Serious Case Review
Child U

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Serious Case Review Report[1]
Regarding a child to be known as Child U

1. Introduction

1.1.1 The Swindon Safeguarding Children Board (SSCB) agreed to undertake a Serious Case Review (SCR) in respect of a child to be known as Child U in January 2018. They recognised the potential that lessons could be learned from this case about the way that agencies work together to safeguard children in Swindon[2].

1.1.2 Child U was a year old when he died. The cause of death was recorded by the Coroner at Inquest to be Unascertained (Sudden Unexpected Death in Childhood). He lived with both his parents and an older sibling.

2. Methodology[3]

2.1.1 An independent lead reviewer[4] was appointed to undertake the review. They had access to the key single and multi-agency documents in the case and met with practitioners involved with the family in a number of reflective sessions where the case was discussed. The pre-disposing risks and vulnerabilities[5] that were known at the time were considered in order to understand the case. This was followed by consideration of the preventative and protective actions taken, in order to understand the interventions.

2.1.2 The agencies that had involvement were asked to reflect on the agency specific learning and their conclusions and any improvement actions to be undertaken will be monitored by the LSCB.

2.1.3 The lead reviewer and a representative of the SSCB visited Child U's parents to discuss the SCR and asked them to reflect on the work undertaken with the family during the timeframe of this review. Their views are included in this report. Both parents will be visited again, to be informed of the conclusions of the review and the SSCB's response, prior to publication[6].

2.1.4 Drafts of this report were shared with those involved as well as with the SSCB SCR sub-group to ensure collaboration and ownership. The recommendations were written by the lead reviewer along with the SCR sub-group.

2.1.5 An older sibling of Child U was appropriately safeguarded following Child U's death. They are the subject of care proceedings, and living with extended family members prior to the final hearing. A criminal investigation was undertaken, with a decision that no further action was to be taken in respect of Child U's death, as the cause of death was unascertained and recorded as Sudden Unexplained Death in Childhood.

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[1] This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the SSCB. The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

[2] It was agreed the SCR would consider the professional involvement with Child U and his family from the birth of his older sibling in August 2015.

[3] The Government guidance Working Together 2015 states that SCRs should be conducted in a way that;

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

This review has achieved these objectives. Consideration has been given to whether it is necessary to 'identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice'. The review has also clearly identified 'what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result'.[3]

[4] Nicki Pettitt is entirely independent of the SSCB and its partner agencies and is an experienced chair and author of serious case reviews and safeguarding adult reviews.

[5] Triennial Analysis of Serious Case Reviews 2016, Sidebotham, Brandon et al, Department of Education

[6] It is anticipated that this report will be published in full, and it contains only the information that is relevant to the learning established during this review.

3. The Case

3.1.1 For the purpose of this report, the following family members are relevant:

Family member:	To be called:
Mother of Child U	Mother
Father of Child U	Father
Older Sibling	Sibling
Other family members will be referred to by their relationship to Child U, for example, Maternal Grandmother.	

3.1.2 Intensive and targeted support was provided to the family by the Family Nurse Partnership[7], the Family Service[8], supported temporary housing provision, and on occasion Children's Social Care (CSC).

3.1.3 There is evidence that Father had a difficult childhood, with agencies having concerns about neglect, sexual and emotional abuse. He attended a pupil referral unit after being permanently excluded from mainstream schooling, for behavioural reasons. Mother had a more stable upbringing, but was known to education welfare due to poor school attendance from her secondary school. She also attended sessions at TAMHS (Targeted Mental Health Service), and had 1:1 youth service engagement. She told professionals at the time that this was due to depression and anger issues, but told the lead reviewer she was not depressed, rather that she had anxiety issues.

3.1.4 The parents were teenagers when Mother first became pregnant. Sibling was 15 months old when Child U was born.

3.1.5 In November 2017 Father called 999 and stated that one-year-old Child U was unresponsive in his cot. Both parents were at home with Child U and Sibling, and stated that they had put him to bed at approximately 8 pm the night before. It was not until 12.45 pm the following day, around 17 hours later that he was checked-on by Father and would not wake up. Child U was dead when the ambulance service arrived.

3.1.6 Neglect concerns had been shared by those involved at the time, and both children had delayed development. There was also professional involvement when Child U had a bruise on his face in September 2017, and when he had an episode in October 2017 where he was described by Father as floppy, vomiting, choking and unwell, requiring hospital admission for three days.

4. Analysis

4.1.1 To analyse the interventions with the family, consideration has firstly been given to the predisposing vulnerabilities and risks in the case that were known or knowable to professionals involved at the time. This is followed by an analysis of the preventative and protective actions taken by the agencies involved.

[7] The Family Nurse Partnership (FNP) works with parents aged 19 and under in the area, partnering them with a specially trained family nurse who visits them regularly, from early pregnancy until their child is two. By focusing on their strengths, FNP enables young parents to: Develop good relationships with and understand the needs of their child; Make choices that will give their child the best possible start in life; Believe in themselves and their ability to succeed; Mirror the positive relationship they have with their family nurse with others. (Taken from the FNP website.) The FNP is a licensed programme supported by a national unit, commissioned by the Department of Health and Public Health England.

[8] The Family Service is a tier 2 (Early Help) service who work with vulnerable children, young people and their families in Swindon. The service aims are prevention of children entering the care system, de-escalation of family difficulties, which may include issues around debt, substance misuse and domestic abuse, helping to improve family relationships and routines, supporting access to work and training, and ensuring that families are more resilient.

Predisposing vulnerabilities:
Child U had been born prematurely and spent time in the special care baby unit (SCBU).
Child U and his sibling were entirely dependent on the care provided by the adult/s responsible for them.
The family had 2 children aged less than 16 months at the time of Child U's birth.
Both parents were 18 years old when Mother fell pregnant with Sibling.
Parents had financial concerns and were in debt.
Being homeless at the time of the pregnancy with Sibling, the couple were placed into supported temporary housing. They were re-housed together just prior to the birth. While living in the supported temporary housing they had weekly support sessions with staff, including budgeting and home care skills.
Partner agencies have evidence that domestic abuse featured in Father's childhood. Mother told the family nurse from the FNP that her mother (Maternal Grandmother) had been a victim of domestic abuse from her birth father.
The relationship between Father and Maternal Grandparents[9] was reportedly 'strained' at the time.
Mother reported a number of health concerns during both pregnancies and was considered 'anxious' by the professionals working with her. The family nurse was aware that Mother was often 'low', and said that Mother had reported being seen at TAMHS (Targeted Mental Health Service) when she was a child due to feeling angry and depressed. The family nurse completed a number of anxiety and depressions questionnaires and Mother saw her GP but refused medication. The family nurse contacted Child U's GP to inform them of her involvement. Mother told the lead reviewer she has never suffered with depression.
Father had been referred to the NSPCC when he was 12 years old, after allegedly being sexually abused. There were concerns about sexual boundaries and sexualised behaviour[10] within his family home. He only attended two sessions, so the assessment was incomplete and no therapeutic work was possible. Father's allocated social worker at the time contacted the NSPCC to confirm that his mother had withdrawn consent and Father would no longer be attending further sessions.
Neither parent had attained at school. Mother did not work and Father was mostly employed in temporary unskilled jobs. The casual nature of the work had an impact on the family's benefits, which contributed to the financial concerns throughout the period being considered by the review.

4.1.2 It is recognised that the adults predisposing vulnerabilities may pose a predisposing risk to the child. The following additional risks have been identified:

The risks in the case:
There were two possible domestic abuse incidents known to the police. When routine enquiries were undertaken by the midwife during Mother's pregnancies, Mother stated that Father was not domestically abusive, but admitted they had arguments. However she did tell the Family Nurse that he could be controlling and emotionally abusive.
During a social work assessment completed by CSC in August 2015, Father stated he would be uncomfortable bathing and changing Sibling. Those involved believed that this would be explored further as part of the Child in Need plan that was recommended following the assessment, to include an exploration of Father's childhood abuse and any risk he may pose to the child. While the social

[9] The Maternal Grandparents in this case were Mother's mother and her husband (Mother's step-father.)

[10] Including Father exposing himself to an older sister and her friend.

worker met individually with Father, there was no detailed consideration of the risk. It was recorded on the case record that it had been agreed with Father that he would not undertake any task he did not feel comfortable doing. Father told the lead reviewer that he had hoped to receive support and advice with this issue, but that it was never referred to again by any professional and he had to 'get over it'.
Father had a very poor diet and was said to drink fizzy drinks excessively and to eat expensive and unhealthy take away food on a daily basis. There was a concern he prioritised his own needs over the children's. The family were provided with a cooker but they did not prioritise finding the money to get it connected.
The condition of the home was often stated to be unacceptable. However there was some debate between professionals involved in the SCR about just how dirty and cluttered the home actually was. It appears it fluctuated, with the communal areas outside the home consistently dirty and cluttered. The children were often described as looking unkempt, as were the parent's themselves on occasion.
CSC undertook an assessment before Sibling was born and considered if there was any risk posed by Father's family. It was identified that while they may be a risk, Father had no regular on-going relationship with them and that they would have no contact with the child.
It appeared that Mother may have had issues when bonding with Child U. Parents reported that Father looked after Child U and Mother looked after Sibling. Professionals noted that Mother would not respond when Child U was distressed, and she expected Father to meet his needs.
Mother was pregnant with her third child at the time of Child U's death. She was described by those involved as tired and unwell with the pregnancy.
Parents seemed unable to maintain improvements in the home or to consistently follow advice about playing with the children. This may be because Father was often depressed. It is noted that during the care proceedings on Sibling, it was identified that Mother has a degree of learning difficulties. This was not known at the time. Those who knew her well stated that looking back they can see this, but that it wasn't obvious at the time. Mother would often speak about the child care course she had attended at college, and described herself as doing well at school. She said the same to the lead reviewer.

4.1.3 There was some evidence of protective actions from the family when considering the case:

Protective actions – family
Father was committed to ensuring the children had no contact with his mother and extended family.
Mother had good attendance at the numerous appointments she had to attend when she was pregnant. She also sought additional advice from the midwife between appointments if she needed to be reassured about a concern.
Father in particular was keen to engage with sessions provided by the family nurse and the family service worker. He said he had not learned how to play when he was a child, and was keen to learn. He would get down on the floor and play with Sibling when prompted. Mother was less willing to engage.
Father had a number of jobs over the period being considered, in an attempt to support his family. The irregular nature of his employment however had an impact on benefits and this led to rent arrears and the need to borrow money. Father was not always honest about the level of his debt.
Mother and the children received some support from the maternal grandparents and great-grandparents, who lived locally. The grandparents worked however. They did not like or approve of Father so most of the contact with Mother and the children was at the grandparent's home. The family nurse had met Maternal Grandmother and knew she had concerns about the children, the state of the home, and Mother's relationship with Father. The family nurse included these concerns in a referral to CSC.

An anonymous referral was made by a 'friend' when Child U had a 'bruise' on his face two months before he died.

4.1.4 Both preventative and protective actions were taken by the agencies involved. They were:

Protective and preventative actions – agencies	
The family were provided with council housing after Sibling's birth. The agencies involved provided support with furniture and equipment including making applications for grants and charity payments.	
Mother received consultant care during her pregnancies because of risks associated with her low BMI[11]	
Mother had timely involvement from the FNP prior to Sibling's birth[12]. The support they received was intensive, and the family nurse provided a higher level of contact and support than the programme generally offers. She knew the family well and had a consistent relationship with them for over two years. She provided 1:1 sessions with Father as well as Mother. The family spoke highly of the support they received from the family nurse, and said they wished she could have visited more.	
Referrals made to the MASH/FCP[13] requesting the involvement of CSC:	**CSC response/involvement:**
December 2014 by a homelessness officer when Mother was pregnant and homeless.	December 2014 case received a housing needs response.
June 2015 by the family nurse due to Father's history of sexually inappropriate behaviour, her observations of his overly sexualised behaviour and language, and concerns about Mother being fearful of Father's extended family.	June – August 2015. Decision was made that unborn Sibling be subject of a child in need (ChiN) plan.
October 2015 by the supported housing coordinator requesting case be stepped up from ChiN[14] to child protection.	October 2015. Assessment completed by CSC and decision that Sibling remains subject to a ChiN plan. It is noted that the case was then closed in December 2015 with a recommendation that an early help plan was recommenced (following supervision of the social worker where the concerns were stated to be 'low level').
June 2016 by the family nurse due to sibling's developmental delay, inconsistent parenting, Mother's disclosed emotional abuse from Father, and general neglect concerns.	June 2016 MASH gathered information following referral from family nurse and decision made to take no further action. The referral had been written in a positive way that did not focus on the impact on the child.
October 2016 family nurse referred to FCP that concerns had been shared by ambulance service when Mother had gone into hospital to give birth to Child U about the state of the home and the presentation of Sibling. The family nurse reiterated that previous concerns remained and that there had been no progress despite 12	October 2016, opened for a social work assessment. This involved a number of visits including a joint visit with the family nurse. No further action was taken by CSC who closed the case in December 2016. It is noted that the assessment was not multi-agency and did not include a health assessment of Sibling although

[11] BMI – body mass index

[12] This was an automatic notification. The FNP are alerted when any family meet the criteria. This includes a pregnancy at 18 or under with a first child and not in education or employment. Parental consent to the work is required. Older parents are considered on a case by case basis if there are additional needs.

[13] Family Contact Point

[14] Child in Need

months of intensive support from the FNP.	neglect and developmental delay was a concern.
Midwife requested information in November 2016 to enquire if the case was open to a social worker and enquire if there were any safeguarding concerns.	Information shared that case closed.
February 2017, both the family nurse and housing officer referred as the family were in rent arrears and facing eviction.	February 2017, following concerns about the risk of the family being evicted, the MASH agreed that the Family Service should become involved.
September 2017 an anonymous referral was received by the MASH stating that Child U had a 'large bruise' to his face, caused by falling from his cot. They also shared neglect concerns.	September 2017. A social worker from the Assessment and Child Protection Team visited, responding to the anonymous referral that Child U had a large bruise to his face. Child U was seen, and the bruise was noted to be a small bruise or perhaps a carpet burn. Father's explanation that Child U had climbed out of the cot and fallen was accepted. (See additional analysis at 4.1.28)
October 2017 a referral to the MASH from the ambulance service. They had taken Child U to hospital as Father had called to state Child U had been unresponsive and needed resuscitation (CPR) by Father. They stated concerns about the home conditions and Child U's weight. The hospital also had concerns about his delayed development and poor maternal interaction with him.	As the case had remained open from the visit above (although it was not being actively worked and should have been closed) the social worker attended a discharge planning meeting for Child U's stay in hospital. Early Help continued to be the plan, with input from a dietician and community paediatrics to monitor his development. (See additional analysis at 4.1.28)
No further referral was made until after Child U's death. During October 2017 the health visitor (who had taken on the children from the family nurse following the end of the FNP involvement in July 2017) and the family worker had considered a referral to the MASH due to the family becoming more difficult to engage and deteriorating home conditions. They decided however that it was unlikely to meet the threshold.	
Following his premature birth, Child U spent time in the special care baby unit. His parents visited most days, and the maternal grandparents visited on occasion, bringing Sibling. Child U's discharge was put back by two days following both parents reporting sickness bugs. Before his discharge the parents were given shaken baby information and watched a video.	
Nursery nurses attached to the SCBU undertook three home visits following discharge to provide initial support post discharge. Three different nursery nurses were involved, which potentially did not provide consistency for the family, and on the third occasion the family were not home. On the two visits undertaken the baby was said to be fine, but the house was recorded to be dirty and messy, the red book was missing, and Sibling had a very dirty nappy. It was recorded that Mother did not seem interested in changing the nappy, and that Father was asleep. The information was shared with the family nurse, but not with CSC or the social worker who had attended the discharge planning meeting after Child U's birth, and no safeguarding supervision was sought.	
The family service planned to provide extensive support from April 2017, to include assistance with debt management and promoting positive interactions with the children. The family proved difficult to engage initially, but they were then seen approximately weekly. The family service worker remained	

involved following the completion of the FNP involvement[15], and took over as the lead professional for the early help plan. Concerns remained about the development of both children, poor budgeting and money management, and fluctuating home conditions. They were still involved at the time that Child U died.
There was a consistent midwife involved with the family throughout the pregnancies. Mother engaged with maternity services, including attending additional ultrasound growth scans and consultant obstetric care.
Single agency learning has been identified about the visiting pattern of the health visitor following handover of the family from the FNP. A gap of three months was evident, and it has been acknowledged that this was too long in a family where there were health and development needs.
Child U (and Sibling) were the subject of both Early Help and ChiN plans. The former because of the involvement of the FNP and the concerns that emerged. This was even though the FNP nurse was the only professional involved much of the time. When the family service became involved and the worker became the lead professional, TAC meetings were held. The last TAC meeting was in October 2017 which included the parents, the family service worker and the health visitor. When a social worker was involved in 2015, Sibling was on a ChiN plan and there were regular ChiN meetings where the plan was reviewed. The focus was on the state of the home, budgeting and nutrition. It is noted that the ChiN Plan reads like a child protection plan, as it involved the parents signing a written agreement and included unannounced visits. The CSC learning from this case has identified this as an issue.
A discharge planning meeting was held at the hospital prior to Child U's discharge in October 2017. The focus of the meeting was on concerns about Child U's developmental delay and how thin he was. It was noted that a referral was made to the community paediatrician to assess Child U's development and that a dietician was to review him before discharge and then see him in 4-6 weeks. The health visitor shared concerns about Mother's limited interactions with Child U. The health visitor offered nursery nurse involvement to help with stimulation and development. There was also to be regular input from the family support worker. (See 4.1.20 onwards below). There was some confusion at the start of the meeting from the social worker who would not chair the meeting or take minutes, as would be expected if it were a safeguarding discharge meeting. As a result the consultant chaired and this could be why the meeting took on a more clinical perspective. It is not clear what the status of the meeting was and those present were not entirely clear if it was a safeguarding or regular discharge planning meeting.
A nursery place was provided for Sibling from September 2017. Attendance was good and Sibling was said to enjoy her time there.

4.1.5 The review has established that the following areas require further analysis and provide us with the learning in this matter:

- **Child's lived experience**
- **Unknown sexual abuse risk**
- **Neglect**
- **Incidents in September and October 2017**

Each theme is considered here.

<u>Child's lived experience</u>

4.1.6 Child U and his sibling had professional involvement throughout their lives. The family nurse, the health visitor and the family service worker provided support to the parents and saw the children regularly. The midwife was involved for some of the time being considered as part of the routine antenatal & postnatal pathway. The children were described by those who knew them as small for

[15] The FNP work with a family until the first child's second birthday.

their ages, but keen to smile at and engage with professionals. Sibling loved playing with the toys that were bought by the family nurse and family service worker, especially playing at tea parties and picnics. There were age appropriate toys in the home, including a dolls house. Father responded better than Mother to professional advice about playing with the children down on their level. Child U was often left in his bouncy chair and the parents were regularly reminded to take him out. They stated he did not like lying on his tummy, yet when it was tried by the professionals he was fine.

4.1.7 Despite being pre-verbal, the children gave clear information to professionals that showed they were not thriving in their home as it was. Their developmental delay, their low weight, their dirty nappies, concerns about Mother's poor relationship with Child U, and reports that Sibling was hitting her Mother were indicators that their needs were not being met. It is also noted that neither cried much. Observing the child's interactions with those caring for them is a clear way of hearing the child's voice, and in this case Mother's lack of responses to Child U could mean he was unlikely to feel loved or cared for by his Mother. The Swindon LSCB neglect guidance asks that professionals describe a day in the child's life, and to put themselves in the child's shoes. This is good practice and should be undertaken in all cases where neglect and poor parenting are an issue. Those involved did not use the guidance at the time or on this case, but were clear that this is something they are now doing, and that they could see the value of. The family nurse wrote the early help plan in Sibling's voice. It included 'Mummy, I need regular meals' and 'I want to play and talk to you'.

4.1.8 Findings from SCRs specifically about the voice of the child were identified and amalgamated in a 2010 report from OFSTED[16]. It found that in too many cases practitioners focused 'too much on the needs of the parents, especially vulnerable parents, and overlooked the implications for the child'. In this case there were concerns about the age of the parents, the amount of debt they were in, the level of support they required to maintain their home, and the impact on Mother of her consecutive pregnancies. Professionals did focus on the need for parents to play with the children, to get down on their level and to have eye contact with them, which was reinforced to Mother and Father on a regular basis. The OFSTED report concluded that 'professionals must use direct observation of babies and young children by a range of people and make sense of these observations in relation to risk factors'. In this case there were concerns about the children and the parent's response to the issues, and to a certain extent they were seen through the eyes of the child. However much of the work focused on whether the parents were doing as they were told, rather than whether the children's need could be met by them maintaining progress without professional oversight. The referral made in June 2016 by the family nurse was detailed, but focused on the parents, including a focus on their strengths, and did not provide detail of the risk to the children or clearly state that their needs were not being met consistently. The clinical approach underpinning the work of the FNP nurse in this case was strengths-based, and focused on the mother (or parents as in this case). This is a proven and beneficial model, however when concerns emerge there needs to be a focus on the child and an understanding that meeting the threshold for a social work and/or child protection response involves using terminology which might be different to the ethos of the FNP model, as deficits need to be clearly stated.

4.1.9 Those involved had to constantly remind the parents about what to do, and felt that without their involvement, it would not happen. They also wondered if the attempts by parents during visits to play with the children was for show, and they now question if the parents maintained any progress when alone with the children. The children's delayed development was a clear indicator that the children were not being stimulated as expected and requested. Consideration also needed to be given to what sense Child U would make of his Mother rarely caring for him while spending all her time with his Sibling (and vice versa for Sibling.) With a third child on the way there was a need to review how the family would manage.

4.1.10 A focus on thresholds dominated, including whether the state of the house, the degree of delay, concerns about the parents relationship and limited engagement with the children, met a

[16] The voice of the child: learning lessons from serious case reviews. OFSTED 2010

professional threshold. For the children they lived in a home where the physical condition of their environment, their meal times and routines, and their stimulation, was inconsistent and regularly lacking. For them, this was confusing and damaging. It is good practice to consider each dilemma about thresholds through the eyes of the child, particularly where concerns are chronic. (See section on neglect below.)

Learning:

Babies are dependent on adults to interpret the 'voice of the child' by spending time with them, by carefully observing them with the adults caring for them, and by finding out about their lived experience. This information should be used when considering the need to step a case up or down.

The risk factors within the home always need to be considered through the children's eyes. The child's experience must run through all work undertaken with families, and thresholds should be focused on the impact of parenting on the child.

Neglect

4.1.11 The NSPCC[17] are clear how important the first year of a child's life is on brain development. Lack of stimulation and / or malnourishment can have a negative impact on brain development and function. The SSCB website states that 'apart from being potentially fatal, neglect causes great distress to children and leads to poor short and long-term outcomes. Possible consequences include an array of health and mental health problems, difficulties in forming attachment and relationships, lower educational achievements, an increased risk of substance misuse, higher risk of experiencing abuse as well as difficulties in assuming parenting responsibilities later on in life. The degree to which children are affected during their childhood and later in adulthood depends on the type, severity and frequency of the maltreatment and on what support mechanisms and coping strategies were available to the child'. The information shared with the review shows that both Child U and Sibling were at risk of significant harm due to the impact of the early neglect they suffered. There was no consideration of a neglect medical being undertaken on Sibling following the referral in October 2016 where the family nurse stated that there were clear indicators of neglect and stressed the impact on Sibling including signs of developmental delay. CSC has acknowledged that their assessment following the referral was inadequate and over-optimistic.

4.1.12 Those involved were aware that neglect was an issue in this case despite the extensive support provided to the family. The state of the home was a concern much of the time, along with concerns about nutrition and food availability. Eviction was a threat due to rent arrears when the family nurse was involved. Having already referred Sibling to the community paediatrician, the family nurse identified delay following Child U's developmental assessment in January 2017 and noted that routines remained poor, food was limited, and there was a lack of stimulation. Sibling was seen by a community paediatrician in 2017 and was said to have mild global delay. She was due to be reviewed again by the paediatrician in 2018. In the meantime she was referred to speech and language therapy, and was to receive additional support in nursery from September 2017, and at home from her parents with support from professionals. This did not happen until after the death of Child U.

4.1.13 In October 2017 the health visitor carried out an 'ages and stages' questionnaire to assess Child U's development and as a result made a referral for a community paediatrician assessment. She also requested the involvement of a community nursery nurse. Neither intervention happened before Child U's death three weeks later.

4.1.14 The family service worker who became involved in April 2017 had difficulties in getting full engagement from the parents. The focus of the work was on debt management and engaging with the children. The plan was for the family to be seen weekly. In July the family service worker became the lead professional due to the FNP involvement concluding, and the focus of the work

[17] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/signs-symptoms-effects-neglect/

included addressing concerns about Child U's development. When Mother announced she was pregnant again in August 2017 a concern was recorded about how the family would manage. It is not clear that a re-assessment was undertaken however, firstly to consider the needs of the unborn child and secondly to consider the impact of a new baby on the older two children.

4.1.15 While professionals shared their concerns and referrals were made to CSC, there was no evidence of a referral being made that clearly stated that the children were at risk of **neglect**. This would have included a clear and detailed written chronology of concerns, providing evidence that the parents were unable to maintain improvements and the impact this was having on the children. Referrers should clearly state why they think an early help response was not sufficient and why a social work assessment is required, and this was not evident in this case. There was an expectation that CSC would log the concerns and come to the conclusion that neglect was an issue and that a child protection response was required. This was unrealistic. There is some truth in the view shared during the review however that if the FNP are involved and there have been limited improvements in the family, this should be taken into consideration when a referral is made. The FNP are used to holding risk, and if they identify concerns, this should be taken seriously.

4.1.16 When working with cases of neglect there is a risk that professionals wait for a serious incident to happen to provide evidence that the children are suffering significant harm on a given day. With neglect a number of small issues when collated may show significant harm over time however. Professionals must recognise that patterns of parenting and the cumulative[18] impact on children of care that dips just above and then below 'good enough' on a regular basis, as was the case for Child U and his sibling, is evidence of neglect. Referrals to step up a case to CSC should provide evidence over time (including from other professionals) of concerns and a clear view that a child is being neglected when the issues are considered cumulatively. In this case, the social work assessments did not recognise the cumulative nature of neglect, and did not sufficiently consider the parenting deficits as detrimental to the children. CSC have acknowledged during this case review that the assessments were not robust, did not adequately consider the history or the views of partner agencies, and did not sufficiently consider the child/ren's needs.

4.1.17 Neglect is the most common form of child abuse and is a factor in 60% of serious case reviews.[19] The SSCB has a Neglect Framework and practice guidance which was revised in July 2016 and is available on the SSCB website. It provides information about identifying and assessing neglect. It clearly states the importance of a good chronology, the need for reflective supervision, and provides a checklist which helps to identify neglect and could be used when referring a case for a social work intervention. It was not used in this case, but the professionals involved are now making use of the helpful tools.

4.1.18 In neglect cases a clear plan, with timescales for improvement, and a contingency plan which states what will happen if the improvements are not forthcoming, is critical. As much of the work on this case was undertaken by individual agencies or professionals, there was a need for a written down and reviewed plan (be it Early Help or ChiN) which set timescales for the expected improvements, measured the outcomes for the interventions being tried, which was then shared with all those involved. There was a large amount of input going into the family, who needed a joined-up plan that set timescales around what was expected, which included the children's weight and developmental milestones for example, to avoid drift. There was also a degree of dependence evident, with professionals concerned about stepping back from the family as they did not think they would manage without a lot of input. Professionals were very clear with parents about their concerns and challenged what they saw. However a transparent and focused consideration of the parent's

[18] The terms 'cumulative risk' and 'cumulative harm' were first identified by Bromfield and Higgins in Australia in 2005[18] who defined cumulative harm as 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'

[19] Brandon, M. et al. (2013) Neglect and serious case reviews: a report from the University of East Anglia commissioned by NSPCC.

capacity to change and maintain changes was needed. The parents told the lead reviewer they required more support than they received, but dispute they neglected their children.

4.1.19 The discharge meeting from hospital held in October 2017 considered neglect and it was thought that the case was on the 'cusp' of needing social work involvement due to concerns about parenting capacity, motivation and lack of change resulting in on-going neglect. Staff on the ward had noted there was very little interaction between Mother and Child U, however acknowledged that Mother was physically unwell due to her pregnancy, and she was actually admitted to hospital whilst Child U was on the children's unit. At the meeting the social worker said there was no role for her and it was agreed the matter should remain an early help case. While some professionals were disappointed, they accepted this decision and did not escalate their concerns at the time.

4.1.20 When making referrals to CSC with concerns about a child, professionals need to be informed if and why there is to be no further action. The professional should be assured that due consideration has been given to the concerns by the MASH and if they are not convinced of this they should use the SSCB escalation policy. It was shared by some professionals during the review that they don't tend to do this because they are not confident in challenging social workers as they think they are the 'experts'. They also question their own thresholds, believe it takes too much time to challenge (which was stated to be 'exhausting'), they have no faith that the challenge will be taken seriously and will make a difference, they worry it will be taken personally and that it will negatively impact on relationships, and that following a challenge nothing happens due to difficulty in getting hold of social workers and their managers and so they wait for next meeting. SSCB need to give a positive message about disagreeing and challenging and that partner agencies ensure that when a challenge happens that it is taken seriously and is responded to in appropriate timescales.

4.1.21 It was established during the review that the maternal grandparents and great-grandparents provided a lot of financial support, and that they had shared concerns with those involved about the children and about Mother's relationship with Father. Just before Child U's death it was agreed that a referral should be made for a family group conference (FGC) to share information and concerns with the family and try to engage them in more formally supporting the children and parents. This did not happen before Child U died. An earlier referral for an FGC and engagement with the maternal family would have been helpful to establish their view of the situation and to find out what help they did or could provide.

4.1.22 Mother's pregnancy with her third child required an assessment under the unborn baby protocol. This was not specifically considered at the discharge planning meeting where a plan for what was required in the case was devised. There is an argument that a family, who were not always managing in their current situation, was going to find it more difficult when a new baby arrived. In October 2017 the pregnancy was very early however.

Learning:

Professionals (singly and together) need to use the SSCB neglect framework and practice guidance to enable them to identify neglect, and then provide evidence of concerns over time, including using a chronology, when asking for a case to be stepped up for a CSC assessment. These concerns should be shared with the family, including information about why child neglect is so serious.

The SSCB escalation policy should be used if there is a disagreement about the provision of an assessment or service, if this will adversely impact on a child. Professionals should consider using the policy jointly if they share a disagreement about another agency's response to concerns.

Supervision is essential in cases where there are concerns about neglect. This should include challenge about whether any positive indicators of the parent's engagement and compliance is actually having a positive impact on the children in the expected timescale.

<u>Unknown sexual abuse risk</u>

4.1.23 There were potential issues for the children due to; Father's alleged history of being sexually abused and engaging in sexualised behaviours with other children; the lack of engagement in work designed to assess his risks and vulnerabilities; and no therapeutic interventions. When Mother was pregnant with Sibling, Father reported his concerns about bathing and changing the baby when she was born. Some of the professionals involved also reported a degree of inappropriate sexualised language and behaviours from Father that they noted during their visits. It was thought at the time that these issues would not have met the criteria for a referral to the MASH in their own right. They challenged Father at the time, but to an extent there was an acceptance of his behaviour because of his age and because the professionals wanted to continue to keep him engaged in the work for the children.

4.1.24 When Father voiced to professionals how uncomfortable some child care tasks made him feel, in light of his own childhood experience of sexual abuse, this was not adequately assessed as a risk factor for Sibling at the time or for Child U when he was born. Father was told that he should not undertake intimate care of Sibling and that further work would be undertaken by the social worker as part of the ChiN that had been agreed. This did not happen, and Father regularly undertook caring roles for Sibling and for Child U when he was born. Those involved acknowledge that they did not pursue the subject or question the lack of action in relation to this as part of the ChiN plan. When Father then voiced his concerns about being a parent in light of his history, this needed a formal specialist assessment. Father told the lead reviewer he felt let down by the lack of support with this issue.

4.1.25 Parents explained to professionals that the children were being almost exclusively cared for by the same gender parent. In other words, Father did the vast majority of caring for Child U. This needed further exploration. At the very least an update was required from Father regarding how he felt about providing baths and nappy changes to Child U, to Sibling, and to any subsequent children. As no specific work was undertaken with Father about his concerns and about the risk he may pose, this was likely to have still been an issue. There was no evidence that advice was sought from agencies who have experience of this type of work.

4.1.26 The planned NSPCC assessment during Father's childhood had not been completed. In addition, no work was planned or undertaken to consider any risk he may pose to others, so this was unknown, although there were concerns during his childhood and he voiced concerns himself during Mother's pregnancy. This is something that needs consideration going forward.

Learning:

If a parent voices concern about being a parent due to their childhood experience of sexual abuse, assessment, specialist support and therapeutic interventions should be made available to the parent, alongside protective behaviours work for the partner and children.

Incidents in September and October 2017

4.1.27 There were two incidents of concern in September and then October 2017 which require further analysis.

4.1.28 The first incident was an anonymous referral made that Child U had a large bruise to his face. The caller stated it had been caused by him falling out of his cot. They also stated they believed the children were neglected. A social worker was allocated to undertake the visit and went to see the family that day, as a child in need visit, on Sibling's case record. There was no strategy discussion. They met with Father and saw Child U. The bruise was described by the social worker as small and possibly a carpet burn. The social worker felt it was consistent with the explanation from Father that Child U had climbed out of his cot and fallen**.** There was no evidence on the record of the visit that the cot was seen, or consideration of the child's developmental stage and whether he could in fact climb from a cot. There is no evidence of safety advice being given, and no comment on the neglect concerns that had also been shared. No further assessment was completed, no medical was undertaken and Mother was not seen. The Family Service was informed and information was

requested from them, but there is no evidence any other professional was spoken to. The plan was to close the case following the visit, however it remained open but was not actively worked.

4.1.29 The known history of the case was clearly one where neglect concerns had been identified in the past, and where despite a lot of intervention, improvements had been negligible. The visit undertaken in response to the anonymous referral was focused entirely on whether the bruise was a non-accidental injury, despite the referral including concerns about the children being neglected. As the social worker went out within an hour of the referral, they did not have the opportunity to consider the case history, and there is no evidence of management oversight. A wider assessment was not completed and neglect was not considered. The social worker who undertook the visit no longer works in Swindon and did not engage in this review.

4.1.30 The second incident was a parental report that Child U had choked on vomit and 'gone floppy and blue' at home. Father stated that he provided CPR. Father called an ambulance and Child U then spent four days in hospital. He recovered well with no additional medical concerns relating to the presentation. Because the ambulance service had recorded their concerns about the state of the family home, and because Child U was seen by the paediatrician examining him at the hospital to be underweight with delayed development, the focus of the investigations and plan on discharge related to these issues. Limited information was shared at the time, or during this review, about the reported incident that led to the hospital admission. Records state Father reported that Child U required CPR, that he had 'gone floppy,' and that he had a 'choking episode.' All of these required a robust investigation as they were on Father's report. Instead it appears the focus shifted to the concerns about the state of the home and Child U's weight and development.

4.1.31 Despite this there was a good plan put into place following discharge which included a focus on the family's daily activities in order to better understand the children's lived experience and to identify 'tricky times' for the family, a referral to a parenting skills course, a focus on the children's nutrition (including a pictorial food diary using a smart phone), assistance in clearing rubbish from the front entrance to the home, a family group conference to explore additional supports in Mother's family, and nursery nurse involvement to explore the maternal relationship with Child U. It was identified however that there was a misunderstanding at least by the hospital regarding the role of the family service worker. It was recorded in the letter that was sent to the GP and in the notes of the discharge planning meeting that a social worker was involved and was visiting regularly. This was not the case and could have provided false assurance. It has also highlighted a lack of understanding for some health professionals about the difference between early help (the family service/support worker) and children's social care.

4.1.32 Relatively minor abusive injuries can precede severe physical abuse in infants. Those involved in the case at the time had not considered whether the bruise and /or the hospital admission with reports from Father of a potentially serious health issue, were so-called sentinel or harbinger injuries. Sheets et al (2013) undertook a study of 200 infants with injuries. They found that 27.5% of the children who had definitely been abused had a previous less serious sentinel injury. This was compared to none of the 101 non-abused infants, whose cases served as controls. The most common type of sentinel injury in children who were definitely abused was bruising (80%). The research concluded that "detection of sentinel injuries with appropriate interventions could prevent many cases of abuse."

Learning:

- *When assessing if an injury is consistent with the story provided by the parent, consideration should be given to the child's developmental stage, including a view from an appropriate health professional who knows or has seen the child. This should be considered in a strategy discussion/meeting, along with the case history.*
- *Professionals should be aware of the research regarding so called sentinel injuries.*

5 Learning

5.1.1 Good practice has been identified in this case. This includes the amount of time professionals put into supporting the family and providing help and assistance as required. The parents and children received excellent support, both practical and emotional.

5.1.2 Providing endless support without stepping back and considering whether the children were thriving and whether the parents could meet their needs was not enough however. While the cause of Child U's death is unascertained, it appears he suffered significant harm due to emotional and physical neglect.

5.1.3 The main issues that have been identified as learning from this case have been highlighted within the analysis section above. The SSCB Case Review Group, along with the lead reviewer, has considered the learning and has identified questions and recommendations for the SSCB in the areas thought to be of most importance.

5.1.4 The Triennial Review states that 'good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies'.

5.1.5 The questions and recommendations for the SSCB are directly linked to the four learning areas of; the child's lived experience, neglect, the unknown sexual abuse risk, and the two specific incidents in this case. In some cases there are actions in place from other reviews or processes such as improvement plans that address the learning identified. These will be outlined in the published SSCB's response to this review.

6 Recommendations/questions for the Safeguarding Board:

1. How will the SSCB make sure that professionals in partner agencies make referrals that provide the information and evidence required when they have safeguarding concerns?
2. SSCB to consider how it can be assured that when there is a concern about an injury on a child that a child's development is considered along with the possibility of neglect. This should include a review of the bruising protocol and the likelihood/significance of sentinel injuries.
3. SSCB to request assurance from partner agencies that professionals understand the risks of:
    - interfamilial sex abuse,
    - a parents adverse childhood experiences (ACE).
4. How can the SSCB ensure that professionals are meeting to share information and risks and to make a multi-agency early help plan when the threshold for CSC is not met?
5. SSCB to continue to raise awareness and promote the LSCB escalation policy.
6. SSCB to consider how it can reinforce to partner agencies the impact of neglect on children's lived experiences.

APPENDIX

Key to Acronyms

BMI	Body Mass Index
ChiN	Child/Children in Need
CP	Child Protection
CPR	Cardiopulmonary resuscitation
CSC	Children's Social Care
DNA/WNB	Did Not Attend/Was Not Brought
EH	Early Help
FNP	Family Nurse Partnership
GP	General Practitioner
MASH/FCP	Multi-agency Safeguarding Hub/Family Contact Point
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education
SCBU	Special Care Baby Unit
SCR	Serious Case Review
SSCB	Swindon Safeguarding Children Board
TAC	Team Around the Child Meeting
TAMHS	Targeted Mental Health Service