Child Safeguarding Practice Review

TS

Lead Reviewer
Nicki Pettitt

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1 Introduction to the case and summary of the learning from this review

This review is in respect of a five-month-old baby to be known as TS[1]. TS lived with their[2] parents at the time of their death. The family had no tenancy of their own and was staying with an extended family member when TS died. The cause of death remains unexplained after a thorough and appropriate investigation. An expert witness concluded[3] that TS's death meets the criteria for sudden infant death syndrome. There was evidence of a low level of parental neglect of TS's basic needs for nutrition, hygiene and safety, and this may have contributed to a degree of underlying vulnerability and exposure to known environmental risk factors for SIDS.

1.2 The learning identified from this review is in relation to:

- Domestic abuse through control
- The need to equally consider fathers/partners
- Parental mental health
- Information sharing and professional communication
- Professional curiosity about the child's lived experience
- The involvement of wider family members
- Responding to injuries in immobile babies
- Professional understanding of the systems that provide health services

2 Process

2.1 Following a rapid review process[4] and consultation with the Child Safeguarding Practice Review Panel, the Sandwell Children's Safeguarding Partnership (SCSP) identified that lessons could be learnt regarding the way that agencies work together to safeguard children and commissioned this local Child Safeguarding Practice Review.

2.2 It was agreed that the review would be undertaken using the Significant Incident Learning Process (SILP) methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time, avoiding hindsight

[1] It is important to protect the identity of the child and family; the pseudonym TS has been chosen for this review.
[2] It was agreed that the review would not disclose the gender of TS.
[3] An expert medical witness was consulted as part of the police investigation undertaken after the child's death.
[4] A rapid review is undertaken in order to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made by the national Child Safeguarding Practice Review Panel.

bias or individual blame. Opportunities for improvement within systems for safeguarding children are identified and strengths are promoted[5].

2.4 The review considered agency involvement with the family during the pregnancy, around the birth and until TS's death. There was some relevant involvement with the parents prior to the pregnancy and this is summarised when relevant to later practice. Detailed personal family information will only be disclosed in this report where it is relevant to the learning established during the review.

2.5 Early family engagement is required in the SILP model of review. The lead reviewer[6] spoke to both parents while undertaking the review[7]. They will be spoken to again prior to publication. Their views are included in the report where relevant.

3 Family structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	TS
Mother of TS	Mother
Father of TS	Father
Mother's grandmother	Great-grandmother (GGM)
Father's aunt	Great-Aunt (GA)

3.2 Father had a child from another relationship, who was around six months old when TS was born. There was no known contact between Father and his older child[8], who was not considered by this review.

3.3 Mother lived with her grandmother (GGM) during her pregnancy and immediately after the birth of TS. Father reported that he lived with his own family, but it appears he had no fixed address and lived between various family members. At the time of TS's death Father was staying with his aunt (GA).

4 The background prior to the scoped period

4.1 Mother was adopted as a young child by her grandmother (GGM) due to concerns about the care she received from her own mother[9]. Professionals believed GGM suffered with anxiety and depression and that domestic abuse featured in GGM's relationships. Mother told the review that the domestic abuse was prior to her living with her GGM and she did not witness this however.

4.2 There were concerns about neglect, domestic abuse and maternal mental ill health when Father was growing up. He was diagnosed with ADHD and assessed for Asperger's, had 1:1 support in school, was known to CAMHS and was prescribed ADHD medication. Father was

[5] As part of the model, agency reports are completed. This gives agencies the opportunity to consider and analyse their practice and any systemic issues, identifying learning from the case. Practitioners, front line managers and agency safeguarding leads come together at learning events[5] to consider the case and identify learning. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued.

[6] The lead reviewer is Nicki Pettitt. She is an experienced and accredited SILP reviewer and entirely independent of the Sandwell Children's Safeguarding Partnership.

[7] This was by telephone, as due to Covid-19 face-to-face meetings were not possible.

[8] It appears that the mother of the baby had not allowed father any contact, but it is not clear why.

[9] This appears to have been organised within the family and without the involvement of children's social care. Mother reported to professionals that her siblings had been subject to care proceedings.

reportedly violent to his mother on one occasion, and spent time living with his father in another area of the country and with extended family locally.

4.3 Around a year prior to TS's birth, Father was prescribed anti-depressants by his GP for 'low mood'. There was no review of the medication and no record of how effective they were for Father or of repeat prescriptions being issued.

5 Analysis by key episode

5.1 Key episodes are periods of intervention that are deemed to be central to understanding the work undertaken with TS and their family. The episodes do not form a complete history but are key from a practice perspective and summarise the significant professional involvements that informed the review.

5.2 From the information gained within the agency reports, the discussions at the learning events and from speaking to family members, the following key episodes provide the analysis and enable the review to identify learning for the SCSP[10].

Key Episodes
Pregnancy and birth
Assessment and support post birth
Emergency department attendance

Pregnancy and birth

5.3 Both parents were in their late teens at the time of the pregnancy. The midwives involved do not appear to have been aware how long they had been together as it is not a standard question. GGM told the police at the time of the birth that Mother had become pregnant within the first two months of her relationship with Father. TS was Mother's first child and Father's second, although Father was clear with professionals that he had no contact with his older child as the relationship had broken down before the child was born[11].

5.4 Mother had the involvement of a number of different community midwifes[12] during the pregnancy and following TS's birth and two health visitors. Routine questions were asked of Mother regarding domestic abuse, mental health, drinking, and substance misuse by those involved. NICE guidance[13] states that the health visitor's primary birth visit and the community midwives' antenatal booking appointments should include an assessment of maternal and paternal mental health. During the antenatal booking appointment, Mother told the midwife who completed the booking that Father suffered from anxiety and depression, ADHD and Asperger's. This was recorded on Badgernet[14] but there is no evidence that it was explored further with Mother or Father, or discussed with and shared with other professionals, including Father's GP.

5.5 Research shows that professionals are aware of the role that fathers play in supporting women with mental health problems, yet less is known about the importance of exploring and monitoring a father's historic or present mental health when there is a new baby. One in 20 men experience depression during their partner's pregnancy, and up to one in 10 new

[10] Each learning point is linked to a recommendation in either this report or within the agency reports.
[11] At the time father said he did not know the baby's surname, date of birth or address.
[12] The agency report notes that 11 different community midwives were involved.
[13] NICE (2014a) Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.
[14] An online information system that is used in Sandwell to record midwifery patient information. It is not accessible to GPs however, and cannot be accessed by all hospitals outside of the borough, unless they have Badgernet themselves. Important information should be shared on a Cause for Concern form which is shared with the health professionals who are involved and are also copied to the relevant safeguarding leads.

fathers are believed to struggle with depression following the birth of their baby[15]. The lack of focus on fathers is partly due to the time constraints within appointments and the amount of information that needs to be covered by the midwife, the fact that fathers are not always present and because fathers are not seen as service users in their own right at this time. There can also be related perceived concerns about where to store any information provided by fathers, as it could potentially be a breach of data protection to store it on the pregnancy notes - although permission can be gained for this. As well as these practical issues, there is a general lack of awareness of father's mental health as an issue. 'The Dad Project' is run by the NSPCC and shows how information, advice and support for fathers can be improved in order to promote their emotional wellbeing and help them to achieve better outcomes for their families. Many of the fathers involved in the project said that they felt isolated during the perinatal period as attention is understandably focused on their partner and new baby. New parenthood is a time of stress and sleeplessness, and both parents are going to be more susceptible to anxiety and a decline in emotional wellbeing.

5.6 Universal provision[16] was planned following the health visitor's antenatal visit, as no concerns were shared or known. Mother did not tell the health visitor about Father's vulnerabilities, but it is possible that she assumed the midwife and health visitor would have shared information. Service users often make these understandable assumptions.[17] Those involved also believed that Mother and the baby would be living with GGM and they had no concerns pre-birth. There is no evidence that any routine questions about domestic abuse or mental health were undertaken in regards to GGM herself, despite the plan for the baby to be living in her home and for her to be the main support to Mother and TS. This type of exploration is not common practice but can result in babies living in homes where there may be unknown vulnerabilities or risks.

5.7 Mother's hospital care was provided by a hospital outside of Sandwell[18]. Mother had most contact with the community midwives and attended the hospital for blood testing and scans. There is no information sharing between the community and hospital services unless there are specific concerns. The system relies on community professionals recording on both the electronic system and the paper handheld notes, and an expectant mother bringing their handheld notes to appointments at the hospital and in the community. When this doesn't happen, it can result in time being spent chasing information, as happened in this case when Mother did not have the correct scan paperwork. It can also result in ineffective information sharing.

5.8 During her attendance at maternity triage at the hospital, those involved were concerned about the behaviour they witnessed from Father towards Mother. It was described as controlling and potentially abusive. While it was discussed in-house, a Multi-Agency Referral Form (MARF)[19] or a Cause for Concern[20] was not completed until Mother was admitted to give birth around 2 months later. The 2017 Department of Health domestic abuse resource for professionals[21] states that health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims. They show evidence that a large number of these victims had attended health settings prior to receiving specialist domestic abuse support services.

[15] https://www.panda.org.au/info-support/how-is-dad-going

[16] Level's are set out by NHS England and outline what all families can expect from their health visiting service. Universal provision involves access to a health visitor, development checks, and information about parenting and immunisation.

[17] The Children's Commissioner for England. Family Perspectives on Safeguarding and Relationships with Children's Services. June 2010

[18] The NHS Constitution states that people living in England have the right to choose where to receive treatment.

[19] https://westmidlands.procedures.org.uk/local-content/zgjN/multi-agency-referral-reporting-concerns-marf

[20] a Cause for Concern Information Sharing Form is used to share information between Midwifery teams who share a Mother's care because this confidential information cannot be documented on the Maternity Hand Held records.

[21] https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals.

5.9 A Young Parent Maternity Support Worker (YPMSW) was allocated during the pregnancy as Mother was under 20 years. They undertook two visits at the request of Mother's midwife. They gathered a lot of information about the family history and current circumstances, including concerns voiced by GGM that Father was controlling of Mother, and Mother's report that she wished to have her own property because of difficulties in her relationship with GGM. Both of these concerns were recorded by the YPMSW on Badgernet but not proactively shared at the time with her supervisor. It is expected practice that information of this type is shared with other health professionals via a Cause for Concern, which the supervisor would likely have requested.

5.10 TS was born at 35 weeks[22]. There was a report from Mother of a domestic incident between Father and GGM just prior to TS's birth. She told staff at the hospital that she had intervened in an argument and implied this had an impact on her blood pressure. They were right to be concerned about the report, they had also observed both GGM and Father being controlling towards Mother and Father being threatening and abusive to Mother and GGM. The Specialist Midwife for Vulnerable Women[23] (SPMWVW) submitted a MARF to the Children's Trust including information of concern, but which could have been more clearly written. Neither the MARF nor the information included in it was shared with the community midwifes who were due to visit on discharge, the GP, or the health visiting service and no Cause for Concern was completed. The midwife who undertook the first postnatal visit was aware there had been an emergency caesarean but not that there had been a dispute in the home prior to this, or that there were concerns about behaviours at the hospital.

5.11 The police were aware of this incident as GGM had made a complaint about the threats she stated Father had made to her. The incident was recorded as a public order offence rather than a domestic incident, so no DASH checklist[24] was completed and there was no information sharing. Father was spoken to by police and no further action was taken.

5.12 There was a timely response to the MARF with a social worker visiting Mother and TS in hospital the same day, and also seeing Father. It was agreed that a single assessment would be completed and TS and Mother were discharged to GGM's address when TS was three days old. Mother had been clear that she wished to live with GGM and not with Father and his family at this stage, although she denied any domestic abuse or controlling behaviours from Father. Mother and Father both shared their hope that they would get housing together and that they would be able to live as a family.

Learning:

- All assessments undertaken by any professional need to consider **both** parents[25].
- The mental health and emotional wellbeing of the father should be considered alongside the mother's, as this can have an impact on their care of a baby.
- When vulnerabilities are evident, assessments need to consider information on a parent's backgrounds and history, including their mental health over time and their own experience of being parented.
- Routine questions and any assessment need to consider the parental relationship and the relationship of the parent/s with other significant family members who are involved in the day-to-day care of the child.

[22] By caesarean section due to maternal eclampsia.
[23] The hospital trust agency reports outline that there had been an email request for the involvement of the SPMWVW following the initial appointment at the hospital, but this was not actioned, with the SPMWVW stating no email had been received.
[24] A risk identification, assessment and management model for Domestic Abuse, Stalking and Honour Based Violence
[25] Including a mother's partner, even when they are not the parent of the child.

Assessment	• Assessments need to consider other stresses, such as the impact of poverty or housing / living circumstances. • Any significant information shared by a parent or family member should be checked with other agencies / professionals, and shared appropriately. Professionals should not assume that other professionals have been told, as service users often believe that information sharing between professionals is more effective that it actually is. • There are enormous expectations of professionals involved at the time of and immediately following a baby's birth and limited time to complete all required tasks. • Cause for Concern forms should be completed to ensure information is shared between health professionals. This is particularly important when part of the system does not have access to Badgernet.

Support post birth

5.13 When TS and Mother returned home they received support from Sandwell community midwives. A discharge letter from the hospital was included in Mother's hand-held notes, but did not have any details of the MARF, just a note at the bottom of the form saying 'SS and SW to visit at home' on the form, meaning 'social services / social work involvement'. Those working in the community in Sandwell stated they would not necessarily understand what 'SS' means, and that they would expect the letter to specifically include that a MARF had been completed. The midwives working in the community were not aware of the MARF or that a social worker was undertaking an assessment. However, to see 'SS and SW to visit at home' written on the discharge letter potentially should have sparked professional curiosity and a question could have been asked.

5.14 After discharge the visiting community midwife was concerned that TS may be jaundiced. It is likely the concerns about this health concern dominated this post-birth visit and that the opportunity to discuss the birth, and the concerning events that preceded it, were lost. In the visits following the birth, Mother was asked about her mental health, but there was no recorded consideration of how Father was at this time.

5.15 When the health visitor carried out a new birth visit, Mother and GGM told her about the domestic incident between Father and GGM prior to the birth of TS, and about the MARF sent by the hospital to the Children's Trust. The health visitor gained permission to speak to the Children's Trust about this, but there is no evidence this happened at this time. During this visit Mother also reported that she was suffering from anxiety but claimed she was effectively using distraction techniques to manage this. There is no evidence this information was explored further or shared with other professionals including the midwives who were visiting regularly, or that consideration was given to whether additional intervention was required, possibly via the GP. The health visitor confirmed at the visit that a Universal service continued to be suitable for the family, despite Mother's reported anxiety, the shared difficulties in the relationship between GGM and Father, and the involvement of a social worker. This was because the family appeared to be open about the issues and were happy to accept support from the health visitor. It was not until around a month later that this was revised to Universal Plus, due to the baby's slow weight gain.

5.16 In 2017 the Royal College of Obstetricians and Gynaecologists conducted a survey Maternal Mental Health – Women's Voices[26] which explored women's experience of perinatal mental health. It established that women were not readily comfortable talking to healthcare

[26] https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf

professionals about their mental wellbeing. The most common reasons given were concerns about the perceived stigma of mental ill health and having it recorded, and a belief that healthcare professionals would not be able to help. It was also established that a relationship needs to have developed in order for a woman to be able to confide in the professional[27]. In this case Mother did not have a consistent midwife, which may have made it difficult for her to speak about how she was feeling. While it is important to ascertain as soon as possible if mental health is a concern in an expectant mother, the issue potentially needs to be on the agenda at all contacts, not just the first, so that relationships can develop and in case things change. The issue was readdressed with Mother by the health visitor when she undertook an emotional health assessment at GGM's home when TS was four months old. No concerns were identified or disclosed by Mother.

5.17 When TS was five days old the midwife had concerns about the baby's weight. It is expected that newborn babies will lose some weight in the first week following their birth. A five percent weight loss is considered normal for a formula-fed newborn like TS. Most babies should regain this lost weight after two weeks. At birth TS was 2.8 kg, their weight dropped to 2.3 kg after seven days, then dropped to 2.25 kg the following week. This is a weight loss of 21%. Mother had stated that she was living between Father's mother's address and GGM's home, so there was an exploration about whether the feeds were being made up correctly at both addresses. There was no robust consideration of or information sharing about these living arrangements however, and no record that Mother was robustly questioned about how she was managing this arrangement.

5.18 TS was initially referred by the Community Midwife[28] to the Paediatric Assessment Unit (PAU) at the hospital where TS was born, due to weight loss. TS was assessed by the Paediatric doctors and discharged later the same day, with a plan for the Community Midwifery team to monitor weight and feeding. They were unaware of the social work assessment that was being completed or of the MARF that had been submitted previously by staff at the same hospital, as it had not been filed on TS's notes. Adhering to the Trust's safeguarding children policy, PAU staff checked the Child Protection Information Sharing (CPIS) system to see whether TS was known, however only those children subject to a child protection plan or in care are flagged and therefore there was no alert to staff that TS had an allocated social worker or was the subject of a social work assessment.

5.19 A week later the ongoing concerns about TS's weight led to them being admitted to hospital for two days for investigation and monitoring. On discharge the hospital contacted the health visitor for information and shared that they had to prompt Mother to wake for feeds during the night, and that on occasion parents had to be reminded to feed TS despite having an alarm set on their mobile phones. Mother and GGM informed ward staff that a social worker was involved. At discharge, the ward contacted the social worker[29] and updated her on the situation but did not record why there was social work involvement with TS. The hospital has identified as part of this review that the liaison with the health visitor and social worker should have occurred at the point of admission rather than at the end of TS's stay. This would have enabled more effective information sharing and ensured that TS's medical condition was not treated in isolation to social factors. The opportunity for a helpful discussion between hospital staff, the health visitor and the social worker around the support

[27] The NICE guidance states that mental health questions are posed at the primary visit, which means that there has been no chance for a relationship to have developed.

[28] This was an appropriate referral in accordance with NICE Guidance 2017 on Faltering growth: recognition and management of faltering growth in children

[29] There is no evidence of any contact from the hospital in the social work records. This appears to be a record keeping issue as the social worker remembers the call.

the family required, possible parenting capacity issues and potential reasons for their faltering growth should also have been taken.

5.20 TS gained weight while in hospital (83 grams within 48 hours) and was discharged home with additional visits to be provided by the community midwifery service. The hospital shared the discharge plan with the community midwifery team by telephone. The health visitor was also informed. This was good practice. This additional community midwifery support continued until TS reached their birth weight, which took just over a month. The family believes the weight was incorrectly recorded at birth, but those involved at the time insist this was not the case.

5.21 There were no other concerns about TS, who presented well and was otherwise meeting developmental milestones. While the weight drop led to a short period in hospital it did not trigger the policy for weight loss which includes referral to a paediatrician and the safeguarding nurse, as TS did not drop two centile points or more at any stage. However, as a medical reason was not found for TS's faltering growth, there should have been consideration of other social and environmental reasons, including parenting capacity. From the documentation it is not evident that this was pursued or planned. There was no evidence that the hospital safeguarding team were notified of this admission. There was no record made by the hospital staff of how TS presented generally while an inpatient, or of their experience of being parented by Mother and Father, including their interaction with TS and each other. The only thing recorded was that they sometimes needed to be reminded to feed the baby.

5.22 GGM shared concerns with the health visitor about the relationship between Mother and Father and her own difficulties with Father on three separate occasions, including her concern about Mother and TS spending time at the paternal grandmother's address, which GGM considered unsuitable. The health visitor contacted the social worker about these concerns on one occasion[30] and shared GGM's concerns. The social worker confirmed she was undertaking a single assessment as a result of the verbal altercation which had occurred between GGM and Father prior to TS's birth. The social worker also stated that there was 'no order in place' to prevent Mother from going to stay with Father, and that she had made a written agreement with Mother and Father that he would not visit them at GGM's home.

5.23 Following TS's discharge from hospital having put on weight, the midwives continued to visit. GGM shared concerns with one of the midwives about family relationships. The midwife then spoke to a community midwife colleague who had also visited the family to establish if there were any historic concerns that might lead to a MARF needing to be completed. None were known. At this point the community midwifery service was working in complete isolation, unaware that a single assessment was being completed and that the hospital midwives had submitted a MARF the previous month. An attempt was made by a midwife to check if the family was known to the Children's Trust, but the IT system was down at the time. They then sent an email to ask for the information, but there is no evidence that there was any reply from Sandwell Children's Trust. GGM confirmed to a visiting midwife around two weeks later that a social worker was involved and they spoke to the allocated worker who said the case was about to close. The opportunity to share the case history and consider any concerns and vulnerabilities was not taken. There is also no evidence that the different midwives involved each day shared information adequately. Issues identified at previous visits were

[30] On another occasion the health visitor suggested to GGM that she speak directly to the social worker herself.

not always addressed at the next visit when another midwife saw the family. This includes the management of TS's weight loss (and paediatrician advice that a feeding diary be maintained by Mother), clarifying where Mother and TS were living, and the difficult family relationships.

5.24 When TS was two months old Father went to see his GP and reported he was suffering with 'mood swings and anger outbursts' and that he had a new baby. He was prescribed antidepressants. There was no communication with any other professionals involved, including with TS's GP. (Mother and baby were registered at a different GP surgery.) There is no evidence that the impact of this presentation was considered in relation to the baby, or that the child or the parent's GPs were contacted as part of the single assessment (with their consent). If contact had occurred, the GP would have been aware of the concerns about the parental relationship, and the assessment would have considered Father's reported mood swings and anger outbursts.

5.25 The only other professionals aware of Father's reported mental health issues were the community midwife team as reported by Mother while she was pregnant, although it is unclear how many of the individual midwives were aware as the information was recorded but records cannot be read on every case by every midwife undertaking visits to a family. As they did not do checks with Father's GP or the community midwives at the start, this potentially important information was not considered in the social work assessment. There is a common misperception by social workers that speaking to a health professional will ensure they will be aware of all the necessary information to undertake the assessment. They are not always aware of the complexity of health provision and that there is no guarantee that health professionals are communicating with each other. Social workers need to be aware that if they are completing an assessment on a newborn baby, they need to ensure that they have information from, and provide information to, the GP for child and parents[31], the health visitor, the community and the hospital midwifery services. A similar finding was found in the Sandwell Serious Case Review NS that was undertaken shortly before this review, where comprehensive checks were not undertaken across health agencies.

5.26 The single assessment that was started following the MARF from the hospital was very focused on the relationship between GGM and Father, along with whether domestic abuse was a feature of the relationship between Mother and Father. There is no evidence that the concerns about TS's weight loss were considered during the assessment, or that there was any consideration of potentially important information in regards to this that was held by health colleagues. During their assessment the social worker observed aspects of controlling behaviour from Father to Mother. She recorded that Father dominated the conversations and that Mother was quiet and did not express her wishes, even when the social worker asked Father to allow Mother to speak. Father did state that his ADHD and Asperger's impacted on his social skills, and it was acknowledged that this may have been a feature of the behaviour observed. No checks were made regarding his diagnosis. The parents consistently denied that domestic abuse was an issue and it was acknowledged that there were no allegations that there was any physical domestic abuse.

5.27 There were counter allegations from Father about GGM during the Single Assessment. He told the social worker that he did not want his family to live with GGM due to what he described as her controlling behaviour and her mental health issues. This was recorded but not explored with the family or other professionals. The single assessment concluded that a referral to Black Country Women's Aid was required. A written agreement was also put in place which required Father not to visit GGM's home and that if he did, she and Mother

[31] With consent

were required to contact the Police. This requirement was not shared with other agencies. There is no evidence of any focus on TS's weight loss or the impact on the baby of contact with Father needing to be outside of GGM's home. The referral to Women's Aid was never made, and there was a gap of around seven weeks between the last contact with the family and the case closing to the social worker without any further contact[32].

5.28 The use of written agreements in domestic abuse cases is questionable practice. The National Director for Social Care at Ofsted said following a thematic Joint Targeted Area Inspection (JATI) in 2018 that written agreements in domestic abuse cases can be 'tantamount to victim blaming', and are at best ineffective. The JATI showed that written agreements should only be used if they are 'underpinned by thorough assessment that is clear about risk and protective factors of all relevant adults and family members', and that there must be 'clarity on how the written agreement will be monitored and reviewed in accordance with multi-agency plans and how this will inform the assessment of risk and action taken'. This was not the case for TS, although the content and quality of the agreement cannot be considered by the review as no copy was downloaded onto the child's social work record. The 2020 Annual Report of the Child Safeguarding Practice Review Panel[33] reinforces the concerns about using such agreements in cases of domestic abuse. It states that 'at best written agreements had little or no protective effect, and at worst provided false reassurance that this would keep children safe'. In this case the plan that Father should be excluded from GGM's home, while Mother continued her relationship with him and while he wanted to be a parent to TS, means that they would have to find somewhere else for TS to see theirfather. No consideration was given to what this might mean for TS.

5.29 Grandmother had shared that the result was that Mother and TS were spending significant amounts of time with Father, which concerned GGM. Where Father was actually living was not sufficiently explored. As Father was not to visit GGM's home, he was rarely seen with the baby by any professional, although the social worker had undertaken a visit to paternal grandmother's home and saw both parents and TS there.

5.30 When TS was five weeks old, Mother called the police to say that GGM was preventing her from taking TS to see Father. Police attended after a short delay due to capacity issues. They saw TS who was fine. They confirmed that there was no legal reason why Mother could not take TS to visit Father but did not record what GGM's concerns were. A notification was shared with the Children's Trust and the case was listed for joint screening. The Social Worker telephoned Mother the same day to discuss the notification and was reassured that things had settled down.

5.31 During this key episode health professionals responsible for TS were working with the family in regard to the baby's weight, the GP was working with Father about his mood swings, and CSC had concerns about domestic abuse and the competing controlling influences and relationships in the family. At no stage were these issues considered **together**. GGM continued to share her concerns with the health visitor about Mother and Father's relationship following the decision to close the single assessment. It was also established during a visit when TS was around 10 weeks old that while the baby was putting on weight, they had dropped a centile. There was still no clear idea about how many days and nights a week TS was spending at GGM's home and how many at Father's accommodation.

[32] The procedures states that visits to TS should have been continued at a minimum of every 14 days in line with all children considered to be a child in need.

[33] The Child Safeguarding Practice Review Panel Annual Report - Patterns in practice, key messages, and 2020 work programme, published March 2020.

Understanding a child's lived experience is an important part of any assessment and any support being provided. Professionals need to put themselves in that child's shoes and think 'what is life like for this child right now?' The understanding of the child's world should then be incorporated into the work undertaken with a family. This is not possible if there is a lack of clarity about where the child lives.

5.32 Because all of the community health professionals visited Mother and TS at GGM's home, and Father was not welcome there, none of the professionals saw Father with TS on a regular basis. This was a significant omission bearing in mind the social worker's concerns about the parental relationship, Father's own acknowledgement that he was suffering with mood swings and anger issues, and GGM's allegations. The opportunity to discuss with Father how he was finding caring for TS by undertaking a visit at his accommodation was not taken.

Learning:
• Health systems are complex and professionals not working in the NHS may not understand this. This has an impact on the seeking and sharing of information. • When undertaking a single assessment on a new baby, social workers need to ensure they consider information held by all of the health professionals involved. [34] This includes the GP for the baby and both parents[35], the hospital midwifery team, the community midwifery team and the health visitor. This should include asking who else is involved. • When a baby loses weight or does not put on weight as expected, social and environment issues always need to be considered as well as potential medical explanations, and a multi-agency response provided. • If it emerges that a baby is living between homes, professionals need to consider the impact this will have on the baby, particularly when issues develop such as poor weight gain. Consideration should also be given to visiting all homes. • Written agreements can provide false assurance and should only be used in very specific circumstances.

Emergency department attendance

5.33 TS was taken to the A&E department of the local hospital by both parents when four months old. They reported that TS had fallen out of their pushchair when getting off a bus, sustaining a head injury. Processes were not followed in A&E, with the parents' explanation immediately being accepted. No information was shared or sought from the Safeguarding Designated or Named Doctor or the paediatrician on call. No Paediatric Liaison form was completed, which would have resulted in the safeguarding team being aware of TS's attendance at A&E and the health visitor being informed. The policy for when an injury is sustained by a child who is not yet mobile was not followed[36].

5.34 During the triage process in A&E both parents were asked if they had ever had a social worker, and they said they had not. This was not checked. Those who know them state that they come across as confident and caring parents, which may have led to a lack of professional curiosity about the family.

5.35 The health visitor saw Mother and TS a few days afterwards. She was not aware of the A&E attendance and the parents did not share the information, so it was not discussed. The health visitor was leaving her role and a new health visitor was to be allocated. There was a

[34] It might be agreed that the health visitor speaks to the GP/s and provides this information to the social worker
[35] With consent
[36] This is covered within Level 3 safeguarding training for health professionals

verbal handover of the case to the new health visitor, including a discussion about the slow weight gain and the case now being deemed 'universal plus'.

5.36 TS's GP received a notification about the A&E attendance but did not question the response and the fact that the correct procedures had not been followed with regards to an injury in a non-mobile baby. There was no consideration of inviting the baby in to be seen by the GP, as would be good practice, and the information was not shared with the health visiting service who were likely to be the only professionals with any ongoing involvement.

5.37 Information sharing has been identified as an issue across the professional involvement in this case. Poor information exchange between agencies at critical points was present in 40% (215) of all rapid reviews considered by the Child Safeguarding Practice Review Panel, as stated in their annual report 2018-19[37]. For TS, there was more communication than is reflected in the case records, but evidence of good information sharing was often lacking. The identified gaps include; the hospital not sharing information about their concerns and the MARF with the community health professionals who had an ongoing involvement; the MARF not being filed onto the child's and Mother's hospital records - so this would not be available in later admissions; the community midwifery service not informing the health visiting service about the weight loss, jaundice and readmission to hospital; the health visitor not pursuing the information she had from the family about the issues prior to the birth and the subsequent MARF with the Children's Trust until after GGM shared further concerns; the information known to the health visitor about GGM's concerns were not shared with the midwifery service; the GP did not share information about Father's mental health with the health visitor; the single assessment did not include communication and lateral checks with the GPs or midwifery service; despite the existence of a Communication and Handover policy between midwives and health visitors this was not utilised in this case and no information was shared; the reported domestic incident about GGM not allowing Mother to take TS to see their father when TS was 5 weeks old was not shared with health professionals; and the A&E attendance was not shared with any professional other than the GP.

5.38 A week after the health visitor had seen Mother and TS at GGM's home, Father called 999 from his aunt's home where Mother and TS were staying. TS was taken to hospital but died following an apparent cardiac arrest. The Sudden Unexplained Death of an Infant or Child (SUDIC) protocol was commenced, and the professional response to their death was well managed. It was not established until following TS death that Mother, Father and TS were residing at the home of Father's aunt. There were serious concerns about the state of the home, which was not judged to be appropriate for a young baby. It is noted that Father had always implied to professionals that he lived with his mother, and this was confirmed by the social worker who visited him there while undertaking the single assessment.

Learning:
• The Bruises and Injuries in Non-Mobile Children Policy should be followed in all cases where a non-mobile child has injuries.

Conclusion and recommendations

6.1 TS died while in the care of both parents at an address that professionals were not aware of and had not visited. Risk factors were evident but not well communicated between the professionals involved. Father had known mental health and anger control issues. There were well reported relationship difficulties between Father and Mother's grandmother.

[37] The Child Safeguarding Practice Review Panel Annual Report - Patterns in practice, key messages, and 2020 work programme, published March 2020.

Professionals were concerned that there was domestic abuse through control of Mother by Father and potentially GGM. There had been concerns about TS not gaining weight and an incident where they received injuries. (Although the police have since told the review that with the help of CCTV footage they believe these injuries to be accidental.) Due to limited professional curiosity, a lack of reflective practice, inconsistent information sharing, and concerns being seen in isolation, there was little understanding of TS's lived experience and an insufficiently co-ordinated response to their needs.

6.2 The Child Safeguarding Practice Review Panel stated in their annual report 2018-19 that partner agencies need to 'move beyond the legislative and procedural, to the technological and the behavioural, and forensically explore how we can develop our multi-agency and multi-disciplinary practice in routine ways, and at critical points, which strengthens information sharing, risk assessment and decision making.' They also state that 'whilst technological solutions are a critical component, we also need to think in terms of human factors. Complexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners. How do we help people talk to each other within a context of high-risk, high-volume and limited resource, often when practitioners are fearful of reprisals from families, employers and society at large?' This case, like many others nationally, shows that this remains one of the main challenges for safeguarding partnerships and professionals.

6.3 The Triennial Review 2014-2017, published in March 2020, found that there continues to be a "dearth of information" in practice, about men. 'The primary focus of health professionals and social workers continues to be on the needs, circumstances and perspectives of the mother. This is the case even in established relationships, when the mother's partner has a major role in looking after the children. Such a lack of professional curiosity in fathers and partners not only potentially leaves women and children vulnerable, it can also leave fathers feeling alienated and forgotten, and their role in bringing up the children dismissed. Services need to find ways to become more male friendly if they are to encourage the involvement of men in the lives of their children.' This review found that improvements in considering the history and involvement of Father were required. He was effectively excluded from much of the professional contact with the family.

6.4 Good practice[38] was indentified during this process and there has been good co-operation and engagement from agencies with the review process, which has been important in identifying the learning.

6.5 It is recognised that actions have already been taken in relation to some of the individual agencies identified learning in this case, and that changes have been made which will be outlined in the SCSP's response to this review. For example, a West Midlands Police force-wide message has been circulated to remind staff of the domestic abuse policy, the definition of a domestic incident, and what constitutes a family member[39], reinforcing the message that domestic incidents are to be accurately recorded to enable effective prosecution, safeguarding and signposting as appropriate. A briefing note has been shared with health visitors regarding the need to visit families at any other addresses where they are living. Work is also under way regarding improved involvement of fathers, improving professionals' networks when there are pre-birth concerns (following SCR case KS) and by the relaunch of an improved Bruises and Injuries in Non-Mobile Children Policy.

[38] Including the identification of coercive behaviour by the hospital midwife and the social worker, both of whom spoke to Mother alone about this. The GP encouraged immunisations and allowed parents to make an informed choice when Father expressed concerns. The hospital midwives spent time with Mother to find out her wishes about where she wanted to live with TS on discharge from hospital. Actions taken by the community midwives in relation to the monitoring of TS's weight and jaundice.

[39] Family members are defined as mother, father, son, daughter, brother, sister, grandparents, whether directly related, in-laws or step.

6.6 The agency reports have made recommendations which have also largely been completed by the conclusion of the review. Some of the learning identified within this report will have been addressed by the single agency actions plans, which are being monitored by the SCSP. They include recommendations regarding the need for GPs to ensure that they request a face-to-face assessment in the surgery following an A&E notification of injuries sustained to a non-ambulatory child, ensuring that hospital staff use the policy around non-medical management of faltering growth, and that a health care needs assessment must carried out by the health visitor where safeguarding concerns are evident and babies are moving or living between address.

6.7 Other local case reviews have been completed with similar learning and recommendations. This review has considered these and not repeated recommendations.

6.8 The review requires that further recommendations for the safeguarding partnership are made, to ensure that any areas identified as being of particular concern that are not included in the single agency plans, or which require an all agency or interagency action, are addressed.

Question 1 for the SCSP to consider:

In light of the learning from this case and the findings of the Child Safeguarding Practice Review Panel in their annual report 2018-19 (see 6.2 above), how can the partnership ensure that information sharing is improved, both using technological solutions and by ensuring that professionals talk to each other and collaborate so that that all information is known?

Recommendation 1:

The SCSP should ask the Department of Education and Department of Health to consider adding to guidance about both routine questioning and assessments in domestic abuse the need to consider whether any household members beyond the parents are experiencing domestic abuse in the child's home.

Recommendation 2:

The SCSP to ask its partner agencies to provide the opportunity for professionals to learn from research to inform practice. The areas required, as highlighted by this review, are:

- The use and validity of written agreements or contracts in cases of domestic abuse
- The importance of equally involving fathers/partners in all areas of work
- Domestic abuse through coercion and control, including outside of intimate relationships
- Trauma informed practice and the impact of adverse childhood experience on parenting
- The importance of non-medical professionals understanding the systems that provide health services
- The need to follow procedures when there is an injury in a non-mobile baby

Recommendation 3:

The SCSP to consider how they can influence a cultural change across partner agencies, regarding the role of fathers and secondary carers in families. This should include consideration of the barriers and what works well.