BARKING & DAGENHAM SAFEGUARDING CHILDREN PARTNERSHIP

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Learning Lessons Summary

'Child F'

Overview

In the Autumn of 2018, when Child F was about 9 months old, an emergency services phone call was placed by Child F's mother, Ms X, advising that the baby had choked. Child F was unresponsive and admitted to Hospital where neurological issues and a bleed on the brain were identified. Child F continued to be unable to breathe without artificial ventilation. Child F died of an injury to head consistent with shaking.

Ms X was very young at the time of Child F's birth, just 18 years of age. Ms X and Child F's father had separated before the birth of Child F.

Key findings and Areas of Significant Practice for Professionals

Mother's vulnerability, troubled childhood and the parental and family background was insufficiently considered in the assessments made and the level of support provided to her and Child F.

Ms X's vulnerability and her history was neglected. She had a series of Adverse Childhood Experiences. There was a long history of social work involvement with the family of Ms X's mother. Information was available but it was not accessed nor fully considered.

In the Early Help records and elsewhere there is no genogram or record of the family history.

There is very little social history for Ms X and her family recorded in agency records including those of the GP who was the only consistent professional involved with Ms X and Child F.

It was highly likely that she would experience difficulties in parenting and in choosing safe partners. Her capacity to protect her child was therefore also impaired.

Ms X's cooperation was not full and, when she did refuse or avoid engagement, this was not always challenged, or a risk assessment carried out.

There was a lack of professional curiosity about Child F's father and particularly in relation to mother's new partner who was "hidden" and unseen. He was not assessed as the co-parent he was for Child F.

In the agencies' records, neither biological father nor mother's partner's details were recorded.

There is no social history recorded for him or Child F's father. When professionals do not know or understand the role of all significant adults in a baby's life, they can only make assumptions about how the baby is being cared for and by whom when they are not visiting.

Several different professionals were involved with Child F and mother as they moved several times and as staff were changed which meant there was little consistency in the support provided. There were also gaps in that support.

The Early Help Service did support Ms X and Child F for a lengthy period from June 2017 to May 2018 so there was some regular professional involvement for a time. There were also joint visits with midwives and health visitors.

Ms X had several moves within the Borough which necessitated a change of health visitor because those services are geographically based in the "place-based" care system. Multiple professionals were involved as a result of changes of address and staff problems – though it was the same GP practice throughout.

In addition, the handovers between different health visitors were not always clear or well carried out to ensure that information was shared. On one occasion, there was a gap in the health visiting service because no new allocation was triggered.

Between late March and early June 2018, a health visitor did not see the child even though they were on the Universal Plus programme and Child F's head circumference issues needed follow up. There was a further 3-month gap in handover and the child was not seen by a health visitor for 6 months in total. There was no clear care plan for Child F's needs.

There had been risks to the health visiting service identified by the managers of the service with issues about demands and capacity in view of long-term staff sickness, existing vacancies, increased client numbers and highly vulnerable parents.

The main focus for professionals seems to have been on engaging mother which may have resulted in less focus on the child and less interprofessional sharing of information about his needs.

Within some records, there is surprisingly little information about Child F's progress and development. The focus was primarily on support and guidance to the parent as a vulnerable young mother. There was no sharing of information through a child in need meeting or Team around the Child meeting, which would have brought professionals together for the purposes of planning and information sharing. Instead, professionals worked individually with no lead professional or assessment.

Within the health visiting service there was no clear care plan for Child F. Information was "lost" within progress notes and all the records would have needed to be read to understand what was required.

There were gaps in joint working within and between agencies to support Mother and Child F

The full context and history of the family was not jointly considered, and each agency or practitioner was not always aware of each other's involvement, so practice was not well integrated.

When Ms X was staying with her mother, concerns were raised about the state of the family home at various points, but these do not seem to have been followed up consistently by midwives or Early Help workers. Additionally, there was no consideration or assessment of maternal grandmother and any risk she may have posed through her lifestyle and parenting of the child's mother, Ms X.

The referrals made to the Children's Social Care service did not prompt a direct response from that service. The seriousness of an incident involving the baby's father when he came to try and see Child F in December 2017 was missed. Although the midwife in her referral to

Children's Social Care mentioned that there had been a hammer present during the affray, the police report did not include any reference to a hammer being present at the scene so there seems to be a disparity of information. Based on the Police report, the Children's Social Care service did not regard the incident as serious enough for it to intervene having noted no mention of a hammer in the Police notification so that it was assumed not to have been present. It would have been appropriate to check this out further with the midwife, but this did not happen.

The earlier referral made by the midwife, which resulted in an Early Help service being provided, was not regarded as providing enough information by the service to warrant a social work response despite the historical information about Ms X's background and troubled childhood. Although there was significant historical information in the Children's Social Care service, it was not immediately accessible within the new client electronic recoding system.

The Early Help service did not have access to the Children's Social Care records but nor was further information sought. There was a lack of integration of practice between the Early Help and the Children's Social Care services.

After a health visitor identified a possible problem relating to the large head circumference of Child F in March 2018, there was a lack of follow up of this when he was seen by other professionals such as the GP and clinic nurses; there was also a protracted communication about who should be investigating this; this was a flawed response to what might have been a potentially urgent matter. At the time of Child F's death this does not appear to have been fully clinically assessed or explored though Child F was referred to a physiotherapist

The health visitors and GP did not liaise directly and so information was not shared for example about Child F's large head circumference.

Positive practice

The likelihood of parenting difficulties was identified at an early stage and responded to promptly by Early Help. Early Help services visited regularly and provided practical support.

Midwives made two referrals – in March 2017 about mother's vulnerability and again in December 2017 when there was an incident between mother's old and new boyfriends.

Considerable efforts were made to engage with Child F's mother, Ms X and to support her by the Teen Pregnancy midwife and others. When she missed appointments, these were rebooked for her so that she did not miss antenatal care.

There were several examples of joint visiting by professionals to ensure that mother was given consistent messages. Health visitors and Early Help workers sometimes visited together.

When they were seen it was noted that Child F was gaining weight, developing normally and Ms X appeared appropriately attentive and caring.

Ms X was referred to the perinatal mental health service by the GP in February 2018 when she was low in mood. Unfortunately, she did not attend, and she was discharged without any risk assessment.

Learning from the review

The likelihood of Ms X having difficulty in parenting and in keeping her own child safe was high considering her young age, her own childhood experience of neglectful care and of experiencing violence at home.

However, the practitioners involved with Ms X did not check out her history, so they were not fully informed. An incomplete assessment of her experience and needs was therefore made. In reality no meaningful assessment of her experience or needs was made and professionals responded to Ms X given the presenting factors at that time and only considering practical needs.

Ms X was an extremely vulnerable young woman but despite her troubled history and her own poor experience of being parented, she and Child F did not receive the consistent, well-informed support they needed, and an over optimistic view was taken of how she was coping.

Views about Ms X's coping and capacity to parent Child F safely took no account of her new partner and the part he was playing in the lives of Child F and Ms X.

Despite much effort to support Ms X, there were gaps in provision and insufficient additional support provided to her particularly after May 2018 when the Early Help service ceased.

From March 2018 to October 2018, the health visiting service was not in touch with Child F and Ms X. It is not clear therefore what sort of life experience Child F was having during those months prior to his death.

There was some coordination of effort between services but also shortfalls in the sharing of information for example about Child F's head circumference.

Conclusions and Summary

This review has identified some positives in the practice in the multi-agency partnership identifying and responding to risk to babies both before and after their birth. However, it has also identified some procedural and systemic shortfalls which should be addressed.

Much effort was made by all the agencies involved to keep Child F safe and to support his Ms X to care for Child F. It was not foreseeable that Child F would be injured and die by anyone at the time as it was believed that there was no evidence of any immediate risk to Child F and that the range of service being provided would protect Child F.

However, more could have been done to explore the vulnerability and risk for this family as set out in the findings of the Triennial Analysis of SCRs 2011-2014 (page 139): "When a child presents with indicators of possible maltreatment and vulnerability, or a parent or carer presents with recognised risks, professionals have an opportunity to explore that vulnerability and risk and take steps to intervene and protect the child. This requires a stance of professional curiosity and awareness of possible maltreatment and cumulative risk."

It is very clear that all the professionals who were involved with Child F and the family did their utmost to help his parent to care for Child F and to keep Child F safe. There was a strong commitment from staff and evidence of efforts being made to support the family.

Recommendations for the Safeguarding Children Partnership to consider and action:

The agencies involved with the family have identified a number of single agency recommendations for improving practice. The implementation and impact of these actions will be monitored by the Barking and Dagenham Safeguarding Children Partnership.

In addition, the following recommendations for learning and improving are made to the LSCP. They reflect the key learning from this review. The Barking and Dagenham Safeguarding Children Partnership should ensure that the following aspects are addressed, and arrangements are in place to monitor their effectiveness:

In all interagency and single agency training there should be clear guidance about the importance of:

• gathering social history information from parents and also

• of checking agency records

• particularly gathering information about and making an assessment of all adults involved in the care of young babies – particularly new partners.

Consideration should be given to reviewing and revising the existing multi-agency guidance about supporting and assessing the parenting capacity of young vulnerable parents to clarify what factors would heighten risks and which would serve as protective factors for their child.

A multiagency review should be undertaken of the effectiveness of partnership working with parents with high needs, particularly those families of vulnerable children under 2 years. This would ensure that there are more effective joint responses, information sharing and systems to support parents and to safeguard children to ensure continuity and the provision of an effective universal safety net for these children involving GPs, midwives, health visitors and Early Help services in particular. This should complement the development of the new pre-birth team and other improvements which have been made to the Early Help service.

The reports from Early Help and MASH set out difficulties for staff in Early Help and Social Care to access or view reciprocal information on Child F's family. This information would have assisted understanding and risk. A review should seek to 'untangle' the various reasons why staff were unable to view information and identify solutions to any obstacles identified.