CHILD O SERIOUS CASE REVIEW

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GLOSSARY OF TERMS	
ACE	Adverse Childhood Experience
CAMHS	Children and Adolescent Mental Health Services
CIN	Child in Need under the definition of the Children Act 1989
CNN	Community Nursery Nurse
CSE	Sexual Exploitation
ECP	Enhanced Care Package (Maternity)
EDT	Emergency Duty Team
EPP	Early Parenting Pathway
EPU	Early Pregnancy Unit
FGC	Family Group Conference
FNP	Family Nurse Partnership
GP	General Practitioner
HCP	Healthy Child Programme
ICPC	Initial Child Protection Conference
JAS	Joint Adolescent Service
MASH	Multi-agency Safeguarding Hub
NHSE	National Health Service England
NSPCC	National Society for the Prevention of Cruelty to Children
PICU	Paediatric Intensive Care Unit
RAS	Referral and Assessment Team
STARS	Sutton Tuition and Reintegration Service
TAC	Team Around the Child
TIC	Trauma Informed Care

Contents

1. Introduction

1.1 This is the Serious Case Review (SCR) into the circumstances of Child O, who suffered a serious brain injury at the age of 11 weeks.

1.2 The SCR was commissioned to be undertaken by an independent author under the statutory guidance of 'Working Together to Safeguard Children' 2015[1]. The Sutton Local Safeguarding Children Board's (LSCB) revised arrangements under Working Together 2018 became operational on 4 July 2019 and are now referred to as Sutton Local Safeguarding Partnership (LSCP). The report is therefore structured as recommended in the Safeguarding Practice Review Panel: Practice Guidance[2] (2019).

1.3 Child O is the focus for this review. It has also considered the care needs of the mother, Miss A with regards to her own complex history and the impact of past trauma on her mental health, cognitive development and her ability to parent. She was year 17 years old when Child O was injured.

1.4 Learning from this review has been drawn from professional interactions during Miss A's pregnancies, and the care of Child O's older half-sibling, Sibling S, who was 16 months at the time of the incident.

1.5 The full methodology is set out in appendix A. It acknowledges the significant contribution made by the family and practitioners in the interviews that inform the learning of this review. The IMR and SCR action plans set out how the recommendations will be implemented.

1.6 Many of the key themes emerged in individual agency reviews of their own practice and many safeguarding system improvements have already been implemented. Their action plans to implement their recommendations are in an appendix at the end of this report.

1.7 The LSCP SCR action plan is also set out in an appendix and the implementation of learning will be reported in the annual review of the effectiveness of the LSCP. The report will be submitted to the Safeguarding Practice Review Panel as required in Working Together 2018[3].

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[1] HM Government (2015) Working together to safeguard children: statutory guide on interagency working to safeguard and promote the welfare of children, London: The Stationery Office.
[2] HM Government (2019) Child safeguarding practice review panel: practice guidance, London: https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance
[3] HM Government (2018) Working together to safeguard children: statutory guide on interagency working to safeguard and promote the welfare of children, London: The Stationery Office.

2. Executive summary

2.1 On 5 October 2018, Child O was taken by his parents to the local hospital where he was found to have suffered a subarachnoid haemorrhage indicative of abusive head trauma. Child O was subsequently transferred to the nearest tertiary hospital for specialist treatment. Child O recovered in hospital but has been left with a debilitating condition and permanent impairment. Following hospital discharge, Child O was accommodated with foster carers under section 20 of the Children Act 1989.

2.2 On 11 October 2018, it was identified that the case met the legal requirement under 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) that the Local Authority must notify incidents to the Safeguarding Practice Review Panel where a child has been abused or neglect is known or suspected if:

a. 'The child dies or is seriously harmed in the local authorities area'

2.3 On 21 December 2018, Sutton LSCB submitted the multi-agency Rapid Review response to the Safeguarding Practice Review Panel as required in Working Together 2018[3]. The Safeguarding Practice Review Panel subsequently confirmed that the case met the criteria for a Serious Case Review (SCR) under the previous guidance of Working Together (2015) because:

> '*Abuse is suspected, a child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.'*

2.4. The SCR Panel was chaired by the Independent Chair of the Local Safeguarding Children Board in the London Borough of Sutton. The Independent Reviewer was appointed by the Panel and the brief provided was the terms of reference for this SCR.

2.5 The investigation was completed during the period of 13 May 2019 to 13 September 2019. The report and its recommendations were considered and approved by the Board of the Sutton Local Safeguarding Partnership (LSCP) on 26 September 2019.

2.6 The information for this review was extracted from the single agency reports, family interviews and follow up conversations with professionals and additional reading. The analysis was framed around seven key questions to identify learning points for practice improvement. The learning points were then organised into six emerging themes: 'quality of assessments', 'supervision and management oversight', 'effective care planning', 'consent and securing engagement', 'multi-agency partnership working', and 'policy and procedures'.

2.7 The overall conclusion is that there is no evidence to suggest that Child O, or Sibling S, were at risk of or had suffered neglect or abuse in the lead up to the incident. Medical experts are yet to provide an opinion to the Court as to the cause of Child O's injury, and the criminal investigation is still to be concluded.

2.8 The review found that the immediate responses to the serious injury followed established safeguarding procedures and care proceedings were initiated for both children as required. As practice followed policies and procedures, there was no learning to be extracted from this aspect of the review.

2.9 The review has considered the attendance and engagement with health and social care services during Miss A's pregnancies and after the birth of both children. A pattern of missed and cancelled appointments has been a recurring feature throughout the review and was particularly noticeable during the time Sibling S and Miss A were subject to a Child in Need plan. Following closure of that plan, a further three referrals were made to CSC in a seven month period, which did not result in ongoing work or early help interventions.

2.10 During the antenatal and postnatal period for Child O, there was appropriate engagement with the hospital and community midwifery services, including during the first two weeks after discharge. Signs of disengagement presented after the handover to the health visiting service. In total, the health visitor visited the home on three occasions and saw Child O in a baby clinic setting once, when he was accompanied by his grandmother. Child O was immunised by the GP at 8 weeks but did not attend for his eight week development check with the health visitor.

2.11 Health professionals assessed Child O as vulnerable and in need of additional services, but did not identify any safeguarding concerns from the time he was born until the incident that led to this review. Additional services were offered but declined by the mother.

2.12 This review raises important issues about working with hard to engage families. It also looks at quality of professional engagement with young people who have complex needs. This is considered in the context of previous social care engagement with the mother that included interventions under S.47 of the Children Act 1989. The history confirmed that the mother had been exposed to a range of Adverse Childhood Experiences (ACEs) which were likely to have had an impact on her cognitive development, parenting ability and ability to form trusting relationships.

2.13 Subsequent multi-agency practice developments have been undertaken as a result of the learning from this review to ensure that young mothers and fathers, in similar circumstances, will be engaged through different and more purposeful

approaches. For example using trauma informed practice and a contextual safeguarding approach designed especially for young people.

2.14 The analysis of findings is comprehensive and the learning is summarised for each line of enquiry into a section entitled ‘Summary of Learning’. Thirty seven relevant findings have been identified and summarised under the eleven learning points. The learning has been further condensed into six themes that underpin the recommendations. The actions from the individual agency‘s own management reviews together with the LSCP action plan will provide the basis for assurance that the recommendations from this SCR will be fully implemented.

Serious Case Review Report for Child O

1. The reason for commissioning a Serious Case Review

1.1 This section provides brief details about the birth and the events leading up to the notification about the serious injury of Child O, and the subsequent decision by the Child Safeguarding Practice Review Panel that the criteria for undertaking a SCR had been met.

1.1.1 On 31st July 2018 Child O was born prematurely by caesarean section at 36 weeks gestation. Both parents were present at the birth. The immediate post-operative period for Child O was uneventful, apart from slight respiratory distress. Child O and Miss A were deemed fit for discharge the next day. A routine discharge procedure was undertaken.

1.1.2 On 5th October 2018, at 22.59 pm Miss A and Child O's father took Child O in the family car to the local hospital Accident and Emergency Department after he was found to be unresponsive and suffering breathing difficulties at home. He was severely collapsed and required resuscitation on admission. The collapse was found to be caused by bleeding on the brain from head injuries that were indicative of inflicted harm.

1.1.3 Following the provisional diagnosis, the statutory agencies followed established child protection procedures and took immediate action to secure the safety, health and wellbeing of Child O and his half-sibling, Child S, aged 13 months, who was living in the family home.

1.1.4 A statutory child protection strategy meeting involving key multi-agency partners took place with a plan to progress to an Initial Child Protection Conference. However the parents of Child O and Sibling S agreed for both children to become Looked After Children, thus becoming the responsibility of the Local Authority. This action rendered the Child Protection Conference as unnecessary. Following CSC assessments Sibling S was placed with his maternal grandmother.

1.1.5 On 11 October 2018, the London Borough of Sutton made the decision that the reported incident of a suspected 'shaken baby' met the criteria for a notification to the national Child Safeguarding Practice Review Panel. The decision was made on the grounds that Child O had been seriously harmed.

1.1.6 The LSCP Rapid Review response was submitted on 21 December 2019 and the response by the Child Safeguarding Practice Review Panel was received on 22 January 2019. A first SCR panel was held on 27 February 2019 when the LSCP made the decision to commission a SCR.

2 Background history, key circumstances, and context of case.

2.1 Housing

Family members of Miss A's household included her mother, stepfather and brother. Her grandmother lived nearby and is described as a significant influence within the family. Extended family members were regular visitors to the family home. Social work records confirm that Miss A is White British and the CSC notes record a link to the travelling community. Child O's father is also White British.

2.1.2 The small family home is part of social housing provision and is situated in an area described as a pocket of deprivation in an otherwise affluent part of the London Borough of Sutton. The family appears to have experienced financial difficulties at times.

2.1.3 When the third pregnancy (Child O) was confirmed, Miss A's mother contacted the MASH to report concerns about the house being overcrowded. She had contacted Sutton Housing Partnership some months before but did not pursue an offer of a housing transfer. A CSC social work home visit followed the MASH contact, but no further action was taken.

2.2 Safeguarding and Mental Health Care Needs of Miss A

2.2.1 By the age of 13 years, Miss A had been exposed to several adverse childhood experiences (ACEs)[4] including sexual abuse and sexual exploitation. Miss A's school referred concerns about self-harming behaviour to CAMHS. Miss A and her parents attended CAMHS appointments which resulted in Miss A transferring to Sutton Tuition and Reintegration Service (STARS), a pupil referral unit for children with complex medical needs. Subsequently, Miss A and her family were offered family therapy to help manage her complex behaviours, but it was not taken up. Professional notes allude to the family minimising Miss A's mental health problems.

2.2.2 A Child Protection Plan for Miss A was in place for eight months when she was 13 years old and deemed to be at risk of child sexual exploitation. The plan was subsequently stepped down to a Child in Need response under section 17 of the Children Act 1989. The case was closed after a further 10 months, near Miss A's 15th birthday, when concerns had reduced.

2.2.3 Miss A became pregnant for the first time at 15 years old. In the early weeks of the pregnancy, she was reported to be self-harming and displaying auditory hallucinations. In February 2016 referrals were made to CAMHS by the school and the social worker. An appointment was offered the next day with a

[4] ACEs:Adverse Childhood Experiences are stressful events occurring in childhood: they can have a long-lasting impact on an individual's ability to think, learn and interact with others.

consultant but Miss A did not arrive at the clinic. In addition, Miss A's mother expressed that she had no concerns about her daughter's mental health, and suggested the CAMHS consultant saw her at school. The CAMHS consultant agreed to this arrangement and an appointment to assess Miss A at school was made. However, Miss A refused to attend the appointment as arranged and it was concluded that mental health problems were no longer a concern. The case remained closed to CAMHS despite information that Miss A was refusing to attend school.

2.2.4 When the first pregnancy was confirmed STARS (Medical Pupil Referral Unit) and a hospital midwife, independently, reported concerns about Miss A's capacity to care for a child. The reports were duly followed up by children's social care but no safeguarding concerns were identified. The pregnancy resulted in a miscarriage a few weeks later.

2.2.5 Mental health concerns were identified again when Miss A was pregnant for the second time with Sibling S, aged 16. A school welfare check was undertaken but CAMHS did not reopen the case for further work.

2.2.6 Safeguarding concerns were expressed by STARS during the second pregnancy (Sibling S). The STARS social worker reported that Miss A did not have the cognitive capacity to care for a baby and she would not be sufficiently supported by her family to parent a child. Miss A disengaged from education at the beginning of the pregnancy and did not return.

2.2.7 Reports of low mood were expressed again during Miss A's third pregnancy and ante-natal period for Child O. This resulted in an antenatal enhanced care pathway (ECP). The service included regular review of her emotional wellbeing by specialist midwives in a vulnerable women's meeting, held in the maternity unit.

3. Miss A's pregnancy with Sibling S

3.1 Miss A was referred to Children's Social Care by the local hospital maternity unit when her second pregnancy was confirmed. A child and family assessment was commenced, following a multi-agency CiN meeting.[5] A social worker was allocated to complete the assessment. As part of the care plan, the social worker provided support to re-engage Miss A with education but this was not achieved.

3.2 Miss A was referred to the Family Nurse Partnership service (FNP) as part of the Child in Need Plan. She was offered the service shortly after the pregnancy was confirmed, but it was declined. She did however engage at 26 weeks gestation and completed an enrolment visit in her home. Subsequently, there

[5] Child in Need Meetings: A statutory requirement under the Children Act 1989. Enable children, young people, families and professionals to be clear about their responsibilities in the plan, the role of the allocated social worker and the timescales for interventions and expected outcomes.

were four programmed visits before Sibling S was born. The last FNP ante-natal visit took place at 36 weeks gestation and Miss A was reported to be preparing well for her new baby.

3.3 STARS referred concerns about Miss A's capacity to care for Sibling during the first trimester of her pregnancy and requested an Initial Child Protection Conference (ICPC). Whilst it was reasonable for the locality social worker to consider that the threshold for an ICPC conference might not have been met, due to lack of evidence indicative of significant harm[6], it would have been appropriate to check out that assumption by means of a strategy discussion, to ascertain the views of other partners. Instead it was decided to explore the concerns through the Child in Need assessment already underway and no strategy discussion or meeting with the partnership took place. The social work assessment concluded that there were no safeguarding concerns at the threshold for a statutory child protection response.

4. The period between the birth of Sibling S and the pregnancy of Child O

4.1 At 38 weeks gestation, Sibling S was delivered by caesarean section. A multi-agency discharge planning meeting was held the next day in the hospital, after which he was discharged home with his mother.

4.2 FNP support continued to be part of Miss A's CiN plan and was therefore reviewed in the multi-agency CiN review meeting after Sibling S was born. Miss A consistently expressed however that she did not want to participate in the FNP programme which consisted of weekly or fortnightly visits lasting 60 to 90 minutes. Eight invitations, with text message follow up, were sent to Miss A to enable the delivery of the FNP program. However, due to a reluctance to participate Miss A participated in only two FNP sessions and a third was cut short after fifteen minutes. The FNP closed the case when it became clear that Miss A had no intention of engaging with the service.

4.3 A CIN planning review went ahead for Miss A, without partner agencies being present, when Sibling S was almost four months old. No concerns were identified in the meeting. The immediate family was said to be giving good enough support to Miss A and her baby and Sibling S was thriving. The case was subsequently closed by Children's Social Care, with management approval.

4.4 At the point of case closure, the health visitor had still not met the family, despite several attempts to try and make contact. A further unannounced home visit was also unsuccessful and a follow up invitation to attend a baby clinic for an

[6] Children Act 1989: "Harm" is the ill treatment or the impairment of the health or development of a child. Ill-treatment includes sexual abuse and forms of ill-treatment which are not physical, e.g. emotional abuse. It also includes 'impairment suffered from seeing or hearing the ill-treatment of another'. Significant harm is determined by "comparing a child's health and development with what might be reasonably expected of a similar child".

assessment was declined. Sibling S was almost 20 weeks old by this stage. The health visitor was unaware that CSC had closed the case.

4.5 The health visitor saw Sibling S for the first time at clinic when he was 23 weeks old. No concerns were identified. Miss A agreed to engage with the health visiting service and a Universal Plus7 threshold was applied.

4.6 Within a month of the CIN plan being closed, Miss A and the father of Child O came to the attention of the police having been involved in a violent incident whilst out with friends. The victim, however was unwilling to proceed with charges. It was jointly decided with the police that the case did not need to be reopened by CSC as the criminal investigation had been dropped. There was a two month delay before informing the family of the 'no further action' decision, which created unnecessary anxiety for the family. The police did express their concern to the social worker about the type of people Miss A and her partner appeared to be socialising with.

5. The period covering the antenatal period and subsequent birth of Child O

5.1 Miss A was approaching her seventeenth birthday when her third pregnancy with Child O was confirmed. She attended the Early Pregnancy Unit (EPU), within two months of the police incident. The father of the baby was a 16 year old boyfriend who had moved into her family home.

5.2 A home visit was undertaken by the health visitor which was satisfactory, but numerous follow-up telephone calls did not elicit a response from the family. Following safeguarding supervision advice, a formal request was made by the HV to the social worker to escalate the concerns about mother's vulnerability and persistent non-engagement. The HV was informed by the social worker that the CIN plan had closed during this conversation. Written confirmation was requested, but was not received by the health visitor until five months later.

5.3 A successful antenatal booking consultation at the hospital took place after the first antenatal appointment had been missed. A referral to the teenage clinic for subsequent care was made. The booking midwife also referred the case to the MASH for the attention of Children's Social Care (CSC).

5.4 MASH recommended support from the 'Families Matter' service, which was part of the Government grant funded Troubled Families programme[8], as it provided a range of Early Help family support interventions. However, 'Families Matter' closed the case immediately, as Miss A chose to decline the service and they could not proceed without consent. A referral for a child and family and pre-

[7] Universal plus offers a targeted response from the local health visiting service for families with additional needs. It is a threshold described in the 'Healthy Child Programme' 0-19 (Public Health England)

[8] The 'Sutton Families Matter' service provided a keyworker-led approach to whole-family support, offering coordination and targeted support to families with multiple problems. The service was commissioned in response to the Government 'Troubled Families' strategy and programme (2012).

birth assessment nearer the due date, was also suggested. Thresholds were not considered to have been met at that

5.5 A further referral was made by Miss A's mother directly into the MASH to request support. Family relationships were said to be under stress due to overcrowding in the home. This would worsen when the new baby arrived. An unannounced visit to the family took place as the family did not respond to initial telephone contacts by the social worker. The social worker reviewed the family's concerns and decided they were not a matter for CSC intervention as they only related to housing needs. The assessment concluded that the care of Sibling S was good. Checks were undertaken on Miss A's new partner, and they confirmed he was not known to CSC. It was noted that he offered good support and care to Sibling S. The case was subsequently closed.

5.6 Routine antenatal care was planned by the teenage pregnancy service after an appointment with the booking midwife. It was documented that Miss O had recently self-referred to the Sutton UPLIFT service[9] for support, due to low mood. This led to the decision to discuss Miss A at the monthly 'Vulnerable Women's Meeting' held by the hospital midwifery team.

5.7 The health visitor saw Sibling S and Miss A in a routine baby clinic setting and nothing of concern was observed. The HV suggested that the Early Parenting Pathway (EPP)[10] could provide useful additional support. A further home visit took place to arrange a meeting with the Community Nursery Nurse (CNN) who would deliver the EPP service, under the management of the health visitor. Subsequently, Miss A did not respond to three telephone invitations from the CNN.

5.8 Miss A missed Sibling S's planned health visitor assessment at the baby clinic and did not attend an audiology appointment. Two antenatal clinic appointments at the hospital were also missed. However, in the lead up to the birth, two successful home visits were made by the health visitor. The family were coping well but the HV noted that Miss A had still not consented to the EPP programme as a means of support following delivery.

5.9 Miss A was admitted in early labour and Child O was born prematurely by caesarean section at 36 weeks gestation. Mother and baby were routinely discharged on the following day. Following discharge from hospital, the community midwifery team, did not identify or report any concerns about the parenting ability of either parent. Concerns related only to persistent jaundice of the new-born, which necessitated frequent monitoring at home and at the hospital.

5.10 The health visitor undertook a routine new birth visit when Child O was 10 days old, but the case was not formally discharged by the community midwives into the sole care of the health visitor until Child O was two months of age, due to persistent jaundice. A professional handover did not occur between these two services at the point of transfer.

[9] Sutton 'UPLIFT' is an integrated primary care mental health service commissioned by Sutton CCG

[10] Sutton EPP is a community parenting programme delivered by health visitors and Nursery Nurses which offers co-ordinated and sustained support to young parents.

5.11 Four hospital appointments to follow up Child O's prolonged infant jaundice were reported to have been missed, although Miss A denies ever receiving them. The case remained closed to CSC as no further concerns were referred by other agencies.

6. The following months until the incident took place

6.1 The health visitor observed positive parenting from mother and father involving both of the children at the new birth visit. Miss A continued however to decline support via the EPP, stating she was already an experienced mother, and had good support from her family.

6.2 The health visitor saw Child O and Miss A at home on two occasions and once in clinic when he was accompanied by his grandmother. A further scheduled eight week development check by the health visitor at the baby clinic was missed, although the infant did attend the GP surgery for an eight week assessment and routine immunisations.

6.3 Child O was not seen again prior to the admission to the local hospital at 11 weeks old following his collapse at home.

7. Key questions and critical analysis

Child O is the subject of this review, however agency involvement was limited prior to the incident that triggered this review. To maximise the learning, the critique of practice has included a wider time frame than just the pregnancy, birth and care of Child O. It also looks at information pertaining to the pregnancy and care of Sibling S, as there was a considerable amount of agency input during this time that is entirely relevant to the care of Child O. Agencies involved at this time include Children's Social Care, hospital services, GP, Community health, CAMHS and STAR services.

7.1 What if any, was the impact of the family history, culture and circumstances?

7.1.1 Details in social care files noted that the family had links to the travelling community. Whilst the family were settled and living in a house at the time of this SCR, many of the vulnerabilities associated with this case are reflected in research relating to travelling and ex-travelling communities[11]. Studies have shown that the physical and mental health and wellbeing of travelling communities, including those who are living in houses, is generally poorer than that of other communities.

[11] Gypsy and traveller healthcare: Health equity, action and learning Fairhealth 2019

7.1.2 Researchers also found that discriminatory attitudes towards travellers' in the past, have caused travelling communities to be deeply suspicious of state intervention generally. This may result in poor engagement when services are offered.

7.1.3 Multi-agency awareness and joint working is an essential approach for overcoming any barriers to engagement for families from any minority group who might be suspicious of state intervention. This is to prevent negative outcomes and improve health and wellbeing[12].

7.1.4 The possibility of a cultural link did not seem to feature in the assessments of any practitioners participating in this review. This suggests a lack of cultural awareness, or lack of application of cultural awareness in the assessment process.

7.1.5 The review has also found evidence that Miss A was exposed to several adverse childhood experiences (ACEs)[13] in her early life, that probably influenced her risk taking behaviour and which contributed to the need for a Child Protection Plan at the age of 13. There is a body of research to support that such exposure is likely to have had a negative impact on her ability to engage, trust and interact with others, including with professionals that will endure into adulthood.

7.1.6 Miss A's relationship with her parents was described as a source of concern by some of the practitioners supporting the family, although there is contradictory evidence in some agency records that suggest the mother and daughter relationship was supportive. Historical notes from previous education and CAMHS interventions note that Miss A's parents struggled to moderate their daughter's complex behaviours and that the actual support Miss A received from her parents was both limited and at times inconsistent. Evidence also confirms that, due to work commitments, Miss A and her partner were left unsupervised for several hours at a time. The assumption therefore, that Miss A was well supported by her family was probably over optimistic.

7.1.7 Miss A's disengagement with, and refusal to go to school resulted in poor educational attainment, which placed her at an even greater disadvantage with regards to developing her own parenting capacity, style and ability.

Summary of learning: The review has concluded that indicators pertaining to family history, culture and circumstances, and especially exposure to ACEs were likely to have had a negative impact on Miss A's education, emotional well-being and ability to trust. This lack of trust might have extended to accepting professional help, thereby limiting the ability of practitioners to deliver early help successfully.

[12] 'You likes your way, we got our own way': Gypsies and travellers' views on infant feeding and health professional support. Louise J Gordon, Debra Salmon (2014). Health expectations:International Journal of Public Participation in Healthcare and Healthcare Policy.

[13] ACEs:Adverse Childhood Experiences are stressful events occurring in childhood:they can have a long-lasting impact on an individuals ability to think, learn and interact with others.

7.2 What, if any, were the consequences of the pattern of the non-engagement with services?

7.2.1 The FNP accepted the case when Miss A was pregnant with Sibling S as it perfectly fitted their profile for early structured support to young pregnant mothers. From the outset, Miss A expressed on several occasions that she was complying purely because she had to. This was due to a belief that her baby would be removed from her if she did not meet the conditions of the CiN plan. She was clear at meetings and home visits that she did not want to participate in the FNP structured activities, or any other intervention. This consistent reluctance to engage, interrupted and reduced the flow of the FNP programme and only very few of the FNP programmed activities were delivered.

7.2.2 The FNP service was subsequently decommissioned and was not available at the time of Child O's birth. Even so, Miss A continued to decline to engage with the replacement Early Parenting Programme (EPP) during the pregnancy for Child O, giving the reason that she was already an experienced mother receiving good support from her family. Support from the 'Families Matter' service was also declined following a referral to MASH early in her pregnancy with Child O.

7.2.3 The non-engagement with services resulted in missed opportunities to receive professional help to develop Miss A's parenting skills and capacity. It also reduced the opportunities for professionals to observe the family dynamics and lived experience of the children. Limited access therefore, affected the practitioners' ability to make well informed professional judgements about the parenting capabilities of Miss A and the health and welfare of Sibling S, which could have further informed the decision making for Child O.

7.2.4 STARS confirmed that Miss A's cognitive capacity[14] was behind others of her age. However, there was no recognition in case records of how her significant gaps in education, coupled with continuing mental health concerns might have impacted on her capacity to make decisions that were in her best interest. This raises questions as to how practitioners communicated information to promote engagement with the services on offer and whether explanations were appropriately tailored to her needs. Without such attention to detail it is possible that she did not fully understand why the interventions might be of benefit, which in turn would have influenced her decisions about participation.

7.2.5 Prior to Child O's delivery and following the MASH referral from Miss A's mother reporting tensions at home due to overcrowded housing conditions, an unfamiliar social worker attached to a new team in a new service structure, interviewed family members on three separate occasions. The proposed solution was that S.20 accommodation for Miss A, Sibling S and the new baby, could be arranged if suitable housing could not be found, the social worker also concluded that the housing concern did not warrant further work from children's social care.

[14] Cognitive capacity: The total amount of information the brain is capable of retaining at any particular moment.

7.2.6 The S20 accommodation suggestion was completely unacceptable to the family and appears to have resulted in the family disengaging from social care services altogether. The family confirmed, during their SCR interview, that the family had established a good working relationship with their previous social worker from the Joint Adolescent Service (JAS) with whom they had regular and frequent contact as part of the CiN plan until it was closed. The family sought no further advice and made no other contact with social care following the visit from the new social worker.

7.2.7 This raises issues about the change of social worker and the importance of continuity in practice to help complex young parents and families engage and remain engaged with services. A joint visit involving a housing officer, supported by JAS (now replaced by an Integrated Youth Service) might have enabled a more meaningful and trusting relationship, to facilitate and engage the family in a solution focused conversation about their housing options. There is no information that suggests a follow up conversation with either the housing department or the previous social work team took place.

7.2.8 This review has considered whether the risk factor of disguised compliance[15] was a feature in this case. Some practitioners believe it was, others do not. Records confirm that Miss A never hid the fact that she did not wish to engage with services and practitioners did not record concerns about disguised compliance when they had direct contact with the family. Similarly, the possibility of risk through disguised compliance does not appear in the safeguarding supervision notes for any practitioner. The definition of disguised compliance, does not easily translate to this case, but there certainly was evidence of deliberate avoidance and deflective strategies being employed by the family.

7.2.9 The SCR concludes that it is the recurring pattern of reluctant and inconsistent engagement, initially recorded in Miss A's school years and a constant concern until the serious injury of Child O, that posed the most significant risk to Miss A's children. The history of disengagement should have been considered within a Child in Need assessment framework, instead, the CiN plan was closed and subsequent referrals did not trigger further CSC activity.

Summary of learning: The pattern of non-engagement with services is a key theme for this review which resulted in Miss A not benefiting from available early help support. Findings suggest there is a need to use more effective approaches when trying to engage young people with complex needs, who through exposure to ACEs and trauma, might find compliance with care plans difficult or threatening. New approaches include restorative practice and trauma informed care, designed to build trust and resilience, for bringing about effective and sustainable change.

[15] '**Disguised compliance**' involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

7.3 Were the responses of individual agencies and the wider partnership sufficient, in respect of family support, multi-agency information sharing and multi-agency working?

7.3.1 In relation to past professional practice for managing Miss A's experience of Sexual exploitation (CSE) in 2013, the SCR panel acknowledged that it did not meet the standards expected today, although the decision to protect Miss A under the category of 'risk of CSE' in 2013 was entirely appropriate.

7.3.2 Prior to the Independent Inquiry into Organised Sibling Sexual Exploitation in Rotherham[16], (2014) that outlined systemic failures in multi-agency practice for managing CSE cases, not all professionals in Sutton were aware of their responsibilities for supporting sexually exploited children. A multi-agency CSE strategy was implemented in 2015 -18 which has led to improved systems and practices. As a result CSE cases are now reviewed through a Multi-Agency Child Exploitation Panel that is set up to review exploitation within a wider context.

7.3.3 Whilst teenage pregnancy per se is not a child protection risk, professionals consistently assessed Miss A to be a vulnerable young person. This was clearly a shared concern for education, health and social care professionals. However, there was insufficient multi-agency engagement to fully discuss Miss A's complex past and behaviours in the ongoing assessment and planning process. The decision to close the CiN plan was taken by Children's Social Care alone, rather than in a multi-agency CiN review meeting. The closure was not effectively communicated to partners, and was not uploaded onto the CSC recording system until eighteen months later. Evidence also confirms that social care professionals were not totally aware that the FNP had withdrawn their service due to lack of participation.

7.3.4 A repeating thread in this SCR, is that the past did not sufficiently inform the future in respect of a joined up multi-agency effort to determine the vulnerabilities and needs of Miss A and her baby. The wealth of complex historical information held within the partnership, particularly highlighting a pattern of disengagement, was not given enough weighting in the assessment process. Had a consistent multi-agency approach with frequent multi-agency information sharing had taken place, it is likely that a pre-birth assessment for Child O would have been undertaken.

7.3.5 Miss A was seen in the A and E department of the local hospital for an early pregnancy related problem when she was 17 and expecting Child O. She was seen by adult clinicians because routine transition to adult hospital services occurs at the age 16. Being seen as an adult commonly interrupts the flow of information in safeguarding cases for young people aged 16 and 17 years old and it has been identified as a problematic area for safeguarding practice for many years. Being unaware of relevant past history, together with unfamiliarity or a lack of knowledge and experience, as adult clinicians, in the field of safeguarding children practice compounds the situation. The A and E

[16] Independent Inquiry into Child Sexual Exploitation in Rotherham (August 2014) Alexis Jay OBE

attendance did not result in information being shared in a safeguarding context although this is by no means unusual. A discharge note summarising the early pregnancy consultation would have been sent to the GP as of routine.

7.3.6 In contrast however, the GP holds information on past history, and has close contact with the community health visitor. GPs are therefore key safeguarding professionals. There is no evidence of any proactive information sharing from the GP in relation to this case. Primary care practice systems must be able to process, code and alert the relevant clinicians and practitioners when vulnerable young people come to their attention. GP's must also be prepared to share information as well as receive it, when it pertains to young patients with complex needs.

7.3.7 Despite Miss A's complex history and recent CSC activity, it would be a full two months after the pregnancy was confirmed that the antenatal booking midwife informed social care that she was pregnant again. Evidence confirmed however that Miss A was seen by the EPU on two occasions as soon as she suspected she was pregnant for the third time. The explanation for the EPU staff not sharing information at the time Miss A presented was that they do not normally share information for very early pregnancies due to the high risk of miscarriage. It was also confirmed that CSC will not accept referrals from the EPU for young women before twelve weeks gestation. It is important that organisations and departments encourage information to be shared about vulnerable young people at the earliest opportunity.

7.3.8 There is little evidence of information sharing within and between health agencies. This was particularly relevant after the deliveries of Sibling S and Child O. Apart from the discharge planning meeting which took place one day following Sibling S's birth, there appears to have been minimal dialogue, if any, between midwives, health visitors and GPs for either child. The transition between health departments or one health service and another is known to be a risky time for children and young people. It is important therefore, that clinical pathways particularly from one service to another incorporate proper handover discussions and information sharing protocols.

Summary of learning: This SCR concludes that some partnership responses were insufficient in relation to multi-agency information sharing and multi-agency working. Insufficient attention was paid to past information, previous involvement and significant situational changes. Information from the wider partnership must be sought and considered by CSC, at the point of referral, during an assessment, and again at the point of case closure.
There is also important learning with regards to information sharing between health professionals and disciplines particularly at the point of transfer from one health service or department to another.
New information held on record should be shared promptly amongst relevant partners and written summaries should not be subject to delay.

7.4. What was the impact of the lack of engagement and inclusion of Child O's father?

7.4.1 Sibling S and Child O had different fathers and they were both relatively young. The first partner was aged 18 years during Miss A's pregnancy and when Sibling S was born. Sibling S' father remained involved for approximately six months until his relationship with Miss A failed and he left the household. The second partner was aged 16 throughout the pregnancy and when Child O was born. He was living in Miss A's family home during the pregnancy and remained there until the time that Child O was injured.

7.4.2 Miss A attended for all of her seven antenatal appointments when she was pregnant with Sibling S. Her 18 year old partner attended for five. However, little information is recorded about him in the maternity notes. After his delivery, there was an expressed intention in the CiN plan to gather more information about Sibling S's father. Despite this direction, he continued to be an unknown entity and remained invisible within the assessments of all the agencies involved.

7.4.3 There is no mention of the relationship breakdown or the arrival of a new partner in any of the agency records at the time that these significant changes occurred. None of the agencies participating in this review have been able to give an accurate account of why. This raises important questions about the role of fathers and the way that professionals incorporate them into assessment and care planning processes.

7.4.4 Miss A started the relationship with 16 year old man, within two months of her previous partner's departure. The new partner, Child O's father, had known Miss A for some time. Despite still being at school, he quickly moved into Miss A's family home. When interviewed, Child O's father explained that he wanted to help Miss A look after Sibling S. Evidence suggests that he did indeed have considerable contact with the infant, caring and playing with him when Miss A needed or wanted to rest.

7.4.5 Miss A's parent's and the young man's parent's accepted the young couple's decision to live together, despite the young man still being in full time education. The young man's parents' were concerned about the arrangement, but were unable to influence his decision. It appears that his attainment at school was suffering as a result. It would have been entirely appropriate and expected practice for the school to raise the adverse impact on his schooling with his parents before passing the matter to the safeguarding designated teacher for an onward discussion with CSC. However this did not happen.

7.4.6 Review of the evidence consistently shows that Child O's father seemed invisible to all of the practitioners involved with the family during the pregnancy and after the birth of Child O. It has not been possible to find any records that pertain to a meaningful conversation with this very young man in relation to pregnancy, childbirth and early parenthood. There was no inter-professional or multi-agency discussion about him to ascertain what his needs might be, despite practitioners knowing that he had a significant role as carer for both children, particularly Sibling S, and was a source of support for Miss A.

7.4.7 During an SCR interview, Child O's father spoke at length about being overwhelmed by the pregnancy, openly saying that he was not particularly

interested in, and rather fearful of small babies. After Child O's birth he recalled how he made a conscious decision and effort to stay out of the way of professionals, believing they would only be interested in mothers and children.

7.4.8 It is not unusual for fathers of any age to be apprehensive about becoming a parent, however, Child O's father was immature, by token of being an adolescent of 16 years. Having only just left school, he would have had a limited experience of taking on adult responsibilities, including caring for others. He was living away from his own parents during the antenatal period, and his main source of support was from Child O's mother. His fearfulness was both understandable and underestimated.

7.4.9 Scientific studies on brain development have confirmed that intellectual development is not complete until an individual has reached their early twenties. The impact of this immaturity creates specific challenges for young people in their teens particularly with regards to complex decision making, impulse control, and being able to consider multiple options and their consequences. A concentrated effort should have been made by all practitioners to prepare Child O's father for parenthood.

7.4.10 Recent national research has found that the lack of engagement of fathers is a common feature in cases of serious abuse and neglect[17] and research into the health visitor role specifically, has established that the non-engagement of fathers is the norm in the UK[18]. From 2014, NHSE health visiting specification documents have emphasised the engagement of fathers as an important feature of practice, but despite this direction, engagement of fathers and the quality of that engagement remains inadequate.

7.4.11 The reason why health visitors consistently miss the importance of engaging with fathers was the subject of another study that suggested the service defined itself according to a deeply embedded culture and long standing belief that health visiting is primarily a mother and child service[19].

7.4.12 This report noted that there is no specific training to prepare modern health visitors for working with fathers (or men in general) and there are few examples of policies and strategies for local health services to assess, meet and measure the needs of fathers. As in other parts of the country, creative solutions need to be found to change the culture of the health visiting service to prepare health visitors to work more productively with fathers and other significant males.

Summary of learning: The almost total lack of engagement with either of the fathers in this review, concludes that practice in this area must improve. Improvement is required in health and social care settings, with a particular emphasis on a change of culture in health visiting services, to ensure that the role of fathers in included in everyday health visiting practice.

[17] Pathways to Harm Pathways to Protection: Review of SCR's 2011-14 (2016) Dr P. Sidebotham Et Al University of Warwick & University of East Anglia.
[18] Why do UK health visitors not engage with fathers? (2016) Family Included, A project of The family Initiative, London
[19] Why Health visiting? DH Policy Research Programme (2014)

7.5 Was there sufficient staff supervision and management oversight of case work?

7.5.1 There were significant issues with the way that the allocated social worker interpreted Miss A's reaction to being exposed to a range of ACEs, including CSE. The social worker recorded that Miss A's behaviour, which was equally aggressive and dismissive, was due to being 'embarrassed by her risk taking past'. Furthermore the notes record that when she was distressed, it was a 'sign of maturity'. Research, however would suggest that the complexities of her behaviour were more likely to be an indication of unresolved trauma. Practice in Sutton has moved on considerably since those records were written. Sutton LSCP has developed and implemented a multi-agency safeguarding operational panel (MACE) for indicators of ACEs which is currently manged within a child exploitation risk assessment and planning framework.

7.5.2 Being more attuned to Miss A's behaviour and how it was influenced by past and present lived experiences, trauma and disadvantage, might have enabled a better contextual analysis of why she was reluctant or felt unable to accept help. A more compassionate and flexible approach to finding solutions which incorporate the child's own wishes, feelings and fears is likely to attract more participation, than a list of directions and instructions.

7.5.3 Trauma-informed care models,[20] now standard practice in the USA, are starting to be adopted in health and social care services throughout the country. Trauma informed practice enables practitioners to make sense of past history and behaviours enabling holistic care that is safer, more effective and more compassionate. Key to this model of care is listening to the child's voice, and exploring what it is they are trying to tell us.

7.5.4 Similarly, there were practice anomalies in respect of the CiN planning process. The approach to Miss A's CiN plan was to carry on regardless with the same actions and interventions, rather than to critically review and reflect on the effectiveness of those interventions in terms of positive outcomes and sustainable change. In particular the planning process never came to grips with issue of disengagement, and did not put forward any options to try to improve the level and quality of Miss A's participation.

7.5.5 The management oversight of the plan failed to critically review the information and rationale for the plan or challenge the issue of disengagement. Neither did management advice explore any alternative strategies to address Miss A's compliance issues. Miss A articulated on more than one occasion that she was complying with interventions only because she felt compelled to, stating she was fearful that Sibling S would be removed by CSC if she didn't comply. This caused her to resent the CiN plan and the professional activity that went with it.

[20] Trauma-Informed Care is a strengths-based framework grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological, and emotional safety for practitioners and service users, and which creates opportunities for service users to rebuild a sense of control and empowerment. (Hopper et al, 2010).

Under these circumstances positive change would be unlikely to occur. These issues were not recorded as significant in the management oversight notes.

7.5.6 The family described how the social worker seemed very close to Miss A, often giving her positive feedback and good reports. This begs the question as to whether this close and positive relationship influenced the decision to close the case. Over identification[21] with a service user can be the unconscious result of working with highly vulnerable and complex people. It can also be linked to the 'rule of optimism'[22] cited in many serious case reviews over several decades, and which blocks the unbiased scepticism that is necessary for social work practice.

7.5.7 High quality reflective, restorative supervision facilitated by trained supervisors is the place where professional relational issues can be tested. Supporting practitioners to reflect on their relationships with clients and what factors are influencing their actions, is an extremely important element of safeguarding practice. Children's Social Care has changed the mode of delivery to a restorative practice model, including group reflective supervision.

7.5.8 Safeguarding supervision was provided to health and social care practitioners involved with the family, although the nature and quality of the supervision delivered was difficult to determine. The supervision notes of the participating agencies were generally brief, descriptive and resulted in a list of management directions. The records did not demonstrate a depth of reflection or critical thinking to identify areas of risk, including those connected to the nature of the relationship. Neither was a clear rationale given for any practice changes. It is the quality, rather than the frequency of supervision therefore, that needs to be assured.

7.5.9 There is also learning in respect of the social worker's decision to close the case without multi-agency consultation, which was agreed in a management oversight meeting. The rationale, put forward by the social worker, was that Miss A had grown in confidence, her mental health was stable and she was parenting the infant well with help from her relatives. A multi-agency view might have provided a very different perspective.

7.5.10 The pre-birth assessment for Sibling S was also discussed in the management oversight meeting. It was described as positive, even though it did not specifically address the baby's needs and did not follow the required protocol. The conclusion of this SCR is that the management oversight did not apply sufficient scrutiny and challenge to the work undertaken for the pre-birth assessment or the assessment for Miss A and therefore the case was closed prematurely.

Summary of learning: Management oversight and supervision for health and social care agencies did not demonstrate best practice and did not facilitate

[21] Over-identification: a form of over protective or benign countertransference when the practitioner loses distance in the relationship and becomes overly engaged in the client's material. M. Shepherd University of Leicester

[22] Rule of Optimism: Belief that what a practitioner is seeing is progress and filtering out or minimizing areas of concern;

sufficient reflection, challenge and/or advice regarding the plan for Miss A and Sibling S.
Cases deemed to be at the threshold for CiN intervention, where early help is refused, require robust supervision, management advice and oversight to prevent 'case drift' and to facilitate lasting change through partnership working. The CiN plan was subject to appropriate management oversight at the point of closure, but the reasoning for closing the case, including why it was safe to close the case at that particular time, was not fully explained in the management oversight record. Subsequently, the decision to close the case was not communicated to the partnership effectively and was subject to delay.

7.6 What, if any, learning was there in respect of the quality of assessment, decision making and care planning?

7.6.1 The initial assessment following the referral when Miss A became pregnant for the second time was completed over a period of six weeks. It concluded that Miss A should receive support as a Child in Need (CiN), as defined in section 17 of the Children Act 1989. A pre-birth assessment for the unborn child (Sibling S) was also considered necessary, and was to be completed later in the pregnancy. Both these decisions were entirely appropriate. At this juncture, actual or likely significant harm had not been identified. It appeared that Miss A was prepared to cooperate and consented to CiN support.

7.6.2 Miss A and her mother in an interview for this SCR, clearly held their allocated social worker in high esteem. They recalled frequent visits and phone calls to see how they were getting on. This level of support showed a great deal of commitment to the family, however many of those contacts were not recorded in the social work assessment record.

7.6.3 As part of the CiN plan, the social worker referred Miss A to the FNP for ante and postnatal support. A health visitor was also allocated to Sibling S and the family. This multi-agency effort to deliver early help indicated a 'Team Around the Child' (TAC)[23] approach and this planning model is confirmed in the CSC notes. A TAC response became popular after the common assessment framework (CAF)[24] was introduced in 2005. It offered integrated and coordinated multi-agency support to children with complex needs, preventing agencies with families in common working in isolation from each other. A TAC approach was entirely appropriate for meeting Sibling S and Miss A's needs.

7.6.4 However, evidence from practitioners in touch with the family, including the FNP practitioners, reported in their interview that they were sometimes unclear about the status of the CiN response and their influence in the CiN planning process. On occasions partners were unsure if the CiN plan was still

[23] TAC is a model of multi-agency service provision, bringing together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family.
[24] The common assessment framework (CAF) 2005, is a standardised approach for the assessment of children and their families, to facilitate the early identification of additional needs and to promote a coordinated service response.

operational. They were not always invited to attend CiN review meetings and minutes from meetings were either not taken, not circulated or delayed.

7.6.5 To be effective, a lead professional is nominated to coordinate TAC actions, to provide clarity and continuity to professionals and service users. The CiN plan for Miss A was uncoordinated, seldom informed by partners and was organised through ad hoc, unminuted meetings. This did not constitute a TAC approach. In this case, the social worker assumed the lead role by default and the FNP and health visitor interventions remained distinct and separate.

7.6.6 There is no available explanation as to why the CIN planning process did not meet TAC expectations, other than a TAC approach can be difficult to implement. It requires considerable time and commitment from partners. This has been recognised and the strategic leadership for Early Help was transferred from the Children's Trust Board to the LSCP in 2018. There is now a dedicated Early Help subgroup to ensure compliance with statutory Working Together and other related guidance.

7.6.7 Low staff morale and staffing shortages were identified as a contributory factor which mostly relates to social work practice in 2013-2016. Since then, a service transformation programme has been implemented, resulting in a locality based restorative practice approach alongside a significant investment in targeted Early Help services for cases below the statutory intervention threshold.

Summary of learning: There is valuable learning for Children's Social Care about the effectiveness of the Early Help planning within a CiN assessment framework. CSC need to be mindful of practice standards for social work case recording, pre-birth assessments and non-statutory TAC interventions.
The CiN plan in this case included FNP intervention, however there is little evidence of shared responsibility, good inter-agency communication or practice coordination.
There is evidence that the social worker was able to engage with Miss A when others could not, but it appears that, over a relatively short period of time, the CiN plan became the sole remit of the social worker, planning in isolation, rather than with the partnership as a whole.
Plans for complex young people must involve the young person and be tailored to their specific needs. New borough approaches embrace trauma informed care and restorative practice as standard.

7.7. What, if any, learning was there in respect of adherence to individual agency and multi-agency policy, procedures and practice guidance?

7.7.1 Statutory agencies complied with statutory child protection requirements after Child O sustained his injuries. Prior to this, there is evidence that thresholds were applied correctly and according to the local threshold guidance for referral

and assessment. Appropriate follow up actions, to address identified needs took place, including allocation to the appropriate social work team.

7.7.2. A comprehensive written summary was provided at the point of case transfer from the Referral and Assessment Service to the local social worker who would be responsible for ongoing casework for Sibling S and Miss A. This followed Children's Social Care operational procedures and was good practice.

7.7.3 The CiN and pre-birth assessments for Sibling S however, were not consistent with best practice and the pre-birth assessment protocol for CSC was not followed. In addition, a record of the assessment was not uploaded onto the CSC electronic recording system within the timescale expected. It took a further 18 months for this to happen. The reason for the delay has not been fully explained but is likely to relate to organisational issues at this time.

7.7.4 Many studies have emphasised the increased risk to babies of abuse and neglect due to their frailty and total dependence[25] [26]. It is of the utmost importance that robust post-birth assessments are undertaken, particularly where vulnerable mothers have been identified, to enable the risks and needs for a baby to be predicted early.

7.7.5 The CiN plan did not provide clarity about goals or achievable outcomes and how actions were going to be delivered and evidenced as completed. Planning in this way requires a robust and sensitive discussion with the client as well as professionals to ensure clarity about what was being done and why, and clearly explaining the expectations for all of the individuals involved. This type of planning and review is not evidenced in health or social care records.

7.7.6 Reflecting on the case, practitioners agreed that not enough effort was made to talk to Miss A and Child O's father directly and alone. Some practitioners observed that there were always family members present when the couple were seen and Miss A's mother was often reported to answer questions directed to the young parents. This would not have facilitated the views of the young people themselves, or given professionals an insight into what was driving their behaviour from their point of view.

7.7.7 Over time, rather than communicating directly with Miss A and Child O's father, Miss A's mother became the principle point of contact and was frequently used by practitioners to deliver and pass on messages or report on progress. This was because it was thought that Miss A's mother would have more success influencing her daughter than the professionals working with the young parents themselves. There was little evidence that this assumption was true, but the practice continued. Previous education records suggested family support was limited and new information suggests the couple were frequently left unsupervised for many hours.

7.7.8 In addition, there is some evidence that practitioners took information, reported to have come from other professionals, at face value from Miss A's mother, rather than contacting the appropriate colleague to check out what had been

[25] A profile of suspected child abuse as a subgroup of major trauma patients: EMJ, Dec v32,12 (2015)
[26] All babies count: prevention and protection for vulnerable babies, NSPCC (2011)

said. Using relatives to coordinate activity or as a primary source of information is unreliable and 'professional to professional' feedback and discussion should be used as standard to ensure accuracy, continuity and co-ordinated care.

7.7.9 Young people must be seen alone and whilst including the family constitutes an important part of an assessment, it is essential that the child's voice is central to the planning decisions and arrangements made.

7.7.10 The review has found no evidence of any face to face interaction, formal handover or communication between health professionals, e.g. hospital and community midwives, health visitor and GP during the pregnancy and following the birth of Child O. This would have been expected practice considering the recent family history. It has been identified as an area of improvement for the hospital in their single agency report.

Summary of learning: The CSC pre-birth assessment process did not follow the CSC pre-birth protocol. Evidence also suggested that insufficient attention was paid to assessing the specific risks and needs of a new born baby, particularly in this case where Miss A was known to be vulnerable. Procedures were not always followed in relation to working with young people on their own rather than through their parents.
There is also considerable learning for all professionals about the importance of adhering to safeguarding policy and procedures and standards for record keeping and processing and sharing information. Established protocols and systems for robust inter-professional communication between community midwives, health visitors and GP's did not work well in this case.

8. Key themes and learning points

The learning points considered against the seven questions in the previous section have been organised into six themes as follows: 'quality of assessments', 'effective care planning', 'supervision and management oversight', 'consent and securing engagement', multi-agency partnership working and 'policy and procedures'. These are also addressed in the agencies own reports and action plans, see appendix C and the LSCP action plan, see appendix D.

8.1 THEME 1: QUALITY OF ASSESSMENTS

Learning Point 1: Using systematic analysis and recording techniques

- Health and social care are both assessment based services which determine the interventions that service users receive. It is an ongoing process and assessments should be reviewed and re-evaluated frequently to assess the quality and gauge progress, so that plans can be changed if outcomes are not achieved.

- The review found that the social care CiN assessment documentation was not consistent with best practice. This also applied to a pre-birth assessment for Sibling S, which failed to follow the Sutton pre-birth protocol. There were particular issues in respect of failing to record all contacts, minimal recording generally and delay in sending assessment summaries and information to partners.

- The CiN assessment was based on minimal information, often taken from family members rather than the wider professional partnership, plus the assessment did not differentiate or articulate clearly the separate needs and risks of the baby, Sibling S, and those of the young people who were his parents.

- Recorded health assessments were brief, mainly descriptive in nature, and vague about desirable outcomes and rationale for interventions. Community family health assessments should be holistic in style and be recorded in a systematic way that includes observations and descriptions, an analysis of the interaction, evidence based conclusions, and outcome focussed care plans.

- A multi-agency pre-birth assessment protocol with health and social care roles and responsibilities clearly set out alongside a process chart and practice guidance should be developed to ensure consistency of practice across the partnership.

Learning Point 2: Risk assessment

- The routine calculation of risk, using established risk assessment models did not inform the care plans for the young people and infants in this case. Incorporating robust risk assessment techniques into all assessment processes for complex cases, used by the partnership, will enable the necessary critical thinking for considering and articulating thresholds in terms of likelihood of significant harm, as well as merely evaluating the case in terms of the absence of significant harm.

- Pre-birth risk and/or perinatal risk assessments need to be distinct and separate from the wider family assessment process, so that the potential needs and risks to babies can be identified and don't become lost or secondary to the family assessment documentation. Health professionals must also be able to assess pre-birth risk effectively.

Learning Point 3: Incorporating family culture and context into assessments

- Health and social care assessments did not fully seek out and incorporate information pertaining to the family's history, culture and context. Whilst not always being immediately apparent, culture, context, especially linked to trauma and adverse childhood experiences (ACE), can have a profound effect on the behaviour and functioning of the individual who is subject of the assessment. Professional knowledge and understanding of this area must also inform the care plan, especially when there is resistance in accepting services.

- The effects of changes in the family's circumstances, for example, when a new partner appeared on the scene and when the housing situation became problematic, were not evaluated to assess the impact on Miss A and her children. Significant changes in circumstances must be fully explored as they are important factors when determining risk and need.

- Very little attention was paid to exploring the needs of Child O's parents when they came to police attention whilst out socialising. CSC might like to consider adopting a contextual safeguarding approach, specifically designed to assess the developmental needs of young people, as they explore relationships outside of their immediate family.

Learning Point 4: Improving the engagement with fathers

- Each agency should ensure that they have clear procedures in place for including fathers (or partners) in screening, assessment and planning processes. This includes undertaking necessary background checks.

8.2 THEME 2: EFFECTIVE CARE PLANNING

Learning Point 5: Planning to achieve outcomes

- Agency care plans did not clearly explain the outcomes that services were hoping to achieve for Miss A, her partner and the children. Plans for young adults should be tailored and mindful of their developmental and emotional wellbeing, particularly when ACEs have been part of their lived experience. Planned interventions should consider involving services that specialise in engaging and working with young people and/or young parents.

- It was noted that the immediate family were acting as facilitators for delivering the plan when professionals were unable to engage with mother. This requires further reflection to take into account who the plan was for and why engagement was difficult. Practitioners in all agencies need to ensure that the voice of the child and their own lived experience is fully taken into account in any assessment and planning process.

8.3 THEME 3: MANAGEMENT OVERSIGHT AND SUPERVISION

Learning Point 6: Case management and supervision in social care

- Case supervision in CSC was of insufficient quality. It did not appear to enable sufficient reflection, self-awareness and the critical thinking to ensure that decisions were objective and made in the best interests of the children concerned. Supervision notes were minimal.

- CSC management oversight did not apply sufficient scrutiny and challenge to test the social workers rationale for decisions, plans and recommendations. This was evident when the CiN plan was closed, within four months of Sibling S's birth despite anxiety being expressed in the partnership.

- At the point of closure, the social worker's rationale and decision to close could not be evaluated against a set of SMART care planning objectives. The decision was a subjective view of progress, which in hindsight was not entirely correct. Management oversight must test the rationale for closure to ensure sufficient change has occurred to meet the needs of the family. Such evaluation can only be drawn from a broad perspective, including the effectiveness of multi-agency interventions. Sign-off for closure should be based on robust multi-agency assurance that service users no longer need support. Adherence to standards of record keeping is an important part of the management oversight process.

Learning Point 7: Quality assurance of supervision for health providers

- The review of the supervision records of health visitors, FNP and social care professionals confirmed that systems were in place and practitioners sought and received safeguarding supervision regularly. However, the quality of the supervision requires improvement. Generally, supervision notes were minimal, managerial and directive in style, rather than reflective and restorative in nature. Supervision records should be thorough and auditable.

Learning Point 8: Safeguarding supervision for practitioners with case responsibilities

- Safeguarding supervision through reflection and analysis promotes a deeper understanding of what is driving decision making. An appropriately trained supervisor facilitates this through sensitive questioning and challenge, in addition to giving direction and practice advice. Concerns about over-optimism, disguised compliance or lack of curiosity can then be probed and tested, enabling safer outcomes for the child and practitioner alike. Good quality reflective, restorative supervision is essential for health and social care practitioners holding case responsibilities.

- Many practitioners closely involved with Miss A and her family did not receive regular safeguarding supervision, in particular the teenage pregnancy midwives and the GP. This is being addressed in the single agency action plans.

- Safeguarding supervision is not always routinely scheduled for staff groups who do not hold ongoing case responsibility for children and families, however some that were involved in this case might have benefited from one to one or group supervision to help them manage this complex case, for example, community midwives, housing officers and EPU staff.

8.4 THEME 4 - CONSENT AND SECURING MEANINGFUL ENGAGEMENT

Learning point 9: Consent and engagement at or below the Child in Need threshold

- Early help support requires the agreement of the parent as there are no statutory levers to secure co-operation. Declining service offers and the

consequences of withdrawing consent and refusing to participate severely limited the support that agencies could provide to Miss A.

- Obtaining informed consent is more than a passing formality: it requires a full understanding of what is on offer within a trusting relationship. Explanations should be in language service users understand, so that interventions are not perceived as a threat or an instruction over which they have no control. CSC did not act to allay Miss A's fear that her child would be removed if she didn't comply with the CiN plan. Engagement under duress is unlikely to be effective.

- Implied consent was obtained from Miss A by the FNP to deliver their programme. However, there is no particular reference or record about how consent was obtained. Given that Miss A's cognitive ability was assessed as poor, she might not have fully understood the nature of FNP interventions and why they might be of benefit. Despite being 16 years old at the time, adapting a standard NHS Gillick Competency assessment approach might have been helpful in this case.

8.5 THEME 5: MULTIAGENCY PARTNERSHIP WORKING

Learning Point 10: Information Sharing and Communication

- There is evidence that the decision to close the case on completion of the CiN plan was not communicated effectively to the partnership. A written summary to partners to confirm the closure was subject to a severe delay of several months. The family were also left waiting to know the outcome of the social workers discussion with the police, when Miss A and her partner came to their attention. Other instances of poor communication are also in evidence. CSC must ensure that prompt information sharing is central to practice.

- The hospital A and E department had good systems in place for notifying safeguarding concerns and making child protection referrals. Less robust was the system in the maternity department. The Early Pregnancy Unit, for example did not have a robust protocol in place for sharing information or making referrals about vulnerable young people under the age of 18.

- The maternity 'vulnerable women's meeting', part of the enhanced care package for vulnerable pregnant women, whilst a very good opportunity for sharing concerns, did not record, circulate or discuss the outcomes with partners. In addition, whilst there was a good example of a post-natal discharge meeting in the hospital before Sibling S went home, no such meeting took place to discuss the vulnerabilities of Child O at the point of discharge.

- Hospital to community midwife communication was generally insufficient, as was the midwifery to health visitor information exchange, with no evidence of ongoing verbal communication or formal hand-over processes. The hospital has identified the need to review and improve a range of information sharing systems and has a robust plan in place to do so. The lack of robust and effective communication systems created the conditions whereby health practitioners worked in isolation from each other.

- GP involvement was negligible throughout the timeline of this SCR. A GP practice is an important repository of information, receiving documentation from a range of agencies, however there was no proactive effort by the GP to gather or share information.

- The case was re-opened by CSC following closure under the 'three month rule'[27] after the young parents were notified to the police having been involved in some anti-social behaviour in October 2017. As it was judged that the threshold for further social work intervention had not been met, CSC responded by contacting the family direct rather than undertaking a face to face visit.

- This relates to the principle of the three month rule where re-referrals are responded to by the social worker previously known to the case. This is seen as positive in respect of preserving relationships, however there is a need to ensure that new information is checked out with partners and that there remains effective management oversight of the decision making. There was some communication between the police, social care and the family regarding this incident but the issue was not sufficiently shared or discussed with multi-agency partner.

- The management oversight during this period appears to have been limited which explains why the case was not closed for a period of time following this intervention. Assurance will be required that this has been addressed by CSC so that there is multi-agency involvement in the case closure of all cases that have been subject to a Child in Need Assessment.

- After Child O's pregnancy was referred by the hospital to CSC there were several failed attempts by the social worker to contact the family by telephone but a face to face meeting did not occur.

- A social worker did however interview family members after a subsequent concern about overcrowded housing was reported to the MASH, but there was no onward communication with partners or dialogue with the housing department.

8.6 THEME 6: POLICY AND PROCEDURES

Learning Point 11: Adhering to safeguarding protocols, policies and procedures

- Recommended practice to initiate a strategy discussion was not followed after an initial child protection conference was requested by a partner agency, early in Miss A's second pregnancy. Instead, the social worker discussed the request with the family. Assessing a child protection concern using information from the wider partnership is standard for deciding whether a child protection response might be required.

[27] Three month rule: Automatic re-opening of a case, when a child or children come to the notice of Childrens Social Care within three months of case closure.

- A CSC pre-birth assessment procedure was in place but was not used for assessing the needs of Sibling S prior to case closure and a written summary for partners was not promptly dispatched when the decision to close the case was made.

- The A and E department in the hospital demonstrated good adherence to the hospital procedure that followed up children who did not attend for hospital appointments. This procedure has been further enhanced recently to adopt the more accurate phrase 'was not brought' to emphasise that the responsibility lies entirely with the parent or carer.

- The GP surgery will need to improve their response when they become aware that a child is not being taken to appointments, and assurance is needed to evidence that there is a plan of action to do this.

9. Conclusion

Child O was 11 weeks old when he was injured, Sibling S was approximately 16 months. Miss A and her partner were also under 18 years of age when the incident happened, and are therefore of interest in this report. Information for this review has come from several sources, although acute and community health services played a significant role, as did professionals from Children's Social Care.

Professionals fully recognised that Miss A, as a complex and vulnerable young person and mother, would benefit from early help. She was therefore considered to meet the criteria and threshold for a statutory child in need response. Records show that a considerable amount of multi-agency resource and effort were directed to offering the family support when the Child in Need plan was in place.

Central to this review is the fact that Miss A repeatedly refused consent or actively disengaged with services. However, there was no evidence being seen or heard by practitioners involved with the family that constituted actual or significant harm. To all intents and purposes Miss A and her young partner were considered to be looking after both children adequately and the children appeared to be thriving.

The overarching learning for this review has focussed on the issue of how to engage young people, who, through previous trauma and adverse childhood experiences, simply do not wish to participate with statutory services. Many, practitioners realised that the lack of compliance was impeding their ability to deliver effective care but the pattern set by Miss A seemed impossible to change. Eventually, Ms A's parenting was considered by CSC to be 'good enough' for the case to be closed. After closure, further issues came to the attention of CSC, but the case was not reopened. Health agencies continued to deliver care to the family following case closure.

Several examples of good practice were identified in this review, and others were found to require improvement. Overall, the learning suggests a change of culture is needed in the way that professionals form their relationships with each other and with service users, using more modern approaches like trauma informed care and

restorative practice to enable meaningful engagement. The review also concluded that more thought needs to be given during assessment and care-planning processes to the impact on the service user of past lived experience, family culture and context. Robust management oversight and reflective, restorative supervision is also essential when delivering this type of care. There is also learning with regards to the significance of changes in circumstances as well as making sure partners and fathers are included in the assessment and care planning process. The last key feature of this review is to ensure that the needs and risks of new babies are given sufficient attention in their own right, particularly when their parents have hitherto, been the focus of multi-agency work.

The recommendations for the independent management reviews (IMR) have been written by the agencies participating in this SCR, to ensure that the weaknesses in their own safeguarding systems can be put right. The IMR recommendations are set out in Appendix C and those for the Sutton Local Safeguarding Children Partnership are set out in the table below. All recommendations will be subject to the robust independent scrutiny and assurance framework set out in the LSCP local arrangements.

10. Recommendations

The independent author recommendations are aligned to the key themes and learning points in this report, and included in the LSCP action plan in appendix D. The expectation is that each agency will take responsibility for undertaking service and system improvements where required.

RECOMMENDATIONS
1. To promote restorative safeguarding supervision practice for health professionals who are involved in the care planning of complex and vulnerable adolescents.
2. To ensure that restorative safeguarding supervision (RRS) is available for GPs, community health professionals, hospital staff and other health professionals involved in case work.
3. To provide information, advice and guidance for non-case holding professionals on what to do and who to turn to if they are worried about any of their cases.
4. To develop guidance on multi- agency pre-birth assessment to identify risk and clarify safety planning processes, to form part of the existing multi-agency perinatal and infant mental health protocol.

5. To review the CCG health assurance report against the learning points in this SCR to ensure compliance with section 11 requirements under the Children Act 2004.
6. To hold a series of learning seminars and develop a training module on the impact of Adverse Childhood Experiences (ACEs) and trauma. To include: a) the complexities of obtaining consent; b) trauma informed approaches for positive engagement with early help and statutory services. c) context, culture and past and present circumstances when planning interventions for children and young people.
7. To seek assurance that health and social care agencies have undertaken practice developments to increase their knowledge and understanding about the importance of including fathers; in the context of early interventions as well as safeguarding.
8. To seek assurance about multi-agency involvement in the case closure of all cases that have been subject to a Child in Need Assessment.

Appendix A - Methodology

Methodology

1.1 The period under review extends from 28th November 2016 until 5th October 2018, covering professional involvement until Child O was admitted to hospital following his collapse. Relevant information prior to those dates is also included in the report.

1.2 All relevant agencies involved with Child O were invited to be part of the SCR Panel and Individual Management Reviews (IMRs). SCR panel members have advised the author and provided clarification about events that were not immediately clear or which required technical or professional interpretation. Where necessary, further evidence has been provided, including copies of original notes and case files created by front line practitioners.

1.3 The Panel also set out that the independent review must clarify whether anything could have been done differently at either period to safeguard Child O and prevent the incident from occurring.

1.4 An experienced independent author with a senior national, regional and local health and safeguarding professional background was appointed by the Panel to undertake this review.

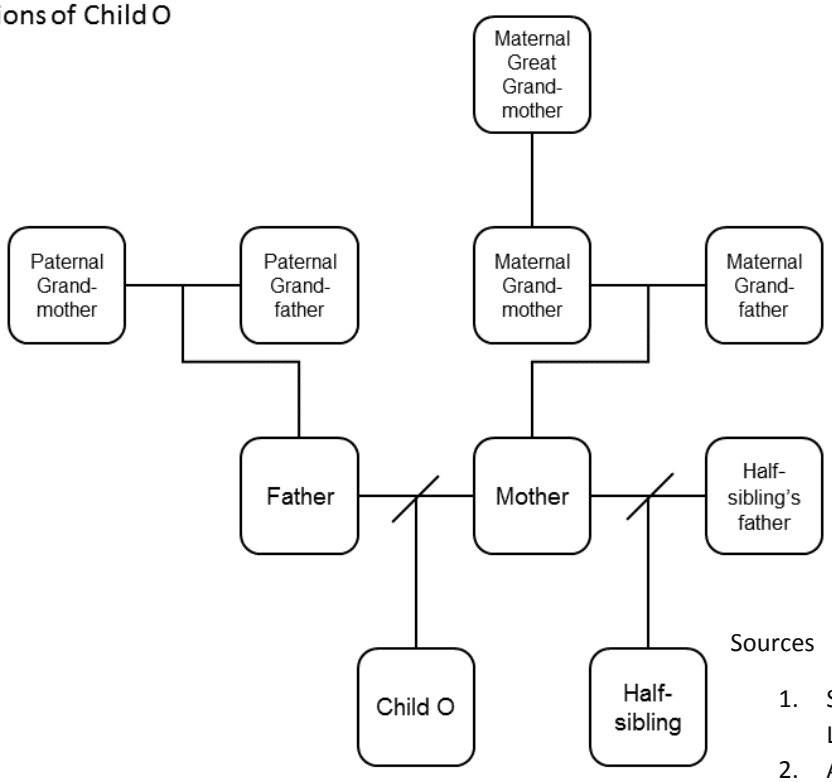
1.5 The initial case chronologies and single agency IMR reports were written by professionals who typically have specific safeguarding responsibilities within their organisation. The reports were based on a desk-top review of records and notes and the thoughts and recollections of practitioners involved with the family to help explain the rationale behind their actions.

1.6 The independent author and the safeguarding quality assurance manager for the local authority met with both of Child O's parents, the paternal grandfather and the maternal grandmother. The visits provided an insight into how the family regarded the care they received as service users. Where appropriate, views from the family were included in the analysis. The learning from this review will be shared with the family members who participated prior to the publication of the report.

1.7 The independent author reviewed all of the information submitted, concentrating on how professionals involved with the family worked individually and together to safeguard Sibling S and Child O. This was done in order to identify the strengths and weaknesses in the wider multi-agency safeguarding system, and to explore whether the single agency and inter-professional collaborative practice was effective in this case.

Appendix B Genogram (anonymised)

Genogram showing relations of Child O



Key	
/	Separated
—	Relation/ship

Sources

1. Spelling of names are taken from LB Sutton records
2. All information is drawn from LB case recording

Appendix C Summary of IMR recommendations

INDEPENDENT MANAGEMENT REVIEW (IMR) RECOMMENDATIONS	
Item	**Recommendations**
1	**Epsom St Helier Hospital**
1.1	That all key practitioners directly involved in the internal management review are debriefed and informed of the review findings.
1.2	That the Trust reviews its protocol on the management of enhanced care service to emphasise the importance of information sharing with other agencies (health visitor/ GP) and include written/verbal handover and Discharge Planning Meeting to include the Community Midwifery Team.
1.3	Review the Trust record keeping standards to incorporate robust information gathering on fathers.
1.4	Review the current record keeping standards to ensure: a) Community Midwives handover form from maternity ward is effectively completed; and b) Vulnerable Women's Forum is effectively monitored/meeting is minuted
1.5	The Trust reviews its Safeguarding Supervision policy to incorporate Teenage Pregnancy Midwives and dedicated supervision session is afforded to the team.
2	**GP Services**
2.1	That all key practitioners directly involved in the internal management review are debriefed and informed of the review findings (15/05/2019).
2.2	Development of was not brought Policy template for all GP practices to access.
2.3	Review practice record keeping standards to incorporate robust information gathering on fathers.
2.4	Review the GP/ health visitor safeguarding children forum to ensure robustness in partnership working.
2.5	Practices and primary care team review GP safeguarding supervision policy to ensure there is adequate support in place.
3	**Children's Social Care**
3.1	To improve Pre-birth assessment, planning and intervention.
3.2	To improve the engagement of fathers within assessment planning and intervention.
3.3	Improve consistency of accurate and timely record, including clear recording of the rationale for case closures.
3.4	To improve the practice skill set of front line staff in engaging with difficult to engage with families when they are distrusting of agencies and do not consent for further assessment / intervention.
3.5	Learning from this case to be shared with social care workforce.
4	**Sutton Health & Care (formerly Royal Marsden Community Services)**
4.1	The community services current annual supervision audit should be reviewed to ensure that all cases on the EPP programme are being brought to supervision and reviewed and that standardized tools are being used at designated contacts.
4.2	The community annual record keeping audit needs to be reviewed to include analysis of language used to record caregiving observations, if CIN minutes and plans are held/recorded on the clinical system and that supervision is recorded in a timely way.
4.3	The community Child protection and safeguarding children policy to be reviewed and incorporate detail about disguised compliance (linked to the NSPCC factsheet and learning from SCR's) and advice on use of chronologies by staff when disguised compliance is suspected and supervision sought.

4.4	The Sutton Health and Care Alliance organisation to consider specific training on trauma informed practice for practitioners working with young people and young parents.
5	**South West London and St Georges Mental Health NHS Trust**
5.1	Training around CSE (Child Sexual Exploitation) has already been improved, and plans are in place to improve it further.

Appendix D – Sutton LSCP Action plan to implement recommendations

CHILD O – LSCP ACTION PLAN

Sutton LSCP
Local Safeguarding Children Partnership

RECOMMENDATION	RATIONALE	ACTION	LEAD	BY WHEN	INTENDED IMPACT
1. To promote restorative safeguarding supervision practice for health professionals who are involved in the care planning of complex and vulnerable adolescents.	Restorative supervision is being embedded within children's social care. It is a recognised model of practice for improving and repairing relationships in a wide range of settings.	To utilise promotional material on restorative practice developed by the Local Authority and disseminate and promote within health settings	Sutton CCG Sutton Health and Social Care Epsom and St Helier University NHS hospital Trust	November 2020	A consistent approach to safeguarding supervision across the partnership.
2. To provide information, advice and guidance for non-case holding professionals on what to do and who to turn to if they are worried about any of their cases.	Improved partnership support to non-case holding professionals involved in case work,	2.1 To develop Children First Contact Service to extend information and advice at an early stage. 2.2 To improve and promote online information, advice and guidance to professional and families.	Sutton LSCP	March 2020	Improved professional support to respond to additional support needs early.
3. To develop guidance on multi- agency pre-birth assessment to identify risk and clarify safety planning	Improved partnership responses to pre-birth concerns.	To add guidance to the multi-agency perinatal and infant mental health protocol.	Sutton CCG	December 2020	Improved pre-birth early help and safeguarding responses.

processes, to form part of the existing multi-agency perinatal and infant mental health protocol.					
4. To review the Sutton CCG health assurance report against the learning points in this SCR to ensure compliance with section 11 requirements under the Children Act 2004.	To strengthen health assurance reporting to the LSCP.	To update the existing Sutton CCG health assurance report as required for scrutiny by the partnership.	Sutton CCG	April 2020	Strengthened practice by health providers.
5. To hold a series of learning seminars and develop a training module on the impact of Adverse Childhood Experiences (ACEs) and trauma. To include: a) the complexities of obtaining consent; b) trauma informed approaches for positive engagement with early help services. c) context, culture and past and present circumstances when planning interventions for children and young people.	To provide professional development support across the children's health and social care workforce in Sutton.	a) To seek assurance on how agencies and schools are supporting trauma informed responses in their work. b) To commission evidence based assessment training for children's social care.	Sutton LSCP	July 2020	Improved practice approaches to respond to vulnerable adolescents.
6. To seek assurance that health and social care agencies have undertaken practice developments to	To evidence learning from this SCR.	6.1 Each agency to provide assurance through a summary report that demonstrates	Sutton LSCP	March 2021	Evidence of improved practice.

	increase their knowledge and understanding about the importance of including fathers; in the context of early intervention as well as safeguarding.		improvement in working with fathers.			
7.	To seek assurance about multi-agency involvement in the case closure of all cases that have been subject to a Child in Need Assessment.	To improve case management system to achieve best practice.	7.1 To undertake actions to strengthen social work supervision and management oversight of case closures. 7.2 To provide assurance to the LSCP of improved social work supervision and case management oversight. 7.3 Practice Directive to be issued to reinforce good practice related to case closure.	Children's Social Care	March 2020	Improved case management and management oversight.