart and when Father was advised of this, he became agitated and Mother suggested they leave. That evening the Police were called out to a verbal dispute between the parents which was about the baby’s weight gain. The next day the nursery nurse cancelled a home visit, on the advice of the Locality Manager, partly because of concerns about Father’s presentation at the clinic the previous week and partly because the FKW was off sick and it had been arranged that they would attend jointly to discuss weaning.

2.8.2 A week later HV2 and SW2 did a joint visit to the family home. They both saw bruises on the baby’s face and arm and a graze on the back of his head. Child V was noted by HV2 to be quiet and watchful with no vocalisation. The parents were in their nightclothes and explained the injuries to the baby as having been caused by the changing table having collapsed whilst they were completing a nappy change. The parents showed the professionals the table which had been dismantled. Child V was weighed, and further weight loss was noted. Following discussion with HV2, SW2 contacted the On-Call paediatrician to request a child protection medical. The advice given was that this was not necessary and that the baby should be taken to the GP the next day. There was also telephone discussion with the Police regarding whether there should be a section 47 investigation which concluded it was not necessary. It is noteworthy that whilst the Practice Manager in CSC recorded the discussion with the Police as a Strategy discussion, the Police Officer considered the conversation to be ‘advice over the phone’ and did not record the conversation in police records; the paediatrician also did not record the conversation about the request for a child protection medical.

2.8.3The parents did not take Child V to the GP the next day, which was a Friday, and the baby was not actually seen until the Monday when the parents went to a walk-in clinic and the baby was seen by a Health Care Assistant not a Doctor or Nurse Practitioner. A mark on the back of the baby’s head was noted at that examination which the parents explained as being a carpet burn. No other injuries were identified however the baby was not fully examined as the staff at the Walk-in Centre were not aware of the previous history, did not know that the child was the subject of a child protection plan, so responded to the presenting concern which was the mark on the baby’s head.

**2.9 Key episode 7:** **Final injuries August 2018**

2.9.1 On 22nd August HV2 did a home visit in order to complete an ‘Ages and Stages’ questionnaire with the parents and to weigh Child V. Father was very agitated and Child V unusually quiet during the visit. The parents questioned why Child V should be naked to be measured despite this being the normal process and when the clothes were taken off, HV2 saw bruising on the child’s shoulder blade, back and spinal area. Father asked HV2 to leave the house which she did after advising the parents to take Child V to the ‘walk-in’ centre for treatment for the injuries. HV2 then telephoned SW2, who was unavailable, so she liaised with the Duty social worker. HV2 then arranged an appointment for the family at the walk-in’ centre and SW2 met the family there. The Police also attended and as the injuries were identified as probably non-accidental, they arranged for Child V to be seen at the hospital for a child protection medical.

2.9.2 After Child V was seen at the hospital it was agreed that, as the injuries were unexplained and probably non-accidental, Child V should be made the subject of ‘police protection’[[11]](#footnote-11) and placed in foster care. The parents were very agitated at the hospital and the arrangements in place there were not ideal because there were other clinics ongoing and facilities were constrained.

2.9.3 Child V remained the subject of ‘police protection’ for three days until the court granted an ‘emergency protection order’[[12]](#footnote-12), this was because the parents refused to allow Child V to be placed in care on a voluntary basis and CSC was unable to get a court hearing until the next day. The preliminary results of the skeletal survey showed 2/3 fractured ribs which were confirmed by a specialist as non-accidental and occurring on more than one occasion. A week later a second skeletal survey identified further fractures of a different age.

**3. VIEWS OF FAMILY**

3.1 At the time of this report being presented to the LSCB, it has not been possible to involve family members because of the ongoing criminal proceedings. Parents have been advised, in writing, of the review.

**4 ANALYSIS OF PRACTICE IN THIS CASE**

**4.1 How was life for the child in this family?**

4.1.1 Child V was born into very unstable circumstances. Child V moved twice in the first few weeks of life and was cared for in temporary accommodation. The baby did not experience the security of a consistent environment, familiar sounds, smells and routine. However, in the early months, professionals did not observe Child V to be an unhappy child or one exhibiting signs of physical distress. Professionals generally observed positive interactions between Child V and the parents, Child V was usually well presented, with the baby’s needs prioritised.

4.1.2 In the latter period when there was increasing evidence of domestic discord between the parents there is some evidence that Child V was adversely affected emotionally by living in a very tempestuous environment. HV2, in June 2018, observed the parents in a heated argument during which Child V remained quiet which suggested that the baby had previously witnessed similar arguments. Similarly, SW2 noted that Child V did not react as might be expected to loud arguments between the parents suggesting that hearing raised, angry voices was not unusual, and Child V was therefore not startled in the way that other babies might be. She also observed Mother to reject Child V’s attempts at proximity seeking during a meeting.

4.1.3 Throughout Child V’s life there was also evidence of the baby experiencing a series of minor injuries which may have been accidental or deliberate but could have been caused by rough handling by the parents. By August 2018 Child V was living in a household with escalating levels of violence between the parents and had also experienced physical harm with several injuries occurring on separate occasions. It is also possible that the domestic disputes were impacting on Child V’s emotional well-being and the impact on the baby, at this stage of development, would be indicated by difficulties with feeding and faltering growth.

**4.2 What was the impact of Single-Agency and Multi-Agency working?**

4.2.1 As Child V was the subject of a child protection plan from birth there was multi-agency working throughout the period of this review. There were two agencies who were not significantly involved in the child protection planning process: The Housing department and the General Practitioner (GP). The Housing Department worked with the parents from prior to the birth of Child V and had relevant knowledge about father’s use of cannabis. They were never significantly involved in the child protection planning process despite poor accommodation being a significant stress factor in the early months of Child V’s life and professionals reporting that they recognised the need to address vulnerabilities in respect of housing and that finances were key to promoting the parents’ care of Child V. The social worker reported that liaison with Housing was good until the family moved and were placed in accommodation managed by a Housing Association when there was less contact. The delay in achieving secure housing delayed assessment and meant professionals focussed on supplying basic needs possibly empathising with parental stress rather than looking at risk. The parents also had significant rent arrears by August 2018 which they had concealed from other professionals. Professionals at the workshop reported that it was not usual practice for Housing to be included as members of core groups and they did not usually attend child protection conferences.

4.2.2 The GP was also not involved in the child protection planning process as they were not invited to the Initial Child Protection Conference regarding Child V and were not sent copies of the minutes of subsequent meetings. This was because at the time of the initial conference there was no GP recorded in the invitation list and this was not addressed subsequently. This review has identified a weakness in the system for organising child protection conference invitations which is now being addressed. This GP practice also did not scan conference notes into patient’s records, which were filed separately in paper records held off site, so even if the reports had been sent it is unlikely that they would have been accessed. The safeguarding policy at this GP practice has since been reviewed and updated in line with RCGP guidance advising the scanning of all letters, reports, minutes from case conferences and any information about safeguarding concerns into child as well as family members’ notes redacting necessary information. The situation was further complicated by the family choosing to access ‘walk-in’ centres most of the time. These ‘walk-in’ centres do not have access to patient records so rely heavily on the information provided to clinicians by the patients. It is clear however that the ‘walk-in’ centre was scrupulous in reporting to the main GP when Child V was seen however there were occasions, such as when Child V was seen in early August with an apparent carpet burn to the back of the head, when knowledge of the wider picture would have prompted a more thorough investigation.

4.2.3 The start of the multi-agency working was the assessment prior to the birth of Child V. Whilst there was good liaison between agencies, with maternity staff informing CSC of the pregnancy immediately, it is noteworthy that there was not an early multi-agency meeting to plan the pre-birth assessment. Pan Sussex LSCB procedures do suggest that a pre-birth Strategy Meeting should be held in circumstances including where:

* A sibling has previously been removed from the household either temporarily or by court order;
* Where there is knowledge of parental risk factors including substance misuse, mental illness, domestic abuse;
* Where there are concerns about parental ability to self-care and/or to care for the child;

In this case the Strategy Meeting was not held until after the CSC Family Assessment had been completed and following the CPF making their decisions regarding legal intervention. This may not have changed the decisions, but an earlier meeting might have ensured a more robust assessment, clarified the expected due date (EDD) and established a more secure professional network including consideration of involving the Housing Department and GP. The pre-birth assessment was also limited because of the parent’s resistance to engagement in the process and the confusions over the EDD. SW1 had only one meeting with the family supplemented by two contacts by the MASH health visitor, both of which were opportunistic rather than planned. This review identified some limitations to the pre-birth assessment process, including the timing of strategy discussions which are being addressed by the development of new guidance.

4.2.4 To some degree the role of the Initial Child Protection Conference (ICPC) was overtaken by the decision of the CPF to pursue a robust community-based assessment. The conference was closer to the expected due date than ideal, and the Chair of the ICPC clearly had some anxiety about whether the protection plan was sufficiently robust, hence her recommendation that there should be further consultation with the CPF. It was unfortunate that the absence of GP involvement in the child protection planning process was not identified and rectified at the ICPC. The explanation for this oversight given by professionals at the workshop was that the absence of reports from GPs at child protection conferences is very common meaning that it was overlooked. The input of GPs to child protection conferences is an area that has been identified within the LSCB as needing improvement. It is clear, however, that whilst the Police were raising concerns about domestic abuse between the parents, Health agencies were broadly positive about the parent’s engagement and co-operation in planning for the birth. An appropriate support package was put in place and the birth and subsequent discharge of the baby into the community progressed without problems.

4.2.5 During February and March 2018 there was close support and monitoring provided to the family with midwives, health visitor and CSC staff (SW1, FKW and FST) visiting regularly and in close communication. There were also regular core groups and it was at one of these meetings that all the key professionals noted the scratch on Child V’s face reported by the parents to be caused by the baby’s bottle. At this stage Child V was only five weeks old and the injury was unusual and unlikely to have been caused in the way that was described. The professionals involved, SW1 and HV1, were not comfortable with the explanation and SW1 did consult with the on-call paediatrician about having a child protection medical which was refused. It has not been possible to clarify the reasons for the paediatric advice, which does not appear to be in accordance with either child protection procedures or best practice, as there is no record at the hospital. A new system for child protection medicals was in place whereby an on-call paediatrician at the hospital provided advice using a mobile phone with no log of the calls received. This has meant that it has not been possible to ascertain definitively who was involved. Police were not consulted and there was no formal strategy discussion held which meant a further opportunity for discussion of the likely causes of the injury was missed.

4.2.6 The Review Child Protection Conference in April 2018 occurred at a time when, despite ongoing concerns about the volatility of the parent’s relationship, professionals had few specific concerns regarding Child V. The family had moved and were settling into their new home. The Police were not present at this conference as they only attend review conferences when they have specific concerns they wish to raise. It is possible if they had attended that there would have been a greater focus on the domestic disputes. The injury said to have been caused by the bottle was discussed at the conference when professionals were told that the Paediatrician had advised that it could be’ rough handling’ or as the parents described. It was reported at the workshop, that there was discussion about the category of registration but that it was felt that the risk of emotional harm was greater than the risks of physical injury to Child V, so the category of registration continued as emotional abuse.

4.2.7 During May and June 2018 concerns grew regarding Child V’s faltering growth and this coincided with a change in health visitor and a combination of annual leave, sickness and compassionate leave by the social worker and her manager. Concerns remained regarding the volatility in the parents’ relationship and it is noteworthy that HV2 rapidly identified this as a significant issue, possibly because she was new and had not become accustomed to accepting the parents’ behaviour. Certainly, HV2 was very concerned about the parents arguing in front of Child V at the end of June and was worried that SW2, who was covering for SW1, may not have observed the full impact of the parents’ dispute, as they changed their behaviour when CSC staff arrived. There was some drift in this period as SW1 did not progress the ‘meeting before action’ which had been agreed at the end of March. This was in part because of work pressures in the team but was also affected by the absence of the Practice Manager because of compassionate leave. The Local Authority solicitor checked with SW1 on 17 April and SW1 confirmed that she would be drafting the LBP that week. On 8 June 2018 the Local Authority Solicitor, having not received a draft LBP, made further contact with SW1. Although Legal Services had sought to check they are nonetheless putting in place a system to ensure that such reminders are timetabled to happen on a monthly basis in every case.

4.2.8 In July 2018 the CSC Practice Manager returned from compassionate leave, identified the drift and the increased concerns regarding the risks to Child V, so discussed with the Local Authority solicitor the possibility of taking urgent legal action to protect the child rather than progressing with the Public Law Outline process. The Legal Department advised that on the available evidence the threshold to issue care proceedings was met but the court would be unlikely to find that the high legal test required to meet threshold for separation was met and that an attempt should be made to engage the parents with assessment under the MBA whilst further information and evidence was obtained from other professionals. The welfare medical that was booked in July was intended to support the legal processes however it is unclear that this was understood fully across the multi-agency system. This medical was a stressful event for the parents and caused some pressures within the multi-agency system with a degree of confusion amongst professionals as to the nature of the concerns about Child V’s physical health and the extent to which these were caused directly or indirectly by the parents care and volatile relationship. There was also a delay in the welfare medical report being sent to the social worker which would have undermined its effectiveness. It is noteworthy that during this time there was little opportunity for professionals to meet face to face and discuss their concerns and no possibility for them to share information away from the parents as the only regular meetings were the core groups which were usually attended by the parents.

4.2.9 A relevant event at the end of July was Mother’s presentation at Accident & Emergency with a fractured finger. It is significant that, despite professionals being aware of the escalating domestic disputes, no-one who saw the injury, challenged mother’s explanation that she had trapped it in a door. There is no evidence that these professionals considered whether it had been caused by Father or assessed the increased risk of physical harm to Child V this could pose. It was clear however that within the professional network there was increased anxiety about the risk that Father posed to professionals, as exemplified by the decision that the nursery nurse should not visit the home address alone. It is surprising this did not trigger consideration of the implications for, and impact on Child V.

4.2.10 The next opportunity for multi-agency working was the incident in early August 2018 when SW2 and HV2, together, saw bruising on Child V’s face and arm. The parents gave the explanation that they were caused when the changing table collapsed, and SW2 rightly contacted the on-call paediatrician to arrange a child protection medical. This could have two functions; firstly, to check that there was no harm caused to the baby by the fall, but also to check out the likelihood of the injuries occurring in the manner explained by the parents. Given that the baby was still only six months old and not mobile, any injury should be carefully checked, particularly where there have been ongoing concerns about the parenting that is being provided. It is therefore surprising that the advice given by the paediatrician was that a child protection medical was not needed and that the parents should instead take the child to the GP. This advice was not in accordance with child protection procedures or good practice guidance. It also had far-reaching implications as it undermined the concerns expressed by the health visitor and social worker and may have influenced the Police in their discussion with the social worker about further actions. The advice was again given by an on-call paediatrician, via a mobile phone with no record being made on the child’s notes. When questioned about why the advice was given, the individual has no recollection of the conversation, which means it is not possible to clarify the thinking at the time. There was also communication between CSC and the Police about whether there was a need for a joint investigation. The record in CSC files is that this was a strategy discussion, where it was agreed that there would not be a Section 47 investigation, but that the child would be seen by the GP with ongoing monitoring by the core group. There is no record of this communication by the police because the police officer involved considered the conversation to be for ‘advice only’ rather than a formal strategy discussion. It is concerning that there is an absence of appropriate formal records of an incident of such significant concern. It is also probable that at this point Child V had experienced some of the injuries which were later identified and a full medical at this time may have identified them and possibly prevented further injuries. Child V was seen at the ‘walk-in centre’, four days later, by a Health Care Assistant who conducted a limited examination. The Health Care Assistant undertaking the examination was not appraised of the full family history and so only examined the baby’s head which was the problem identified by the parents and reported as being a carpet burn, a plausible explanation for the mark noted. It is relevant that usual practice would be that children under one should be seen by either a doctor or Nurse Practitioner and any infant with an injury should have a full physical examination.

4.2.11 The final significant event was in mid-August when HV2, undertaking a routine visit to weigh Child V and complete a questionnaire with the parents, noted that the baby had significant bruising to his back. HV2’s actions were prompt and appropriate despite Father becoming quite aggressive and insisting she leave the home. She advised the parents to take the baby to the near-by ‘walk-in centre’, as the Father was already intending to go there, and immediately liaised with CSC staff to facilitate their presence when Child V was examined. The parents took Child V to the ‘walk-in’ centre and an examination of the baby immediately identified injuries of concern. The baby was referred appropriately to the hospital for a more thorough examination including a skeletal survey. There were some challenges at the hospital due to limited accommodation being available however, once Child V was in the hospital, all professionals worked together to effectively secure the baby’s immediate safety and appropriate action was taken via the court process to enable the longer-term security of the child. It is noteworthy that in this case an immediate medical examination was achieved with the medical staff being full appraised of the full circumstances and this resulted in timely and effective actions by the professionals involved.

4.2.12 Throughout the review period there were occasions when there were difficult relations between professionals. These issues were fully discussed at the first workshop and professionals were able to discuss events in an honest and open manner. It was apparent that some of the conflict stemmed from the different individual experience the professionals had of the parents. The social workers were very aware of the pressures the parents were under and knew their personal history so sometimes had better understanding of the reasons for their behaviour than other professionals, who had more limited contact, and, expected them to act in a more appropriate manner. This was particularly true regarding the parents’ behaviour in the hospital in August where hospital staff were concerned about the impact on other patients as well as the impact on the child. The social worker however was very aware of the effect on the parents of the possible removal of Child V from their care and viewed their behaviour in this context. It is also clear that the parents did not always behave in the same way with different professionals which led to some splits in perceptions about the levels of risk. This was evident regarding the parent’s arguments, which they sometimes concealed from the social worker but not from the health visitor. Professionals at the workshop also reported that they thought the parents were more stressed by the health visitor’s contacts because the health visitor would need to see Child V naked for a weight review which may have affected the parents’ behaviour.

4.2.13 There is limited evidence that professionals successfully formally escalated concerns, despite on some occasions, there being unhappiness with decisions reached. HV2 did challenge SW2 regarding the child protection medical and escalated her concerns to her Line Manager, who discussed it with the Named Nurse for Safeguarding and liaised with SW2’s Manager. These discussions did not achieve any change and were not escalated to the Designated Doctor or the Head of Safeguarding in Children’s services. This was particularly surprising regarding the decisions by the on-call paediatricians regarding child protection medicals. In part this is explained by a view that ‘the medical professional knows best’ and the professional hierarchy which tends to preference a senior health professional’s decision; however, it is a matter of concern that requires further exploration. The frontline staff raised their concerns, but these were not progressed satisfactorily by more senior managers. There needs to be assurance that there is full understanding of escalation processes and that managers are confident in applying them.

**4.3 How were assessments, including risk assessments, undertaken?**

4.3.1 Each agency undertook individual risk assessments throughout the review period, and these are detailed in the previous section regarding multi-agency working. Formal assessments were commissioned from SWIFT regarding Mother’s mental health, her cognitive functioning and Father’s mental health and specifically issues around anger control. These assessments were completed, and the information was shared with other professionals, however it is unclear as to how much they informed the inter-agency interventions. It is not apparent that much consideration was given to Father’s unwillingness to work with SWIFT regarding anger-management and the implications of this regarding the ongoing domestic abuse between the parents and its impact on Child V.

4.3.2 In their report for this review the police stated ‘*From considering the documentation for this review, it is unclear what had changed in respect of the mother and father’s ability to provide for Child V since Sibling1 had been adopted. Their chaotic lifestyle, allegations of domestic abuse and limited engagement of the parents with partner agencies appears to be at a consistent level and similar to that when [Sibling1] was in their care’.* Whilst this may be valid it does not explain why no agency (including the Police) was expressing this view at the time. In some ways the explanation may be best provided by the CSC report author who stated that ‘*No-one anticipated that either parent would* ***intentionally*** *(my highlight) harm Child V; whilst occasional abrupt responses were noted, the vast majority of observations were that parents’ interactions with and care of Child V were positive, it was their response to each other and their poor self-care that caused concern’.* Professionals were presented with parents who appeared to genuinely care for their child but who had limited resources to manage their emotions having had difficult childhoods. Professionals did not focus on the child’s experience, partly because he presented as a happy baby and was too young to verbalise his distress, this meant they failed to identify the real and significant risk presented to Child V by the parents ongoing chaotic and disruptive behaviour. This was not true of all professionals and HV2, particularly, was alert to the risks, however she was less successful at getting them heard effectively by the professionals within the safeguarding system.

**4.4 Were individual agency policy and procedures followed?**

4.4.1 In the main professionals followed agency policies and procedures. There were clearly limitations in the safeguarding policies in place within the GP practice regarding record keeping and these have been addressed and their safeguarding policy updated.

4.4.2 The major procedure that was not followed, by all agencies, was the ‘Unexplained Injuries to Young Children’ section 8.40 of the Pan-Sussex Child Protection and Safeguarding procedures. According to this ‘*any suspicious injury in a pre or non-mobile and/or pre or non-verbal child must be regarded with extreme concern – this should include minor injuries with an inconsistent explanation and significant bruising. Any injury and its explanation must be assessed in relation to the infant's developmental abilities and the likelihood of the occurrence’*.[[13]](#footnote-13) The procedures also state that ‘*If at the outset, or before the conclusion of initial S47 Enquiries, the mechanism for an injury to an infant or young child remains unknown, a serious unexplained injury strategy discussion should be convened’*. Furthermore in the section 4.2.28 on joint agency investigation the procedures also state that ‘*Cases of minor injury should always be considered for a joint investigation if the: Child is already subject to a Child Protection Plan*;’.[[14]](#footnote-14) Child V experienced two separate injuries, where professionals were unconvinced by the parents’ explanations, but at no point was there a formal strategy discussion meeting enabling professionals to discuss and consider the possible causes of the injuries. There was also no medical examination of the child. One possible explanation for the absence of such meetings is that it is rare that such processes are required when children are the subject of child protection plans as usually core group meetings provide the opportunity for multi-agency discussion. Such meetings, however, usually involve the parents, and where there are unexplained injuries it is important for professionals to be able to have discussions apart from the parents. In this case the child protection plan provided a false sense of security and a formal strategy meeting involving all relevant agencies would have allowed a more planned and considered approach.

 **4.5 To what extent were professionals aware of domestic abuse and were appropriate actions taken?**

4.5.1 All professionals involved in the child protection conference process were aware of the high levels of parental conflict and reports of domestic abuse incidents between the couple as it was a matter discussed and reported at those meetings. The GP was unaware of the issue as they did not attend the conferences or receive minutes of the meetings. Housing staff had no contact with the family after the birth of Child V but were aware prior to that date that the couple had an acrimonious relationship.

4.5.2 SWIFT clinical staff were aware of the historical domestic abuse at the time of their involvement and this informed the service offer made to Father. When he disengaged from the intervention, this was clearly shared with the allocated social worker, but it is unclear whether there was any discussion as to the implications this had with regards to the couples’ relationship and risks to Child V.

4.5.3 The social work team including duty workers and the FKW all experienced Father’s quick temper but also spoke of being able ‘to talk him down’ and to recognise this as an expression of his fear and frustration. He was noted to be employing safe practices, for example by leaving the property with Child V when Mother was agitated. There was also a perception, supported by experience, that Mother was equally aggressive as Father, and that the domestic abuse was mutual. This may have resulted in an acceptance of problematic behaviour by both parents, excused by their personal histories, without enough consideration of the impact on Child V.

4.5.4 Health visiting staff were more concerned about Father’s behaviour and discussed it with social work staff leading to some tensions as there was a perception that the risks were not being sufficiently acknowledged or understood by the social workers. This may have also been affected by the parents’ behaviour as there is some evidence that there was less conflict displayed before the social work staff.

**4.6 To what extent were professionals aware of substance misuse by the parents and what action was taken?**

4.6.1 Professionals involved in the child protection planning process were aware of cannabis use by Father but did not see it as a significant concern. Once the couple moved to their flat it was acknowledged that there was sometimes a smell of cannabis but that this pervaded the block of flats and was not traced to the family home. The only agency that identified Father’s cannabis use as problematic was Housing and that was before the birth of Child V and was not known by the professionals working with the family after the baby was born.

4.6.2 This review has not identified that substance misuse (either alcohol or drugs) was a significant factor in the abuse of Child V. There remains however a question as to how the couple were spending their money as they accrued significant rent arrears and it was thought that this was possibly used for purchasing drugs.

**4.7 How aware were professionals of the legal processes concerning possible care proceedings regarding Child V and what was their involvement in them**

4.7.1 Professionals involved in the child protection conferences were aware of the legal processes ongoing however the decisions regarding legal intervention mainly took place apart from the multi-agency child protection meetings. At the beginning, the CPF decision to pursue a community-based assessment limited the discussions at the ICPC. There was some discussion of other options including a mother and baby unit, the conference chair did recommend a return to the CPF, but this was not progressed until March as the manager considered that the advice already received was very recent. Overall professionals outside of CSC were distanced from the legal process. When there was some delay in progressing the ‘meeting before action’ this does not appear to have been picked up by the core group.

**4.8 Identified good practice**

4.8.1 Practice prior to the birth of Child V was generally positive with good communication between health agencies and CSC. There was close work across all professionals to monitor Child V, particularly in the first weeks of his life and later when the parents started to avoid professionals there was significant efforts by CSC and Health staff to engage parents and to make sure that Child V was weighed regularly. There were regular core group meetings and key professionals attended and worked together to help the parents care for Child V.

4.8.2 HV2 was particularly tenacious in her work with the family and her actions in August when she observed the bruising to Child V was competent and effective despite Father being aggressive and threatening to her personally. This was particularly apparent in her prompt action in contacting social worker and arranging for the family to be seen promptly at the walk-in centre.

4.8.3 The welfare medical report produced in July by the paediatrician was an excellent report that highlighted her concerns about the parents’ presentation and the possible risks to Child V.

4.8.4 The social work team worked closely together to provide cover when SW1 was away on planned and unplanned leave, due to sickness. It was good practice to allocate SW2, who had already worked with the family as a duty worker, when it was apparent that SW1 needed to be replaced. SW2 was responsive in arranging the ‘meeting before action’ in order to progress the care proceedings quickly.

4.8.5 Professionals at the workshop felt that one of the significant aspects of good practice was the strength of positive working relationships within East Sussex. Professionals felt that they knew people well enough to work to build and strengthen relationships; and that this was evidenced by the willingness of everyone at the workshop to share together their views on each other’s practice (good and bad) in an open and learning way.

**5 LESSONS LEARNED ABOUT THE WIDER SAFEGUARDING SYSTEM**

**5.1 Role of GPs – importance of them being part of the Child Protection planning process**

5.1.1 A relevant aspect of this review was the absence of the GP from the multi-agency child protection planning process. The GP was aware of the concerns about Child V as the social worker consulted the GP as part of the family assessment however the GP was not invited to the ICPC and did not receive minutes from those meetings. This was because of a failing in the CSC invitation system which has now been rectified. GP records are seen by other health professionals as the central point to which reports of all other health interventions are located; so, when a child is seen in hospital a summary report is always sent to the GP. Safeguarding professionals also identify the GP records as a hub for all health information to be located.

5.1.2 This review has identified that there is a need to improve information sharing between agencies and the GP. As the way patients access healthcare changes and the size of practices grows with an increased dependence on locum GPs due to recruitment issues, the challenge for primary care is continuity of care. Surgeries often use locum doctors, paramedics and nurses meaning that the traditional GP relationship has changed, and GPs do not necessarily know their patients well. Patients also have the option to attend walk in centres and out of hours centres which without robust communication can increase the risk to vulnerable patients. This means GP practices must be scrupulous in ensuring that electronic records are updated and relevant information is coded onto the electronic systems but also other agencies need to ensure the GP is always included in information-sharing as the GP record is the only one that follows a child throughout their life wherever they are.

5.1.3 In this review there were points at which if the professionals at the GP Surgery and Walk-in Centre had been aware of the full picture then there may have been more thorough and rigorous examinations which may have identified the injuries to Child V earlier. Furthermore on at least one occasion Child V was seen by a health care assistant when good practice argues that children under one should be seen by either a doctor or Nurse Practitioner and any infant with an injury should have a full physical examination. It is noteworthy that this was a recommendation from a serious case review in East Sussex in 2005 when a child died.[[15]](#footnote-15)

**5.2 Recognising and understanding domestic abuse and the risks to small children**

5.2.1 Research about children experiencing domestic abuse indicates an increased risk of physical harm to children, particularly babies or other non-mobile infants, when they are living with or are in close contact with violent adults. There is clear research evidence of the increased risk of harm to children from physical abuse by men who are violent to their female partners. In the UK, ‘in 40-70% of cases where women are being abused, the children are being directly physically abused themselves.’[[16]](#footnote-16) Domestic violence is also a key indicator for child abuse and neglect, ‘with children experiencing domestic violence being three to four times more likely to experience physical violence and neglect’. [[17]](#footnote-17) In the USA where families experience parental domestic abuse ‘there is an overlap of between 30 and 60%in rates of physical abuse for the children’.[[18]](#footnote-18) The routine co-occurrence between adult domestic violence and both physical harm and neglect of children is underlined in a study of the characteristics of parents and partners.[[19]](#footnote-19).

5.2.2 In recent years there has been a significant focus on the emotional effects on children of living in households where there is domestic abuse which may have resulted in less attention being given to the risk of physical harm to such children. There was limited reference to the increased risk of physical harm in the assessments and the emphasis was placed on the risk of emotional harm which was the category of registration for the child protection plan. There was no reference by practitioners to the risks faced by babies or other non-mobile infants whose physical dependency makes them more vulnerable. One explanation provided by professionals at the workshop for the decision to define the primary risk as emotional abuse, is that child protection plans must identify one primary risk as the system does not allow for two categories of registration. This means that there must be great clarity about the greatest risk to the child, as for many professionals (particularly GPs) the category of registration may have significant impact on how they view the family and risks, as they will not have sufficient time to read all accompanying documents.

5.2.3 It is particularly important that consideration is given to the nature of risk posed by domestic abuse to small children and babies. Particularly when they are pre-verbal, their emotional distress may be presented in physical symptoms such as faltering growth. While periodic conflict between couples is natural, and something which most children will be exposed to at some point in their lives, couple conflict which is frequent, intense and poorly resolved is very harmful. Research indicates that ‘Babies as young as six months, for example, exhibit higher physiological symptoms of distress such as elevated heart rate in response to overt, hostile exchanges between their parents when compared to exchanges between non-parental adults’[[20]](#footnote-20). Also, the risk of physical harm may not be from deliberate abuse but through rough handling when parents’ anger is insufficiently under control. Consideration needs to be given to how the issue of domestic abuse is being addressed with the parents. Father was offered work around anger management however when he withdrew from this there was no consideration of how this could increase risks to Child V. There was no specific work with Mother, or with the parents together around domestic abuse, despite it being clearly acknowledged that Mother was also a perpetrator of domestic abuse within their relationship. In part this is because services regarding domestic abuse are predicated on a model of service delivery that assumes a victim and perpetrator where the man is usually the perpetrator. In this case Father was offered work around anger management, but Mother was assessed for depression. A better service may have been couples counselling for both that could have addressed the difficulties in their relationship that resulted in them expressing their anger and aggression in front of their child.

**5.3 Sympathy for parents leading to optimism – impact on the professional network**

5.3.1The ‘rule of optimism’   that can affect assessment and decision-making in child protection work was   first identified by Dingwall, Ekeelaar and Murray[[21]](#footnote-21). The key concern they identified was that child protection professionals may wish to ‘see the best’ in people and have hope and optimism that their interventions can help the safety and well-being of the child involved. This important set of attitudes can, however, also leave children being abused and neglected.

5.3.2 In this case the social work staff initially expected that little would have changed within this family and that therefore there would be a need for legal intervention immediately after the birth of Child V. This view changed when their first contacts with the parents indicated a change in their attitudes which was supported by Health professionals who felt the couple were co-operating and preparing well for the birth of the baby. This may have resulted in a more optimistic presentation of information at the CPF and resulted in the move to a community-based assessment. Certainly, the CSC report for the review identified that the social work professionals and the FKW ‘noted that these were parents whom you wanted to succeed. Professionals were ‘drawn to’ the couple and sympathetic to their very difficult circumstances’. Professionals were aware of the parents’ difficult personal history and their grief over the adoption of Sibling1 and wanted to help the couple succeed with Child V. In this context the decision to allocate the case to the social worker who had removed Sibling1 was complex. It meant that the worker knew the family and understood their history, however the parents clearly felt that the social worker would not be objective and initially requested another worker. It also placed a significant pressure on the worker involved; it is hard to remove a baby from their parents but doubly hard when doing it for the second time. Good consistent supervision is essential in such work and the pressures within the social work team because of vacancies and unplanned leave meant that this was not always possible.

**5.4 Importance of full investigations of all injuries to infants**

5.4.1 It seemed that in this case the Child Protection plan providing a false sense of security meaning that usual investigative processes were not followed. At no point after the decision to initiate a child protection plan were there strategy discussion meetings despite there being several points at which these processes could/should have been triggered. This meant that there was no opportunity for professionals to meet and discuss the family and concerns about Child V without the parents being present. There were regular core groups and the review child protection conference but there is a sense that these meetings may have had to be handled quite carefully to accommodate the high levels of anger expressed by the parents. It is reported that they often left meetings early and in distress, this often leads to the focus of discussion being on the parents’ needs and can result in the child being overlooked.

5.4.2 There were two occasions when there was evidence of injuries to Child V which were not thought to be consistent with the explanations given and if on those occasions there had been formal Section 47 assessments with strategy discussions that planned the investigations it is possible that a fuller picture of the risks to Child V would have been achieved earlier. Certainly, it would have afforded a fuller discussion about why and when child protection medicals should be undertaken.

**5.5** **Pressures in the system**

5.5.1 There were capacity issues for CSC in the East of the County and one Family Support Team (FST) had been temporarily disbanded meaning that the remaining four managers were covering a wider area. The team working with Child V had been relatively stable although the Practice Manager was relatively new in post. Both the PM and SW1 had personal pressures and compassionate leave which impacted on their availability and resilience across the period in question but particularly it is of note that both were absent throughout most of June with the PM absent again in August. There is evidence that the team were proactive in organising duty visits to the family and that they had a sense of risks within this family. However, management cover of this specific case during the PM’s absence was unclear, particularly because the case was in the process of being reallocated.

5.5.2 There was also some evidence of pressures in the wider multi-agency system. Much of the communication between professionals was by phone with limited recording of those contacts. There were few face-to-face meetings without the parents present. There were changes in the safeguarding system, people at workshop talked about changes in personnel and structures meaning that previous personal relationships were no longer as strong as previously. After the domestic abuse incident in July there is no record of core groups or a forum in which the lived experience of Child V was discussed by the professional group collaboratively.

5.5.3 The changes in the arrangements for organising child protection medicals were intended to improve the process. The previous arrangement was that if CSC staff could not contact the on-call paediatrician they would contact the Safeguarding Unit within the hospital who would arrange a telephone consultation between the CSC staff and the on-call paediatrician. This meant that there was a log of the request for a medical and that the telephone conversation could take place at a time that was mutually convenient. The new system was that CSC staff were given the mobile phone number for the on-call paediatrician and make direct contact. Whilst this may result in a slightly speedier response, it also meant that the conversation was not planned, and the on-call paediatrician might be juggling conflicting demands at the time that the call was made and may not have immediate access to records at the time of the call. It is noteworthy in this case there was no record made by hospital staff of the two requests for medicals or the outcome of those conversations.

5.5.4 Finally, within the workshop there was discussion about staff feeling that there had been some significant changes in personnel within the wider East Sussex safeguarding system which meant people did not know each as well as previously. It was suggested that relations in East Sussex has been dependent on known relationships and there were concerns that some of these have changed with new personnel and structures for service delivery. It was felt that agencies no longer fully understood each other's ranks or hierarchy, did not know who senior people were and did not know who to escalate issues to, and that this made it harder for more junior staff to challenge decisions or to raise concerns.

**6 CONCLUSIONS**

6.1 This review has indicated some areas where single agency practice could be improved. These issues include recording systems and safeguarding policy within the GP practice; arrangements for GP invitations to child protection conferences; workload pressures within CSC; examination of babies by appropriately qualified medical staff in walk-in settings; and individual practice by paediatricians within the hospital. These are all issues that are being addressed by the agencies involved but the LSCB may wish to receive reports regarding progress in improving outcomes. It would also be useful to check if the matters raised within individual teams reflect wider issues across the agencies. Thus, it may be helpful to audit recording systems across GP practices and walk-in settings and to review wider workload pressures in CSC.

6.2 The review has also identified some areas where multi-agency working to safeguard children needs to be strengthened. This includes GP input and involvement in child protection conferences; housing staff input to child protection plans and involvement in core groups; the use of formal face to face strategy discussion meetings to plan multi-agency pre-birth assessments; the use of and recording of strategy discussions for section 47 investigations particularly where children are already the subject of child protection plans and ensuring clarity between consultation and formal strategy discussions.

6.3 The review has also shown limitations in professionals’ application of the child protection procedures regarding unexplained injuries to pre-mobile infants. This may be a result of individual error but the fact that the same issues arose twice suggests that this is an area of practice that needs improvement. The procedure is sound however professionals did not operate in accordance with it; specifically, there was no strategy discussion to plan the investigation and the child was not medically examined. The LSCB therefore needs to remind practitioners of the importance of these actions when responding to concerns about unexplained injuries in young children.

6.4 The review has also underlined the importance of professionals having a thorough knowledge of the complex nature of domestic abuse and the need for a nuanced understanding of its different nature and how this affects children. Training for staff should enable professionals to understand the ways in which small babies are particularly vulnerable to both physical and emotional harm and how to identify this in pre-verbal children. Consideration also needs to be given as to whether current service provision for perpetrators of domestic abuse is suitable to address the needs of couples who are mutually aggressive and may require couples’ intervention.

6.5 Finally the review has highlighted a lack of awareness by managers of the escalation policy. In part this seems to be because there are usually very good working relationships in East Sussex nevertheless it is clear that managers need to be reminded that the policy exists so that when there are difficulties there are clear pathways to resolve problems.

**7 RECOMMENDATIONS**

**7.1 Recommendation 1**

That the LSCB receive progress reports from those agencies where there were single-agency limitations; specifically: CSC regarding workload pressures and invitations to child protection conferences; CCG regarding GP recording practices and children under one being examined by a doctor or nurse practitioner; ESHT regarding the individual paediatrician practice issues.

**7.2 Recommendation 2**

That the LSCB, as part of its regular review of multi-agency working audit and improve practice regarding GP input to conferences; housing involvement in child protection plans and the use and recording of strategy discussions.

**7.3 Recommendation 3**

That the LSCB re-launch the protocol regarding ‘Unexplained Injuries to Young Children’ with a focus on the importance of strategy discussions and medicals in such circumstances.

**7.4 Recommendation 4**

That the LSCB consider whether the safeguarding policy, procedures and training regarding domestic abuse include enough focus on the risks of physical harm to young children and babies and whether there is enough detail regarding how emotional harm may be manifested in younger children. There should also be consideration of whether services for perpetrators of domestic violence include provision for those couples where there is evidence of mutual abuse and there is not clarity that one partner is the perpetrator and the other the victim.

**7.5 Recommendation 5**

 That the LSCB review whether the current escalation policy is sufficiently understood by managers across all agencies.

Fiona Johnson

10th September 2019

# Appendix 1– Glossary of Terms & Abbreviations

|  |  |
| --- | --- |
| ACPO | Association of Chief Police Officers (UK) now called the National Police Chiefs' Council |
| CPF  | Care Planning Forum |
| FKW  | Family Keyworker |
| FST  | Family Support Team |
| GP | General Practitioner |
| HV | Health Visitor |
| ICPC  | Initial Child Protection Conference |
| LAC  | Looked After Child (team) |
| LBP  | Letter Before Proceedings |
| MASH  | Multi-Agency Screening Hub |
| MBA  | Meeting Before Action |
| PGM  | Paternal Grandmother |
| PLO  | Public Law Outline. This is the framework within which Local Authorities are required to work in cases where it is considered by the Local Authority the threshold criteria for legal intervention is or may be met. Within the framework of the Public Law Outline there is a requirement to attempt to work with the family and their legal representatives before issuing proceedings. |
| PM  | Practice Manager |
| SCR | Serious Case Review  |
| SWIFT | Specialist Family Service Provision - A multi-disciplinary substance misuse and mental health service working with children and families. |
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3. The Multi-Agency Safeguarding Hub (MASH) is a partnership between East Sussex County Council, Sussex Constabulary, and Sussex health agencies working together to safeguard children, young people and vulnerable adults. [↑](#footnote-ref-3)
4. The CPF is a panel of operation managers,  practice managers  and a solicitor who meet with allocated social workers to discuss specific cases in relation to risks, safeguarding and case management, including whether threshold is met, whether the case should proceed to MBA under the Public Law Outline or whether to recommend to head of service that care proceedings should be initiated. Funding is the decision of the Head Of Service or Assistant Director following the recommendation of the CPF. [↑](#footnote-ref-4)
5. If child protection enquiries show that a child may be suffering or is likely to suffer significant harm, an initial child protection conference will be organised and if the conference decides that the child is suffering (or is likely to suffer) significant harm then the decision will be made for him/her to have a child protection plan. The aim of the plan is to try and stop any harm happening to the child and make things better for him/her. [↑](#footnote-ref-5)
6. SWIFT Specialist Family Service is a multi-professional specialist service comprising of three teams of practitioners and clinicians, whose areas of expertise include the following parental presentations: Mental Health; Drug and Alcohol Misuse; Learning Disability; Domestic Abuse; Sexual Risk. The service is jointly commissioned by adult health and children’s services; all practitioners and clinicians work within one integrated management protocol and the service is subject to external governance and supervisory frameworks. [↑](#footnote-ref-6)
7. A core group is a small group of inter-agency staff with key involvement with the child and family who meet on a regular basis with the parents, and where appropriate the child, to review, progress and make arrangements for implementing the child protection plan [↑](#footnote-ref-7)
8. Within the framework of the Public Law Outline there is a requirement to attempt to work with the family and their legal representatives *before* issuing proceedings. Within the framework provision is made for an **LBA** (letter before action) to be sent to the parents setting out the Local Authority’s concerns, setting out what the parents are required to do to address those concerns and inviting them to a meeting with their legal representatives to discuss and plan how to address the concerns raised. The meeting is known as an **MBA** (meeting before action). The parties all agree at an MBA what action should be undertaken and a review date is set. If the actions agreed within the MBA are not adhered to the Local Authority, then goes on to consider/issue care proceedings. [↑](#footnote-ref-8)
9. A centile chart is a size for age chart that is used to decide whether the size of a child falls within the normal (average) range or whether the child is larger or smaller than normal. The size of a healthy child will increase normally with age. A centile chart is based on the size measurements of thousands of healthy children recorded at different ages. A centile chart is made up of lines called centiles. [↑](#footnote-ref-9)
10. Laryngomalacia is a congenital softening of the tissues of the larynx (voice box) above the vocal cords. This is the most common cause of noisy breathing in infancy. The laryngeal structure is malformed and floppy, causing the tissues to fall over the airway opening and partially block it.In most cases, laryngomalacia in infants is not a serious condition — they have noisy breathing but are able to eat and grow. For these infants, laryngomalacia will resolve without surgery by the time they are 18 to 20 months old. However, a small percentage of babies with laryngomalacia do struggle with breathing, eating and gaining weight. <https://www.chop.edu/conditions-diseases/laryngomalacia> [↑](#footnote-ref-10)
11. A Police Constable has the legal right to remove a child from accommodation or prevent removal, where they have reasonable cause to believe the child would otherwise be likely to suffer significant harm - Section 46 Children Act 1989 [↑](#footnote-ref-11)
12. The Local Authority has the legal right to remove a child from accommodation or prevent removal, where they have reasonable cause to believe the child would otherwise be likely to suffer significant harm – Section 44 Children Act 1989 [↑](#footnote-ref-12)
13. <http://sussexchildprotection.procedures.org.uk/tkypy/children-in-specific-circumstances/unexplained-injuries-to-young-children> [↑](#footnote-ref-13)
14. <http://sussexchildprotection.procedures.org.uk/zkho/response-to-child-protection-referrals/section-47-enquiries/#s183> [↑](#footnote-ref-14)
15. JH Serious Case Review East Sussex ACPC [↑](#footnote-ref-15)
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