Serious Case Review

Baby B

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1 The circumstances which led to a Serious Case Review (SCR)

1.1 Baby B was born prematurely at 28 weeks gestation. Due to the medical complications associated with prematurity, Baby B remained in a hospital neonatal intensive care unit for 14 weeks prior to being discharged to the care of the parents.

1.2 Baby B was the first child born to the mother MB and second child of the father FB. MB and FB were aged 17 years and 20 years respectively at the point of Baby B's birth. FB had an older child with a previous partner who had been subject to public law proceedings within the preceding year.

1.3 Whilst in the care of the neonatal intensive care unit a referral was made to children's social care for an assessment which led to Baby B being identified as a child in need. The issues of concern included the relationship between the parents, their ability to parent safely due to low level maturity and concern about FB's use of cannabis and his anti-social behaviour. Alongside the issues of concern identified in respect of FB and MB, Baby B was a physically vulnerable baby who would require additional health support once discharged.

1.4 Approximately three weeks after Baby B's discharge from hospital, MB made a 999 call and Baby B was taken by ambulance to hospital. Upon examination, it was discovered that Baby B had suffered a significant head injury which resulted in acute bilateral subdural haemorrhages to both sides of his brain. The injuries were assessed as non-accidental. In addition to the head injury, Baby B had two marks to the body, one to the hand and one to the leg which were believed to be consistent with bite marks.

1.5 A police investigation commenced and FB was subsequently charged and found guilty of grievous bodily harm for which he received a 12 months prison sentence.

1.6 Working Together 2015 outlines specific criteria under which a serious case review must always be undertaken by applying Regulation 5 of the LSCB Regulations 2006.

For this serious case review Regulation 5(2)(a) and 5(2)(b)(ii) applied, that being that Baby B had been seriously injured, abuse or neglect was known or suspected and there was cause for concern as to the way in which the authority, their Board partners or other relevant persons had worked together to safeguard the child. Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 require LSCBs to undertake reviews of serious cases in these specified circumstances and to 'advise the authority and their Board partners on lessons to be learnt'

1.7 The Independent Chair of Hull Local Safeguarding Children Board (LSCB) confirmed that the circumstances surrounding the serious injuries sustained by Baby B met the criteria outlined in statutory guidance and made the decision to initiate a serious case review.

2 Methodology

2.1 Working Together 2015 requires that serious case reviews are conducted in such a way that they:

- recognise the complex circumstances in which professionals work together to safeguard children;
- seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- are transparent about the way that data is collected and analysed;
- make use of relevant research and case evidence to inform the findings.

2.2 In line with statutory guidance, Hull LSCB committed to approaching the review through adopting a rigorous and objective analysis of what happened and why, so that important lessons could be learnt and services improved to reduce the risk of future harm to children.

The Board appointed an Independent Reviewer experienced in undertaking serious case reviews to facilitate the process and write an overview report.

2.3 A review panel of senior officers representing the agencies that had been involved with the family was established and this comprised :

Role	***Agency***
Independent Reviewer	
Operations Manager	Sanctuary Housing Association
Named GP Safeguarding Children	NHS Hull Clinical Commissioning Group
Safeguarding Specialist Practitioner	Humber Teaching NHS Foundation Trust
Safeguarding Practitioner	City Health Care Partnership CIC
(Interim) Complaints Manager	Hull Children, Young People and Family Services
Detective Chief Inspector	Humberside Police
Strategic Domestic Abuse Services Manager, Citysafe and Early Intervention Directorate	Hull Children, Young People and Family Services
Assistant Chief Nurse	Hull & East Yorkshire NHS Hospitals Trust
SCR Sub-committee members	• Head of Humberside NPS (Hull and East Riding), Her Majesty's Prison and Probation Service • Designated Nurse Safeguarding, NHS Hull CCG
HSCB advisors	• Manager • Professional Practice Officer • Child Review Co-ordinator

2.4 The review panel members coordinated and maintained their agency engagement with the review by identifying and supporting the professionals involved with the family to contribute directly to the review, and through the provision of an agency learning and reflection report based on their contacts and interventions with the family. The review panel considered each of the agency reports supporting the appraisal of the practice from which the issues key to this review emerged.

2.5 The review set out to involve completely those practitioners who had worked directly with the family.

Practitioners were offered the opportunity to meet together with the reviewer at the commencement of the review, and the majority attended a one day learning event as a multi-agency group which together considered the strengths and vulnerabilities of multi-agency working in this case and how this related to wider practice. This management of practitioners' involvement was complex as the review of practice raised some emotive responses of unresolved difference that required tactful but honest exploration.

3 Scope and Terms of Reference

3.1 The review panel chose not to set specific terms of reference from the outset but allowed the key issues to unfold as the review progressed. This approach allowed a wider exploration of events rather than a pre-determined focus on specific issues without prior understanding of what happened, when and why.

3.2 At the beginning of the review, each agency submitted a chronology of interventions and this was collated to illustrate the multi-agency activity around the child and family. It was agreed that the general timeline for the review would cover the period from when the pregnancy of Baby B was known to the date of the critical incident. This was a 12 month period. Given that both MB and FB had a history of receiving services as children themselves, agencies were also asked to provide any contextual information that may have had relevance to understanding MB and FB prior to this period.

3.3 The second panel meeting, with the benefit of agency learning reports, identified that the examination of practice fell into four key episodes of practice. These included the following:

- Parental history and relevant risk factors
- Pre-birth events and safeguarding activity

- Post-birth to discharge from hospital of Baby B
- Post discharge from hospital of Baby B to critical incident

Each of these episodes was addressed in detail at the practitioners' learning event.

3.4 The review panel was mindful that Baby B had a half-sibling who had been subject to recent public law proceedings which primarily related to risk of harm from the mother. FB did not take a part in the proceedings and was never assessed as a parent or potential carer. For this reason, the review did not follow a line of further enquiry in relation to the half sibling of Baby B.

4 Parallel Proceedings

4.1 The review has been particularly mindful of two parallel processes, public law proceedings in relation to Baby B and criminal proceedings in relation to FB and potentially MB.

4.2 Consultation took place throughout with the police with regard to communications with potential witnesses to the criminal trial. As the investigation focussed on the physical cause of injuries, it was agreed that the review could engage with the professional officers without concern about witness contamination. It was further agreed that the parents would be informed of the review from the outset, but offered direct engagement once the criminal trial was completed.

5 Overview of what was known to Agencies

5.1 FB and MB first presented as a couple in October 2015, ten months before the birth of Baby B. They contacted the local authority who nominated them to a housing association since they were threatened with homelessness whilst moving temporarily between different family members.

Jan – early March 16 - prior to confirmation of pregnancy

5.2 FB and MB were both offered hostel accommodation which they did not accept offering the reason that other residents took drugs. They continued to stay with family members for a further three months. Information from police reveals that FB could become verbally aggressive with family members and FB was also verbally aggressive to the housing officer. FB commenced a personal housing tenancy in February 2016, where he lived together with MB.

5.3 Shortly after moving into the tenancy, the police were called twice to incidents. Firstly by a member of the public stating that a male who was in company with a female had threatened him with a knife. CCTV resulted in the identification of FB and MB as suspects by police although a stop and search did not find the knife. Shortly after this, FB made a 999 call threatening to stab his brother -in- law as well as set his house on fire if police did not attend and speak to his brother- in- law about an ongoing issue between the two. The police attended and calmed the situation.

5.4 Prior to the confirmation of pregnancy, MB presented for medical services on seven occasions in an eight week period. Four related to hospital presentations, three because of abdominal pain and one following a deliberate overdose of iron tablets. MB stated that she had been arguing with her partner and 'got really mad to the point she wanted to harm him but took tablets to hurt herself instead'. MB said that she and her partner regularly argued and that she had assaulted him in the past.

MB left the hospital before being seen by the mental health service and a notification was made to the hospital safeguarding team for follow up. The hospital telephoned MB who refused the offer of a 1:1 appointment. A multi-disciplinary discussion in the mental health service determined that MB could only be discharged to the care of her GP given that she had capacity to make informed decisions.

5.5 MB presented at the GP on three occasions. MB stated that she was acting as a carer for her boyfriend who had ADHD and autism. The third occasion was when pregnancy was confirmed in early March 2016.

5.6 FB's mother contacted FB's GP in late February 2016 seeking a prescription for methylphenidate which was not provided on the understanding this had not been prescribed for the preceding six months.

March to August 2016 – confirmation of pregnancy to birth

5.7 MB's pregnancy with Baby B was confirmed by the GP in early March. MB engaged with all ante-natal services and continued to have a high number of medical presentations, four with the GP between March and May, six attendances at Accident and Emergency and two admissions to maternity.

5.8 In April and May, the relationship between FB and MB was unstable, as evidenced by three calls to the police, two by FB and one by MB, during which their relationship and extended family issues were the subject of concern. In March, FB contacted the police asking that they be aware that he had asked MB to leave and that she intended to get her family involved. On this occasion he stated that that they both smoked weed which made the arguing worse and that he would like help to stop. In April, FB contacted police and alleged that MB had punched and kicked him causing minor injuries to his face. He reported that MB was 17 years old, currently pregnant, and that she smoked weed. When the police followed up the call, he stressed that he did not want MB to know he had contacted them and to cancel the call.

The police pursued contact with FB. However, he refused to meet with them. Review of the information by a Detective Sergeant in the domestic abuse unit took place which concluded 'whilst there is no recorded domestic abuse between the couple, there is information recorded which shows that he poses a risk to children. A request is made for a visit to MB to confirm a pregnancy so that the information can be shared with social services'.

5.9 Whilst police were pursuing the matter, MB made a further call to them. MB stated that she and FB had had an argument over keys. MB was calling from a telephone call box and was afraid that FB was kicking the door down at the home. MB advised that she was four months pregnant and had four children with her. The police response time was 67 minutes, during which time FB made four separate contacts. The police established that the couple were in dispute about property and money, and that MB was refusing to give FB one of two sets of keys to the property. The attending officers assessed the incident as medium risk due to MB's age, pregnancy, FB having ADHD and their chaotic lifestyle. A referral was made to children's social care and City Healthcare Partnership. The referral was considered by children's social care twelve days later and a decision was made to consider the circumstances at an early help allocation meeting. The agency records cannot evidence further decision making beyond this point. It should be noted that, although the information stated that FB and MB had gone to stay with respective parents, on the same day the referral was considered, FB and MB presented together at an antenatal appointment.

5.10 Following this event, five further calls were made to the police prior to the birth of Baby B. Three were from separate members of the public relating to FB, two by a neighbour who alleged that FB was setting fires and one by a shop keeper alleging that FB had stolen alcohol. One call was made by MB alleging that the neighbour was staring at her through the window. In addition, a call to police was made by FB's mother who believed he was under the influence of drugs, had a knife and was making threats to burn the house down and smash the windows.

The incident could not be resourced by immediate police attendance, and FB's mother was later seen by appointment. She explained that FB believed that his parents were responsible for his benefits being cut and advised that he had ADHD and autism and that she suspected he was taking MCat (stimulant drug). Police records state that a referral was made to both children's and adult's social care, however, these are not recorded as being received.

5.11 The housing provider had also received contact from the neighbour to report that FB was making fires and that the fire brigade had attended. A housing officer spoke with FB in June who agreed that the fire brigade had attended and advised him not to make fires. During this appointment which took place in the home, the housing officer advised that they needed to look after the property, noting cans and food takeaway containers left on the floor.

5.12 In July the midwife referred MB to the family nurse partnership. After two 'no contact' home visits by the family nurse, MB contacted the family nurse by text and stated that she did not need this service.

5.13 MB was admitted to hospital on two occasions, for a four day period in July and in August which led to the birth of Baby B at 28 weeks. Following the first admission, MB was counselled about the possibility of premature delivery and the risks associated with a baby being born before 30 weeks. During the four-day admission, both MB and FB proved to be difficult to manage. Both at times were rude and sarcastic to staff, and FB was advised that if his behaviour did not change then he would not be permitted on the ward. On one occasion, hospital security was alerted when MB was shouting at her family members.

5.14 MB was re-admitted to hospital 27 days later. A similar pattern of behaviour ensued. MB would not stay on the ward as advised, and was leaving with FB to smoke or go to the cafeteria. Baby B was born by caesarean at 28 weeks of pregnancy and required immediate ventilation and neonatal intensive care. The hospital were concerned and frustrated that MB was not following advice and staying put, and she was keen to be discharged two days later. A suggestion of early help services was made again by the hospital staff which MB declined.

August - December 2016 - birth to discharge of Baby B

5.15 Within three weeks of the birth of Baby B, the neonatal intensive care unit made a referral to children's social care. The hospital had found MB and FB continually erratic and difficult to manage. Hospital security had contacted the police to report that the parents had broken vending machines, stolen drinks and the food of other parents visiting sick children. Professionals found their attitudes to be frequently challenging and not focused on Baby B's care needs. FB had for instance kept asking if he could adjust the oxygen level for Baby B when saturations were high/low despite being informed this was a nursing task. FB was also observed to 'pause' the alarm on the ECG monitor yet denied this when challenged. MB was more able to listen and learn about Baby B's care needs, and both parents presented as affectionate to their baby. On one occasion FB was observed to smell of cannabis and to have slurred speech. FB was observed to be nasty to MB when not on the ward. He was also reported to brag to other parents that he intended to continue to flood the shower room to irritate the nurses so that Baby B would be discharged earlier. Baby B required oxygen and was tube fed.

5.16 During the post-birth period, a neighbour reported threatening behaviour to the housing provider on several occasions with concern about continued fire setting. Further emergency contacts were made to the police from FB's phone, but when he was contacted he informed them that nothing was wrong. On one occasion he telephoned the police stating he was scared that either someone had been in the house or a spirit was present.

5.17 The health visitor made a primary home visit at which MB's post-natal mood was assessed without concern. The health visitor did not ask about domestic abuse as would routinely be expected because FB was present with MB during the visit. The health visitor concluded that Baby B would meet the criteria for a universal plus service because of the prematurity.

5.18 Children's social care made the decision to allocate a social worker to undertake a child and family assessment to ascertain the parents' ability to meet Baby B's needs and identify what services and support were needed to safeguard the baby's welfare. The hospital did not advise the parents of their specific referral for fear of how they would react. After speaking sternly to FB about several nuisance issues, MB confided in a nurse that she wanted to leave FB because he hits her including when she was pregnant. She showed the nurse bruising. MB said that FB was controlling and kept her bank card and did not allow her any money. The nurse gave MB a leaflet about domestic abuse and encouraged her to call the number on it. MB stated that she planned to leave FB and return to her mother's home the following day. This information was reported to children's social care. Later FB telephoned the ward and asked if Baby B would be taken into care. MB was encouraged to engage in the assessment and speak with the social worker.

5.19 The following day, three abandoned emergency calls were made to the police from FB's phone. FB told the neonatal nurse later that day that he and MB had argued because she wouldn't let him do any of the care for Baby B. MB attended the hospital with FB and was crying. When asked why, she indicated it was because she wanted Baby B home. Noting that FB was behaving in a controlling manner, the nurse took an opportunity when FB was briefly out of the room to ask MB whether she needed to have a discussion with her alone which she declined.

5.20 Health records indicate that the social worker visited the parents on the ward six days later although there is no corresponding entry by children's social care in the chronology. Throughout September the parents continued to visit Baby B daily, observations revealed MB was the more capable and attentive of the parents and that whilst FB showed affection, he was easily distracted and quick to become offensive and defensive.

5.21 Further contacts were made to the housing provider to report that on 20th and 21st, the fire brigade had to attend due to lit fires becoming out of control. In addition, the RSPCA had been called for a second time as the dog had been left in the property alone for long periods of time.

5.22 At the beginning of October, FB's presence on the ward was restricted following an altercation with a father of another baby, in which FB was the protagonist. The hospital discussed this incident with the social worker and advised they had no option, because of maintaining safety and order in the ward. On 9th October, MB became upset when FB would not leave the ward as per the agreed time because she was concerned he would jeopardise Baby B's return to their care. After the intervention of the nurse, FB left. MB then became further upset, and repeated that FB had hit her in the past and locked her in the home so she was unable to leave while he went out. MB stated that she wanted to get in touch with the social worker and the nurse contacted children's social care to ask that the social worker contact MB. The chronology does not indicate that this happened. The following day, FB was accompanied from the ward by the security staff after being advised he could not visit for the foreseeable future because he would not observe the boundaries. MB was asked if she was safe to go home. She stated that she was but was also seeking independent housing and FB was supportive of this. Later that evening FB rang the hospital to say MB would not be visiting the following day. It was five days later before MB returned to the hospital with her mother. Health records suggest that the social worker told staff that he had visited the couple but did not discuss domestic abuse with MB because FB was present.

5.23 On 14th October, the social work assessment indicated a plan for Baby B to leave hospital to the care of the parents, stating they were willing to engage with agencies to make positive changes to their parenting. The social worker sent a letter to MB only which included information regarding self-referral to a Strength to Change[1] course which was to address domestic abuse and Let's Talk, a counselling service. The letter stated that a planning meeting would be convened to discuss Baby B's discharge. The hospital recorded that a conversation took place with the social worker who stated that FB could not stay with MB and their baby until he had completed a Strength to Change course.

5.24 In mid-October FB contacted the hospital on several occasions asking when he would be allowed to visit again. He was told that he could not visit until further notice. There was continued police activity in relation to a neighbour alleging that FB had stolen his bicycle and then tried to intimidate him into withdrawing the statement. In early November, FB was arrested in relation to making threats to kill, allegedly gesturing to a neighbour with a knife. No charges were pursued.

5.25 On 1st November, the consultant social worker recorded that consideration would be given to convening an initial child protection conference if a further domestic abuse incident occurred.

5.26 On 4th November, a discharge planning meeting was held. FB, MB, MGM, the social worker, neonatal nurse and consultant were present. A plan was discussed that Baby B would return to MB's care, that FB would be monitored and given assistance until it was felt he had the skills to care for their baby. The neonatal nurse raised concerns with the social worker after the meeting about MB's age and maturity, FB's unpredictability and Baby B's special needs. On 9th November, it was agreed that FB could commence hospital visiting again.

[1] Strength to Change is a voluntary programme for perpetrators of domestic abuse

The following day, FB self-referred to the Strength to Change course, and he was advised that he would be placed on a 12-16 weeks waiting list. FB declared cannabis use and he was given details for RENEW.[2]

5.27 The neonatal nurse requested safeguarding supervision with the named nurse because she was concerned about the discharge plan specifically in relation to FB's behaviour and his history of domestic abuse. During the supervision a telephone call was made to the social worker to share information and to ask for an update. The social worker shared that the case was being transferred to a locality team and had not yet been allocated.

5.28 On 16th November MB contacted the police reporting that she was locked out of her home address after ending her relationship that day, and that two days prior, FB had bitten her. MB informed the neonatal nurse that FB had bitten her, was too controlling and using money for cannabis, and that she intended to move to her mother with Baby B. The neonatal nurse informed the social worker of this and that FB had stopped taking medication for bi-polar. By the following day, MB had reversed her decision to live with her mother. A housing worker called to discuss rent arrears and upon hearing shouting at the address was asked to call back because of a family crisis. MB retracted what she had said to the police, stating that they had been play-fighting and it was not an assault. When the information was discussed by the social worker four days later, there was no change to the plan. FB advised that he had an appointment with Strength to Change in about six weeks and with Let's Talk. He was advised to see the GP about his medication. Both said the biting incident was historic. The social work transfer was completed on 21st November.

5.29 The neonatal nurse raised the same concerns with the second social worker as she had done with the first one. She asked the social worker to read the hospital files to illustrate why. She reminded FB of his need for a GP appointment.

[2] RENEW is the local service for adults who misuse substances.

On 27th November MB presented at the neonatal unit with a split lip and a bruise/red mark on her left cheek. The nurse was unable to ask MB alone whether she was okay and overheard the couple bickering about who should be undertaking the care of Baby B. The neonatal nurse informed the social worker. MB said she had a cold sore and had simply snapped at FB the previous day. The neonatal nurse was considered 'extremely judgemental' of MB and FB by the social worker. The social worker said she had read the hospital files and read nothing that she wasn't aware of. Baby B was discharged home on 30th November.

December 2016 - discharge to critical incident.

5.30 Baby B spent a further night in hospital in the first week of discharge after presenting at accident and emergency due to not keeping feeds down. In the three weeks Baby B was at home, the family were visited on seven occasions, twice by the social worker, once by a family practitioner, three times by the neonatal outreach nurse, and once by the health visitor.

5.31 There is no indication that the GP, police or housing provider had been included in any planning. MB saw the GP on one occasion, and FB did not attend a GP appointment.

5.32 A further neighbour complaint was made to the police in relation to FB's behaviour, and the housing provider had completed a notice seeking possession for arrears which they received on 12th December.

5.33 On 23rd December, Baby B was taken to hospital by ambulance, unwell and crying uncontrollably where he was found to have a serious non-accidental brain injury.

6 The Family Perspective

6.1 The Independent Author and an officer of the Local Safeguarding Children Board met with MB and MGM together. Both were keen to contribute to the process and hoped that their reflections could assist the overall learning process.

6.2 MB advised that her biggest recollection of working with professionals is the sheer number of people that she met and felt that they had 'passed through so many people'. MGM remembered a worker who accompanied them to the hospital after Baby B was injured for his kindness and humanity in what was a very difficult and frightening situation.

6.3 MB recalled that her relationship with FB had been tempestuous, but that they had got along much better after the birth of Baby B. MB stated that she had to mother FB as well as Baby B, and was always worried that Baby B would be taken from her because of something that FB was doing. MB said it was always in her mind to go home to her mum with Baby B after discharge from hospital, and sometimes wished this is what professionals would direct her to do.

6.4 MB recalled that she was confused as to why FB was not permitted to visit the hospital but seen as safe enough to live with Baby B. MB said that looking back, she now believes that social workers should have taken more control. MB recalled the social worker telling FB that he 'could not do this when the baby came home' after she shared that FB had bitten her. MB said that young mothers, inexperienced in relationships and experiencing abuse, sometimes need professionals to take charge. MB said she would always have chosen Baby B over FB, but once the professionals said it would be okay for them to live with FB she was reassured that the professionals thought this was okay.

6.5 MB said that she wanted a nice family unit, and allowed herself to be too optimistic. MB said she was under a lot of pressure to make things work, she recalled they were told at the discharge meeting that if FB did anything to jeopardise Baby B, then Baby B would be taken off them. MB stressed that in her wildest dreams she never thought that FB would physically harm their baby.

7 Analysis

The examination of single and multi-agency working leading up to the precipitating incident of this Serious Case Review has facilitated agencies and practitioners to reflect carefully on how effectively multi-agency infrastructures were used to support judgements at key points of interventions. The analysis is structured around the four identified key periods of practice which illustrates the chronological pathway of decision making and the critical points which impacted significantly on the direction of single and multi-agency safeguarding including points of deviated positions. The analysis is drawn from the agencies' written contributions to the review, the reflections of practitioners, the discussion and challenges that occurred within the review panel as well as the reviewers own contributions.

7.1 Parental History and Relevant Risk Factors

7.1.1 Both MB and FB went into a relationship together each bringing a range of personal and situational vulnerabilities. MB was legally still a child at 16-17 years, and FB was a father from the age of 18 years to a child who became subject to legal proceedings. FB had not been assessed during the proceedings. This would indicate that he did not perceive himself as being in a position to parent or willing to commit to a programme of learning that would provide him with the skills to do so.

7.1.2 FB's ongoing approach to seeking police assistance was established prior to the confirmation of pregnancy of Baby B, in that he would call the police to threaten criminal action if they did not attend an emerging incident. On the one hand this could indicate that he had insight into escalating behaviour and wanted to place some controls on himself, but another perspective could be that he quickly became overwhelmed by an inability to self-regulate his behaviour and calling police was part of an escalating drama.

7.1.3 As a child aged 6 years, FB was identified as having an IQ of 74 which placed him within a low average range of ability. Throughout his education FB had a Statement of Educational Needs, assessed as having a learning disability based on a moderate to low range of functioning.

At the age of 7 years, FB was diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD), characterised by aggressive and often violent behaviour and a lack of empathy towards others. FB was prescribed medication to support the management of his condition from the point of diagnosis.

7.1.4 FB was regularly monitored through child and adolescent psychiatry. He was supported by his parents to attend a penultimate appointment in June 2015. At this point FB was 19 years old, a father to his first born child and had commenced a relationship with MB. During the appointment, FB said that he was irritable and snapping at his girlfriend and that he had been aggressive to other close family members. FB denied drinking alcohol but shared that he was using cannabis. FB was considered to have good insight into his situation with no abnormal thoughts towards his child. The psychiatrist recommended FB to continue taking a long standing medication for ADHD (methylphenidate) and also commence a prescription for an anti-psychotic drug (quetiapine). The psychiatric consultancy faxed a letter to the GP which advised that a change in medication was needed and that quetiapine should be prescribed. The latter did not reference whether this was intended to be additional to, or a replacement for, the prescription of methylphenidate. FB was seen again in November 2015 and on this occasion a further faxed letter was sent to the GP which indicated that an increase of quetiapine was necessary, but again did not reference the position about methylphenidate.

7.1.5 The cessation of methylphenidate was not intended by the psychiatrist. However, on each occasion where change was made to medication, reference was only made to the changing medication not the stable medication regime. It can only be concluded that the lack of reference to methylphenidate was interpreted as no further prescription necessary as this was taken off FB's repeat prescription list with a note to say 'discontinued' in December 2016.

7.1.6 The Royal College of Psychiatrists describe the following symptoms of ADHD:

- becoming easily distracted and finding it hard to notice details
- finding it hard to listen to other people or follow instructions

- finding it hard to wait or sit still with tendency to fidget
- becoming easily irritable, impatient and frustrated and losing temper quickly
- finding stress hard to handle
- tending to do things on the spur of the moment without thinking through leading to problems

The prescription of methylphenidate was a key means of stabilising mood and minimising the symptoms of ADHD for FB and, without this, his presentation of ADHD associated behaviours, was very likely to have increased.

Learning Point

Under a shared care medical protocol, a secondary care physician should be required to outline a complete medication regime when recommending any change to the GP.

7.1.7 During this period, MB presented at hospital having taken an overdose of iron tablets. Whilst she did not wait to be seen by psychiatric services, she did share information which indicated the presence of risk factors in relation to potential parenting. MB stated that she and FB argued, that there was aggression, violence and high levels of frustration in the relationship and that this had reached danger points in relation to her feelings of self-harm.

7.1.8 To conclude, shortly prior to the confirmation of pregnancy, information was available across the safeguarding partnership that FB and MB had a volatile relationship, experienced high levels of extended family dysfunction, experienced compromised mental health and that FB was using illegal substances which had the potential to exacerbate his mental health. All of these issues were significant to the subsequent assessment.

7.2 <u>Pre-birth events and safeguarding activity</u>

7.2.1 There was a five month period between confirmation of pregnancy and the premature birth of Baby B. During this time, several safeguarding agencies individually held information that indicated the need to initiate a multi-agency sharing of information and safeguarding response.

7.2.2 FB continued to contact police at points of stress and, during these occasions, he shared that MB was pregnant, that both were using drugs and that there was violence in the relationship. The contacts became a pattern for FB whereby after making an initial contact with the police he would then withdraw from further communication. The police showed a patient and persistent approach to achieving further contacts and communication with FB, and when this could not be achieved, oversight of the specialist domestic abuse officers requested that further attempts be made to try to establish with MB the circumstances of her pregnancy. This evidenced that the officer was alert to the risk of domestic abuse to the unborn baby and that this was flagged within the force response to further incidents. When MB contacted the police again in relation to a further domestic abuse incident, a referral was made to children's social care.

7.2.3 The response to this referral has proved difficult to clarify. Whilst it is evident from the children's social care recording system that a referral was received, the outcome of the referral is undocumented. It is noted that the referral would be discussed at an Early Help allocation meeting but there is simply no further information about the response to this referral, or any recorded rationale for decision making. A later referral noted that no further action was taken because FB and MB had separated and stayed with their respective families. It must be stated that the response was short-sighted and that the prospect of reconciliation should have been factored into it. There was also no follow up with maternity services, when the sharing of information would have prompted the midwives to establish a greater understanding of the parent's relationship and whether there was ongoing risk.

7.2.4 In July, police record that a further referral was made to children's social care in respect of FB's behaviour towards the home where his older child resided. This review has been unable to establish what happened about this referral. The police confirm that it was sent, whilst there is no record of it being received by children's social care.

7.2.5 The midwifery service held a key role in safeguarding the interests of the unborn baby. MB attended a midwifery booking appointment 15 weeks into pregnancy at which point a vulnerability risk assessment was completed with no additional vulnerabilities identified. This appointment was shortly after the domestic abuse incidents reported by police to children's social care and contemporaneous to consideration of need within the early help service. A consultation with the midwife through the early help screening process would have revealed far greater concerns than the midwife was aware of. As FB was present at the appointment, MB was not asked whether she experienced domestic abuse within the relationship as is expected during a vulnerability screening. Although not identifying any additional vulnerability, the midwife did make a referral to the Family Nurse Partnership, as is standard practice for first time mothers aged 18 and under. This service, when taken up, offers intensive support up to the child's second birthday.

7.2.6 From the information available to the midwife, she had no specific reason to be concerned for the safeguarding of the unborn baby. However at a subsequent appointment also with FB present, MB withdrew her consent to working with the Family Nurse Partnership. During this consultation, MB stated that she had little family support despite having indicated the opposite at the earlier appointment. In addition, MB stated that she had difficulty in reading and writing which was also at variance from her earlier response.

7.2.7 The agency report from Hull and East Yorkshire Hospital Trust considers that, alongside the referral to the Family Nurse Partnership, and in particular when MB withdrew her agreement to this support service, a referral could also have been made to the early help service within children's social care for targeted support. The opportunity to refer across agencies for services creates a greater propensity for information sharing as well as creating a process from which the impact of refusal of services can be more effectively assessed.

Learning Point

The refusal of a service identified to support a particular area of vulnerability should trigger consideration regarding the impact on the child of the need not being met. Referrals in accordance with the threshold criteria should be considered where an unmet need could be detrimental to the welfare of the child.

7.2.8 The question of professional curiosity is raised through the approach to ante-natal care in that MB was not asked the commonly expected questions with regard to domestic abuse and, in particular, given that FB was present at appointments, the opportunity to establish whether he had any parenting history was not taken. For obvious reasons in midwifery services, the expectant mother is the primary client, but in order to be effective in the role of safeguarding children, it is necessary, as in all safeguarding services, to establish a more inclusive approach to engaging with males to gain a better understanding of the support and risks that may be a significant factor in the well-being of the child and family life.

Learning Point

Maintaining a focus on fathers of children, born and unborn, will support practitioners to establish more clearly the potential implications of their needs and role in the family, in order to promote and safeguard the welfare of the child.

7.2.9 When considering this five month period, the evidence of erratic behaviour between FB and MB, alongside the number of police contacts and indicators of anti-social behaviour, it seems difficult to appreciate why the pre-birth risks were not exposed through the existing multi-agency structures. In the absence of understanding the response to the referral into children's social care, this case illustrates the very reason for unborn baby safeguarding procedures.

Clearly a range of risk factors were evident across the safeguarding partnership but not shared in a way that supported structured consideration of potential risk. Whilst no agency failed in any duty of referral, it is also the case that no agency collated information in such a way as to gather information and assess the totality of risk factors. One would have expected that the screening of the referral into children's social care raised some alarm given the very recent proceedings in relation to FB's older child. The impact of these factors on Baby B and the parent's capacity to protect and promote the wellbeing of Baby B became apparent immediately after the premature birth.

7.3 Post Birth to Discharge of Baby B from Hospital

7.3.1 The premature birth of Baby B was not unexpected and plans were made for this possibility in the preceding four weeks. The focus of medical interventions was on the safe delivery of Baby B and during the preparation for birth, MB demonstrated maturity in her approach. MB's demeanour changed however shortly before the birth when, having attended hospital the day prior to delivery, MB signed her own discharge. When MB returned to hospital, she was advised to rest but went outside of the hospital and was described as shouting and causing offence to others. Once on the labour ward, MB again left against medical advice. Baby B was born by caesarean section and immediately transferred to neonatal intensive care unit (NICU).

7.3.2 Baby B required intensive nursing and was initially tube fed and oxygen dependent. MB remained an inpatient for two days before discharge. From the outset the nursing staff found both MB and FB, but particularly FB, difficult to manage in such a critical care environment. Their behaviour was described as frequently loud, aggressive and dismissive of the nursing staff who developed grave concern about their level of maturity and how this would impact on their ability to parent a particularly vulnerable baby. The staff had noted on one occasion that FB smelt of cannabis and presented with slurred speech.

7.3.3 The referral to children's social care was made by the hospital when Baby B was 3 weeks old. The referral outlined concerns about FB and MB's ability to parent their baby, raising concerns about anti-social behaviour, domestic abuse, and hazardous conduct around medical equipment, FB's cannabis use and his inability to take direction and advice from nursing staff. The referral stressed that Baby B would have on-going complex health needs when discharged from hospital. The screening of the referral by children's social care noted that the previous referral by the police was considered for early help and a decision was made by the consultant social worker to allocate an experienced social worker in the Access and Assessment Pod. A social care assessment was needed to ascertain the current situation, the parents' ability to meet Baby B's needs, and the impact of domestic abuse and drug use.

7.3.4 Three weeks after the allocation, and five days before completion of the assessment, the NICU nurse reported to children's social care that MB had disclosed to her that she wanted to leave FB because he hit her and was controlling. MB showed the nurse bruising which she said was caused by FB. Following this disclosure, MB became anxious that Baby B would be taken into care and withdrew from the assertion made.

7.3.5 The completed assessment recommended that further 'support and monitoring' was needed and that the family should be referred to a locality team for this longer-term work. The assessment identified risk factors such as MB and FB's lack of understanding of Baby B's health needs, their level of immaturity and ongoing risk of domestic abuse. The assessment also highlighted that MB and FB needed to make improvements to make their home suitable for their baby's discharge. On a positive note, the assessment highlighted that the parents had a bond with Baby B, that MB was proving herself to be a capable carer, that they had support from extended family and were prepared to work with agencies to make positive changes.

7.3.6 The assessment concluded that Baby B was a child in need and a child in need plan was completed. The plan, whilst outlining that Baby B was very vulnerable and change was needed by the parents to be in a position to parent safely, also went on to state that Baby B could be discharged to MB who had to ensure that FB's parenting was monitored until he was more confident in what he was doing.

7.3.7 No child in need meeting was held whilst Baby B was in hospital, nor after discharge. The assessment and plan were drawn up solely by children's social care, and to this end excluded the necessity for multi-agency working, the extensive experience that other professionals had of the parents and the knowledge about the specific needs of Baby B. The plan was not supported by the nursing staff who felt frustrated that they had no forum for debate or disagreement. Significantly, the assessment did not source information from the housing provider which would have revealed wider concern about FB's erratic behaviour from a source outside of the hospital and this would perhaps have challenged the perception that the nursing staff were 'extremely judgemental' of MB and FB.

7.3.8 The practitioners' learning events considered the circumstances within which children's social care developed a powerful and dominant narrative which resulted in MB and FB being viewed too simplistically and optimistically as parents who needed ongoing support, as opposed to parents who posed a potential risk of harm to their baby. The social worker advised that he perceived the conditions of a hospital environment to be very challenging for FB as he had something of an anti-authoritarian attitude, and, in this situation, felt on the outside and highly defensive. The social worker said he was influenced in his thinking by relying on what he believed was a previous assessment of FB during legal proceedings on his older child and the fact that there was no order in place restricting contact. The social worker was falsely reassured given that FB was never assessed, and although there was no restrictive order in place, the contact was managed safely by FB's parents who helped with parental responsibility.

7.3.9 The children's social care agency learning report (for this review) concluded that 'there appears to have been too much focus on the adults and an over-optimistic view about their ability to care for Baby B when he was discharged from hospital'. The participating practitioners considered the impact of behavioural biases that can compromise objective judgements, and the presence of 'confirmation bias' in this instance, which led to professionals dismissing information that did not support their strongly held views and placing too great an emphasis on the information that supported these.

Recognising how easily behavioural biases can come into play, particularly when time is a constant pressure, the feedback from practitioners suggested that it is necessary for agencies to 'see time for critical and reflective thinking as important and not an indulgence.' The average case load within the Pod during this timeframe ranged from 100-150 cases and the allocated social workers caseload varied between 30-50 cases over the course of a year in addition to a twice weekly commitment to pursuing any new section 47 enquiries.

7.3.10 The child in need plan outlined that Baby B could return home despite identifying that significant parental change was needed to ensure the baby would be safely parented. The plan reads as a static document rather than a proactive approach to working with the parents through a series of planned interventions from which the evidence of impact could be measured prior to assessing the strengths and vulnerabilities in their care of Baby B. At the conclusion of the assessment, the social worker wrote to MB and FB with information about services that FB could access. This included the Strength to Change course offered by the Domestic Abuse Partnership and a counselling service. The letter advised that a planning meeting would be held to discuss the plans for Baby B returning home. The social worker advised that whilst the plan outlined the areas of work that FB needed to specifically engage with, the department has no control over the allocation of the resources needed and this is why no timescales were attached to tasks or achieving the objectives. This perception cuts to the heart of this review: that a child's plan is, and must be, constructed as a multi-agency partnership. It is the ownership from across the partnership which will achieve shared and accurate assessment of current risk and what needs to be done to manage that, alongside a commitment to risk reduction that will direct resources and provide the source of information to undertake a shared analysis of impact.

7.3.11 The agency report from children's social care states that 'at no point did MB or FB present as being hostile or aggressive or under the influence of cannabis during the assessment process'. The Independent Reviewer did not support this specific interpretation, as, during this time, the hospital found FB's behaviour so unmanageable that they restricted his time on the ward and later invoked a total ban for over two weeks.

This statement somewhat reinforces the position taken by children's social care that undermined multi-agency working and effectively dismissed the very real experiences of the hospital staff. The absence of a working partnership amongst the professionals created the circumstances where a lack of trust between professionals of different disciplines made it easier for the parents to further divide professional approach based solely on their own experience of the parents.

7.3.12 The absence of the use of structures to support multi-agency collaboration and challenge allowed agencies to work without challenge and with a single agency mind-set. This is illustrated by the single agency decision to exclude FB from the hospital for long periods of time, which although done for immediate safety reasons within the hospital environment, had the consequence of removing FB from the sight of professionals and making him more invisible within the ongoing teaching and observations in the care of Baby B.

Learning point

Faithful adherence to the structures to support multi-agency working is fundamental to working together across agencies to support the best outcomes for children. Deviation from process compromises the strength of multi-agency working and can result in increased, unknown or unmanaged risk.

7.3.13 MB had twice stated to nursing staff that FB was abusive to her. On the second occasion, MB did not attend the hospital for five consecutive days which was not consistent with her previous pattern of attendance. Undoubtedly the child in need plan placed too great a responsibility on MB to oversee FB's parenting and the Independent Reviewer questioned why it was considered that MB could exert a degree of control over FB, in particular when she had disclosed that he controlled her access to money and had locked her in the home. Whilst MB was highly motivated to care for her child, her ability to share any information that could increase concern could be perceived as highly compromised.

The social worker accepted this point when reflecting on the case, but also considered that MB was making an informed choice to stay in the relationship and accept the consequences having been given the support and opportunity to leave. Within the spirit of the agreement for Baby B to live with both parents, the question as to how this could be kept safe should have been addressed within the multi-agency child's plan, not made to be the responsibility of the person perceived to be the safer parent alone.

7.3.14 The only meeting that took place was a discharge planning meeting. This meeting was convened by the hospital as is standard process for babies coming up to discharge from NICU. The meeting was attended by the social worker but not the community health visitor. It was also attended by the consultant paediatrician who, under working together arrangements, is required to be satisfied that a child would be safe upon discharge. No alternative plan to discharge was considered despite the statement that FB would need to be monitored and given assistance until he had the skills to care for Baby B. The practitioner learning event spent some time considering this vital point in the planning for discharge, and it was clear that, whilst the nursing staff believed their grave concern about the discharge to the parents' care was understood, children's social care believed there to be no formal expression of their dissent to such a plan. The neonatal nurse believed that they made their dissent to the plan known to children's social care and within their own organisation. It should be noted that no further questioning or dissent was made by the consultant paediatrician.

7.3.15 The neonatal nurse advised that she expressed concern to the social worker immediately after the discharge planning meeting and sought out safeguarding supervision with the named nurse. She did not however raise concerns within the meeting. The neonatal nurse had approached the named nurse in the first instance prior to the discharge planning meeting. The named nurse recalls a conversation with the social worker reporting that the couple were planning separation. Almost a week after the meeting, the neonatal nurse sought safeguarding consultation with the named nurse who recalls that the neonatal nurse, although expressing concern, could not articulate just what the concerns were and appeared to have no real knowledge of the child in need plan.

The named nurse agreed to ask for a copy of the child in need plan which she received and sent to the neonatal nurse with advice to contact her further if she remained concerned. The neonatal nurse did not make further contact with the named nurse, but clearly remained frustrated, hoping that a change of social worker would provide a further opportunity for review of decision making. The named nurse advised this review that as a consequence of the learning from this case, the safeguarding team should undertake daily ward contact with the NICU and the neonatal nurses now have regular safeguarding supervision rather than rely on a specific issue to prompt this.

7.3.16 The case was transferred to a longer term social worker shortly before the discharge was planned. The social workers made a joint visit to MB and FB in their home to transfer the case. The social worker advised the review that the transfer of cases was, and still is, often subject to unplanned delays, with this case being an illustration. The social worker considered that once a case is ready for allocation, there is limited capacity to undertake further proactive work as other assessments are allocated. The social worker was honest in reflecting that this case was a finely balanced decision to manage as child in need rather than convene a child protection conference, and could provide no explanation as to why a multi-agency meeting was not convened under child in need procedures. The social worker was of the view that the delay in transfer, caused by a backlog of work in the receiving team, may have resulted in less focussed social work than was needed at a critical period of changing circumstances. Children's social care has a robust case transfer policy and procedure, with a no delay principle central to implementation.

Learning Point

Delay in the transfer of cases across social work teams can result in a static assessment of a child's needs, which, particularly when combined with changing circumstances, can lead to increasing and insufficiently assessed risk.

7.3.17 The second social worker was asked to read the hospital records by the neonatal nurse but concluded that the nurse was showing a prejudiced approach to young parents who needed support. When Baby B was discharged to the care of parents, the neonatal nurses described feeling fear and inability to influence the views of the social workers.

7.3.18 The transition across social work teams can provide a key opportunity for review and reflection, to establish that a clear plan is in place that is supported by the multi-agency partnership. The change was perceived by the neonatal nurse as an opportunity to produce a different position. However it was made clear that the social work approach had already been outlined and would be followed. In the weeks prior to the discharge of Baby B, children's social care were not open minded to the concerns of the neonatal nurse and the neonatal nurse was not vigorous in escalating concern through a formalised process. During the practitioners learning event, the hospital staff advised they were not aware of the LSCB escalation procedure, or that they could escalate concerns outside of the hospital management structures.

Learning Point

There remains a need to ensure that the LSCB escalation policy is disseminated and understood across the whole safeguarding partnership, and for each constituent agency to ensure that all of their practitioners and managers act on their responsibility to challenge rigorously when there is a difference of opinion about the steps required to keep children safe.

7.3.19 The responsibility to convene the first child in need meeting within the child in need procedures clearly lies with the social work pod that had completed the assessment. The procedure states that the first meeting should be held within 15 days of completion of the assessment and should include family members and any professional/service that was either involved or required to support the family.

It is also stated that the first meeting should establish an ongoing date for a child in need review, with the core group of professionals meeting at a minimum frequency of 4-6 weekly. Had this procedure been followed, two child in need meetings would have been held whilst Baby B was in hospital. The only meeting at which more than one agency was present was the Discharge Planning meeting. This was clearly not structured or managed as a child in need meeting.

7.3.20 The absence of use of structures to support multi-agency working was a significant deviation from established child in need procedures and served to alienate professionals from a functioning safeguarding partnership, one within which challenge and shared responsibility and accountability should have been established. It remains difficult to appreciate how this occurred, and why this was not identified through the management oversight of the case. The consultant social worker of the access and assessment pod reflected that he had placed too great a confidence in the experience of the social worker and, in a busy social work setting, allowed this to influence a lighter touch regarding management oversight. The consultant social worker of the second social worker recalled that the case transferred into the pod at a particularly busy period which meant that she did not have as full an oversight from the outset as she would normally. It should be noted during the timeline of this review, consultant social workers as well as having overall case management responsibility for the cases within the pod, also carried their own complex cases. Since April 2018, Hull Children's Social Care has put in place a more traditional management structure with larger teams of social workers managed by a Team Manager who does not have additional direct case work demands. This allows for a stronger management focus on casework and practice developments.

7.3.21 At the time of concluding the review, children's social care was also proposing to move the assessment work on new referrals to the service into the locality teams. This proposed change was designed to provide greater continuity for children and families and reduce the number of 'hand over' points, which was a factor in this case.

7.3.22 The limitations of the multi-agency partnership created an environment where difference flourished into unmanaged dispute. This was an issue that required careful consideration during the practitioners learning event, where moving from destructive criticism to respectful challenge and self-reflection was required. The participants were encouraged to reflect on how serious case reviews remind us that disagreement in safeguarding between those involved is not uncommon, but in order to be managed effectively it needs to be openly acknowledged and addressed.

Learning Point

Critical thinking skills in complex decision making will be enhanced by investing time in exploring professional disagreement openly and with a genuine focus on the safeguarding of the child

7.3.23 The agency report from children's social care concludes that whilst there was evidence of identified areas of risk within a strength-based model of assessment, the assessment had shortfalls in the depth of analysis because it relied too much on readily available information and some key areas of risk assessment in respect of the potential impacts on the child. Although it was known that FB had a diagnosis of ADHD and was not accessing medication, and that FB was using cannabis, there was no exploration about the impact of these two critical factors in relation to FB's presenting behaviour and the potential risks this created for Baby B. There is no doubt that a more accurate understanding of risk would have been achieved if further agencies such as police, GP and housing had been contacted for information. Although there were outward indicators that FB struggled to take on board and process information, this was not considered in the context of his ability to participate in an assessment process. This was particularly pertinent given that there was information available in the local authority that he had been assessed as having a learning disability as a child which impacted upon his cognitive functioning. In such circumstances, a PAM (parenting assessment manual) assessment should have been considered as a tool which helps the assessment of a parent with a learning disability.

Learning point

The quality of assessment is directly correlated to the relevance of the plan to support and protect a child. Accessing source information from a range of agencies across the safeguarding partnership is entirely necessary to establish the most accurate profile of family functioning and to establish the clearest understanding of the areas of strength and vulnerability

7.3.24 The approach to the issue of domestic abuse within the assessment led to the conclusion that the incidents were 'petty bickering', and mistakenly inferred that an absence of incidents referred to children's social care by the police indicated a diminishing concern. In reality, the relationship between MB and FB was very fragile, and there was clear evidence of this impacting on MB's emotional welfare. This was particularly significant as not only was she identified as the capable parent, but was also expected, within the child in need plan, to oversee FB's contact with Baby B despite stating that she 'did not feel confident in tackling FB regarding issues'. The chronology would indicate that, shortly after the assessment was completed, the social worker and consultant social worker had increasing concerns about the risk of domestic abuse, noting that one more incident would result in a child protection conference. The neonatal nurse also believed that the social worker had indicated that FB would not be living in the family home until he had completed a Strength to Change course. Despite this position, no additional measures were put in place across partnership agencies to highlight that further knowledge of domestic abuse should be treated as a critical cause for concern.

7.3.25 The child in need plan that emerged from the assessment was not a meaningful way of safeguarding the welfare of Baby B. Whilst it outlined some of the areas of risk, it did not systematically describe how these would be addressed and reviewed to minimise their potential for impact on the safety of Baby B. The fact that FB had referred himself to a Strength to Change course was seen as a measure of success without understanding what impact such a programme would have on his attitudes and behaviour within the family unit.

The self-referral resulted in FB being placed on a waiting list and being offered an induction to the programme four months later. The child in need plan did not identify waiting time as a cause for concern or consider how this impacted on risk to Baby B in the intervening time. The key professionals around Baby B were not working to a shared plan and there was no contingency planning to outline how increasing risk would be addressed.

Learning Point

Where a programme of intervention is identified as necessary to address risk of domestic abuse within a multi-agency plan for a child, any delay in service delivery should be addressed through a risk assessment which focuses on the potential impact for the change with a review of what control measures need to be in place to manage outstanding risk.

7.3.26 Although the health visitor had made a primary visit to MB during this period, and assessed her post-natal mood positively, the events at the hospital were unknown to the health visitor. The health visitor was invited to attend the discharge planning meeting by the social worker but was unable to do so. The health visitor had no information about the identified areas of risk and was informed of Baby B's discharge by the neonatal outreach nurse.

7.3.27 The plan for discharge in no way addressed the level of risk. Baby B was a vulnerable premature baby who needed high level care and patient parenting. The circumstances of the family included a father with non-medicated ADHD, the presence of substance misuse and domestic abuse and untested parenting outside of the structure of a highly organised hospital environment. The Independent Reviewer questioned whether the threshold criteria were appropriately applied at this point and considers that thought should have been given to convening a child protection conference. If this had happened, there would have been greater level of information sharing across agencies and an established pathway for this to continue which proved to be necessary in the two weeks prior to Baby B being discharged.

7.3.28 Approximately two weeks after the discharge planning meeting and two weeks prior to the discharge, MB stated to the neo-natal nurse that she planned to live with her mother because FB had bitten her and was using money to purchase cannabis. MB also contacted the police because she could not access her home and alleged that FB had bitten her. During this information exchange, it was also recorded that FB had ceased taking medication for ADHD and bi-polar disorder. All this information was given to the social worker, and MB subsequently retracted the allegation, qualifying it by saying that it had occurred during play fighting some time ago. This information did not cause the alarm that would be expected when reading the chronology of this case. The stated intent to hold a child protection conference if a further domestic abuse incident occurred was not followed through. FB reassured the social worker that he had self-referred to the Strength to Change course and no further enquiries were made with other agencies such as the police or GP. Consultation with the police or housing provider would have revealed several incidents of erratic anti-social behaviour including a fascination for making fires in the garden area which would have led to deeper consideration about the stability of FB. Contact with the GP would have revealed that FB had had no contact with psychiatric services for twelve months and his case was due to be terminated without further contact. As the social worker received information from the neo-natal nurse only, this was received in the context of believing FB and MB to be unfairly represented by the neo-natal unit. The only approach to checking the validity of the concerns was through the self-reported responses of FB and MB.

7.3.29 There is a sense that, within the term domestic abuse, an over-emphasis was placed on physical incidents rather than the pervasive nature of coercive control. In 2013, the cross government definition of domestic abuse was extended to include any pattern or incidents of controlling, coercive, threatening behaviour , violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members. At this stage, there was a clear need to work with both MB and FB through a structured programme that addressed domestic abuse from a victim and perpetrator perspective, and to understand the lifelong impact on a child.

Learning Point

When investigating safeguarding concerns all potential sources of agency information should be directly accessed in order to triangulate the evidence to form a basis of evidence beyond that which is self-reported.

7.3.30 Although FB's use of cannabis is referred to in agency records frequently, the potential implications of this are not addressed within the assessment or child in need plan. FB self-disclosed cannabis use when self-referring to Strength to Change, and he was provided with the details of a drug and alcohol service. The use of cannabis by a young parent with an untreated mental health condition in itself creates a number of risks and should lead professionals to be mindful of the potential for abusive head trauma which is the leading cause of death and long-term disability for babies who are harmed. The risks to Baby B required a better co-ordinated and robust assessment and plan to establish what actions were needed to safeguard the baby and whether FB and MB could provide immediate protection whilst longer term approaches to support change were achieved.

7.4 <u>Post discharge from hospital of Baby B to critical incident</u>

7.4.1 Baby B was in the sole care of his parents for just three weeks when the significant injury was inflicted. During this time they had seven contacts with professionals in the family home. Although the professionals were from three separate agencies, there was no structure to support multi-agency working, no multi-agency child in need meeting took place and the child in need plan was effectively a single agency document within children's social care.

7.4.2 Whilst children's social care, as the lead agency, had not followed the child in need procedures, professionals from other agencies offered no formal challenge, albeit the NICO did seek support to challenge through the Trust safeguarding arrangements. Of the professionals involved with the family when Baby B was discharged home, none had access to a child in need plan or had attended a child in need meeting, and all needed to question why this was.

Learning Point

All professionals should have access to a plan for a child when applying a multi-agency plan of intervention. In the absence of a plan, the professional cannot effectively support the multi-agency safeguarding of a child.

8 Findings

8.1 Multi-agency structures

Hull LSCB has comprehensive and embedded multi-agency procedures which support agencies to work together. In this case the structures were not used and this had a limiting impact on the quality of how agencies worked together to safeguard Baby B. The circumstances for the child, for instance being perceived as safe in hospital, should not detract from the need to adhere faithfully to the structures that facilitate high level information sharing and collaborative analysis of risk. All professionals involved with children in need have a shared responsibility to ensure that regular multi-agency meetings take place to ensure proactive work is being undertaken and reviewed to establish the impact on the assessment of risk. In addition, it is the responsibility of every professional involved in a child's plan to contribute to, and take responsibility for, the implementation and review of the purposefulness of the plan to achieving good outcomes.

8.2 Child and Family Assessment

Whilst this is an assessment for which children's social care take responsibility, this should be undertaken in an inclusive manner with agencies across the safeguarding partnership which should include housing, GP and police as well as core and specialist agencies. Great care must be taken to access all sources of information as the route to accurate analysis. The assessment underpins the programme of work and the quality has a direct correlation to the likelihood of successful outcomes. To this end an assessment should evidence careful analysis of all relevant information to outline the specific areas of risk that are required to be addressed by the child's plan.

8.3 The Value of Critical Thinking Skills

Practitioners face complex dilemmas in achieving good outcomes for children. Powerful thinking requires powerful questioning and the ability to be aware of, and eliminate, the effect of behavioural biases. Increased focus on developing the skills of critical thinking will impact on the quality of decisions to improve safeguarding across the partnership.

8.4 Escalation Processes

Escalation processes are an integral part of maintaining a safe child protection system. The safeguarding partnership should create a culture that welcomes and listens to difference and challenge which in turn enables professionals to feel supported to do so and escalate within LSCB procedures where interagency agreement cannot be reached. All professionals have a responsibility to ensure that professional difference does not become unmanaged dispute which will impact negatively on working together to protect children.

8.5 Working with parents and carers of all genders

Within the multi-agency plan and team, careful consideration must be given to best practice with regard to maintaining a focus on the role of fathers and significant males in family life. Practitioners should take care to mitigate the pitfall outlined by Cameron at al. 2014 who suggest from literature findings that men's lack of involvement is not due in the main to their absence or difficulties engaging them but from a 'strong tendency amongst child welfare workers to overlook fathers' involvement with their families'.

8.6 Mothers as gatekeepers of safety

Professionals must be mindful not to place mothers in positions where they are given responsibility for the behaviour of a male partner, particularly in circumstances where domestic abuse is featured. Children's plans must hold fathers accountable for their behaviour and avoid placing inappropriate responsibility on a mother to exert control over her partner. In developing safe plans for children, professionals must be ever mindful that mothers may be reluctant to share information with professionals that is suggestive of increasing risk, for fear of losing their children.

8.7 Risk assessment as a dynamic and accurate process

The child's plan should incur risk assessment and in particular where an assessed need for a service cannot immediately be met. Any gap in provision should be considered with regard to the potential impact on the child and adjustments made to the plan or threshold of intervention accordingly. Child in need plans and associated assessments of risk are not intended to be a static process but reviewed through a developing knowledge of the family incorporating the impact of programmes of work. Children's social care will need to be particularly attuned to the possibility of drift in a process of dynamic assessment, and this review identified the need to guard against this possibility as cases transfer across teams services and workers.

8.8 The learning event with practitioners was an honest and forthright appraisal of this case. It was a challenging event for practitioners, but one in which there was a genuine commitment to learning from practice. The following comments by practitioners indicate some key messages of what they had learnt on the day:

- To focus less on quantities outcomes at the expense of quality. To approach deadlines with more emphasis on qualitative outcomes – targeted approach regarding quality of assessments rather than simply numbers of completed assessments within set timescales
- Make time to stop and think – seek agency support to see time for critical and reflective thinking as important not an indulgence
- Always challenge and reflect on unusual circumstances and presentation of a parent
- Use escalation policy – I didn't know of this and am now aware……..
- Create more multi-agency discussion
- Anyone can and should request multi-agency meetings
- To contact source of differing views from [partner agencies – not relying on secondary versions)
- Contact partner agencies when there is a dispute
- To be more proactive in respect to questioning professionals /partner agencies
- Ensure multi-agency meetings are more commonplace

- To be more curious when establishing views and understand the thinking of others
- Listen and hear what is being said by others
- When I supervise, make sure workers are engaging with a professional's points of view on the domestic abuse a victim/perpetrator is experiencing
- Trust my judgement
- Look more from a parent's perspective to think about how they understand things

8.9 The review has been conducted with a high level commitment from both practitioners and senior managers who have formed the review panel. Each agency has completed a learning and reflection report to a good standard and the individual actions plans, attached as an appendix to this report, reflect the commitment to single agency learning.

9 Recommendations & Progress Update

1. **The Board to be assured by children's social care that multi-agency child in need plans are in place and reviewed for children in need and for all partner agencies to brief their staff on their responsibility to ensure child in need plans are in place.**

In January 2019, Ofsted judged the overall effectiveness of children's social care services as inadequate. They found "widespread and serious failures in the recognition of risk and in the quality of social work practice for children in need of help and protection……risk and need are not identified quickly enough for too many children.'

During the period February 2020-September 2020, the service initiated a review considering all Child in Need plans in place for 9 months or over. The outcome revealed a small number of cases which required escalating to safeguarding procedures. A further group of cases were stepped down to early help services and another group where the work had concluded and the case could be closed.

The majority of plans reviewed did demonstrate a multi -agency approach to delivery of child in need services. The challenge however remained in applying processes which actively reviewed the actions and impact at regular intervals.

The service is embarking on a mandatory comprehensive learning and development programme for all front line staff and managers which will immerse staff in an analytical approach to risk. In addition the City Council has commissioned a 3 year Signs of Safety programme to deliver multi-agency training which is poised to commence in October 2020.

2. **That management oversight of assessment ensures a strong focus on content so that all agencies can be assured that facts are established and analysed without assumption and that judgements are made by accessing all relevant information across the whole family footprint of services.**

OFSTED report January 2019 found "that actions leaders have taken have not sufficiently addressed the weaknesses in frontline practice and management oversight in particular for children in need of help and protection".

The Service audit programme has highlighted shortcomings in giving due consideration to the family history and impact on identified risk.

The recent audit of supervision (CSC) has evidenced some improvement in both the frequency and quality of supervision, including good examples of critical reflection, but this is not yet consistent in all circumstances and for all children.

In April/May 2019 CSC commissioned 'Research in Practice' (RIP) to provide training for all practice supervisors. A revised supervision policy has been issued (August 2020) (which also has embedded the tools for supervisors from RIP). The policy includes updated expectations of senior managers to observe supervision. All practice supervisors will undertake the seven RIP modules on 'risk' (referred to above) alongside their practitioners and will each then undertake two additional modules on reflective supervision and effective leadership skills. It is expected that this immersive learning programme will be complete by February 2021.

3. Across the partnership, agencies need to satisfy the Board that effective dissemination and implementation of the multi-agency Escalation Policy has been achieved. This should include the making and receiving of challenge

The OFSTED report January 2019 identified "senior leaders constructively challenge partners when multi agency practice has fallen below expectations". Audit work has indicated the staff are appropriately using the escalation protocol within council services.

Unresolved professional disagreement, and failure to escalate concerns effectively, has also featured in other local serious case reviews, which highlighted, partly, a lack of awareness of the (LSCB) escalation procedures but, equally, in some cases, a lack of practitioner confidence in challenging each other in the best interests of children.

The LSCB had a clear focus on strengthening this important aspect of practice, culminating in a multi-agency section 11-style audit in November/December 2018. Partner agencies confirmed the work that they had completed to raise awareness and were able to confirm successful outcomes from escalations.

4. All professionals need to be particularly attuned to domestic abuse in children's plans and to ensure that responsibility for safety is not inadvertently placed with victims

The OFSTED report in January 2019 commented that "Domestic Abuse features significantly in social work caseloads. Referrals are progressed appropriately where there is information about immediate risk of significant harm. Value is added in the EHASH by the presence of the Domestic Abuse partnership workers to provide information. Children and families benefit from services when domestic abuse is a feature of their lives".

The service audit programme identifies that in many cases this statement is still applicable to current practice. Staff are well aware of the impact of children living with domestic abuse but also the potential for escalation of violence within the family and additional physical risks to children. The volume of these incidents is at an all-time high and services will need to maintain focus on this area to ensure quality standards are met.

Multi-agency triage systems are in place in EHASH that support timely and effective responses in this area. DAP supports victims and offers joint working and advice at triage stages to ensure victim needs are pro-actively identified and acted upon.

5. **All relevant safeguarding partners should report back to the safeguarding partnership on how the learning from this review has been disseminated, what improvements have been made and what mechanisms have been established to audit practice and measure impact.**

OFSTED reported in January 2019: "A significant area of challenge for senior managers is affecting the cultural shift within the workforce to create an environment focusing on improving basic social work practice."

This is a major feature in the current service improvement plan. A number of initiatives have been introduced since February 2020 following the OFSTED monitoring visit. A team of external auditors audited the CLA population of 860 cases at that time over an 8 week period leading to an improvement plan on many cases. These cases have been progressed and monitored by senior managers reporting into the senior leadership team on a 2 weekly basis. Children's social care has implemented a quality and performance programme setting targets and monitoring systems allowing for timely alert when standards are dipping.

The impact of the training programme previously mentioned will be closely monitored.

Targeted improvement is applied to promote improved standards of practice. Currently this is provide by additional capacity from service sector experts.

All agencies involved in this review have reported back to the 'Learning from Individual Cases' sub-group about how learning has been disseminated and, via their action plans, what actions have been taken as a result.

Additional multi-agency learning events are planned to take place in September and October 2020, focusing on the recurring themes from this, and other, serious case reviews.

6. **All agencies involved in this review should provide assurance to the safeguarding partners that their individual action plans have been implemented and on the improvements to practice as a result.**

All agencies involved in the review have provided updates to the Learning from Individual Cases sub-group about how their identified actions have been implemented and the resulting improvements.

Given that the social work practice and management issues identified in this review, were also highlighted in the Ofsted inspection (and subsequent monitoring visits) these are now captured within the wider improvement plan for children's services, as described above.

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