Confidential

London Borough Hillingdon Safeguarding Children Board

Serious Case Review

Baby W

Report Authors

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1. INTRODUCTION

1.1 This serious case review has been carried out as a result of four fractures incurred by Baby W who was living with his mother and father at the time. Investigations identified that the fractures were non-accidental and following a police investigation, a full file of evidence was submitted by the Metropolitan Police to the Crown Prosecution Service. At the time of writing, (September 2016) the criminal investigation is ongoing; papers have been sent by the Metropolitan Police to the Crown Prosecution Service but no decision has been made as to whether anyone will be charged with causing the injuries to Baby W.

1.2 On 23rd September 2015 the Hillingdon Safeguarding Children Board serious case review subcommittee considered the case and agreed that as a child had been injured and abuse or neglect was suspected, the case met the criteria for a serious case review. Relevant background information which informed this decision was that Baby W lived with his mother and father. The family had been known to children's social care in boroughs outside of Hillingdon due to Mother's history of alcohol misuse; substance misuse; mental health difficulties; eating disorder and being a victim of domestic violence during a previous relationship. At the time of Baby W's injury, the baby was subject to a child protection plan and Father was subject to stringent bail conditions that included not to have contact with Mother or approach the family home. This was following admittance by Father of assaulting Mother.

2. REVIEW PROCESS

2.1 Following agreement by the subcommittee that the case met the threshold for a serious case review, the chair of Hillingdon Safeguarding Children Board commissioned this review and appointed Dr Sonya Wallbank and Jane Wonnacott as lead reviewers.

2.2 The lead reviewers worked with a small team of senior professionals from within Hillingdon who represented the organisations who had contact with Baby W and his family. This team consisted of:

- Hillingdon Safeguarding Children Board Business and Development Manager
- Named Nurse Safeguarding Children for Central and North West London NHS Foundation Trust
- Designated Nurse Safeguarding Children, Hillingdon

- Named Nurse Safeguarding Children, The Hillingdon Hospitals NHS Foundation Trust
- Metropolitan Police Representative
- Assistant Director, Safeguarding and Children's Service Improvement

2.3 Each organisation prepared a chronology and outline of their involvement and the review team agreed questions that would need to be considered by the review.

2.4 The review aimed to understand events from the point of view of practitioners working with the family and the lead reviewer arranged to talk to individual practitioners with the member of the review team representing their organisation.

2.5 Mother and Father were contacted and offered the opportunity to contribute to the review, neither wished to do so. The panel recognised that their feelings could change following conclusion of the criminal investigation and agreed that they would be contacted again at that point.

2.6 Whilst this report could not be finalised and published until after the conclusion of the criminal proceedings, it was agreed that it should be presented to Hillingdon Safeguarding Children Board in order that recommendations could be agreed and action taken to implement learning. An amended updated report ready for publication would be prepared at the conclusion of criminal proceedings.

2.7 For further details of the review process please see appendix one.

Report Format

2.8 This report has been written taking account of the requirement within Working Together to Safeguard Children (2015) that it should be a public document. Many specific details relating to the injuries and family members have therefore been omitted. The report sets out a case summary and evaluation of practice in relation to:

- The antenatal period of health and social care prior to the birth of Baby W
- The post-natal health and social care of Baby W and his mother immediately before the injuries occurred

- The events surrounding an incident of domestic violence which occurred nine days prior to Baby W's injuries

2.9 The evaluation of practice is used to determine thematic findings from the review. These findings form the basis for the conclusions and recommendations to the Hillingdon Safeguarding Children Board.

2.10 A response to this review from Hillingdon Safeguarding Children Board is attached as a separate document. This response identifies changes in practice that have already taken place as well as plans for addressing the issues identified by the review.

3. ANTE NATAL PERIOD – CASE SUMMARY

3.1 The mother of Baby W had extensive history of involvement with Mental Health, Drug and Alcohol, Accident and Emergency and GP services. She is also known to have experienced domestic violence prior to her pregnancy being confirmed by the GP in December 2014. She was then seen at Hillingdon Hospital when she was 18 weeks pregnant which would have been regarded by maternity professionals as a late booking. This was her first pregnancy.

3.2 Mother had some difficult adolescent experiences which left her vulnerable and she often made decisions which compromised her safety. Her ways of coping included alcohol and drug dependency and this meant that she was further vulnerable to poor physical and psychological health. This is important, as the extent of this history and the impact it would have on Mother to parent effectively was not fully explored by health and social care professionals.

3.3 When Mother attended the GP surgery to confirm the pregnancy, she reported that she had stopped drinking completely. This would have meant that despite her extensive history of alcohol abuse she had managed to reduce her daily intake from 3-4 litres of cider in early October 2014, to zero some nine weeks later. It is important to note that the referral from the GP to the maternity services did not specify alcohol type and at no point was the information regarding alcohol use checked or tested.

3.4 At the same visit, Mother also reported that she was not in a relationship with the father of Baby W. The GP did not therefore ask any further questions about him. She had recently separated from a previous partner who had been violent towards her. She also explained that she was addressing her mental health issues on her own. Mother did want to seek help for her smoking.

3.5 Since becoming pregnant, Mother also advised the GP that she had resolved previously difficult family relationships and she felt that she was well supported

by her family and they even attended appointments with her, including the initial GP visit.

3.6 A standard referral was made to maternity and health visiting services by the GP. The referral noted risk factors of substance misuse; domestic violence and alcohol dependence. Drug misuse was noted as not occurring for a matter of months. A number of mental health risk factors were noted as well as physical health issues. In this referral, the level of alcohol consumption is noted as 3-4 litres per week on one page and then zero on the next page. This discrepancy was not picked up by either the GP, maternity or health visiting services demonstrating a lack of early challenge from both maternity and health visiting.

3.7 Maternity services assessed the referral and it was decided that alongside standard midwifery services the pregnancy should be managed by a consultant obstetrician and a referral would be made to the specialist midwife for substance misuse. In line with usual practice, Mother was invited to attend the hospital for a scan appointment.

3.8 Health visiting services assessed the referral and offered a targeted ante-natal contact.[1] This meant that they offered specific support to Mother and wanted to meet directly with her given her higher level of need before the baby was born.

3.9 Between the 18th December 2014 when the GP confirmed the pregnancy and the 18th June 2015 when Baby W was born, Mother was offered 29 appointments by maternity and health visiting services. She did not attend twelve of these appointments, although several occurred on the same day as each other meaning that she did not attend the hospital eight times. This lack of attention to her antenatal care concerned maternity service professionals.

3.10 During this time, Mother had been met and assessed by 15 different professionals within maternity services. The health visiting service re-arranged their initial appointment as the health visitor was ill; Mother re-arranged their second appointment but she was not in when the health visitor went to the property as arranged. Following this failed contact, no further attempts were made to see Mother despite the risks identified within the referral from the GP and subsequent discussions with maternity services. The role of Baby W's father with the pregnancy and his future plans with Mother were not clear to professionals. Where discussions did take place which suggested Father may be more involved than first thought, they were not documented.

3.11 On the 23rd March 2015, when Mother was 29 weeks pregnant a referral to children's social care was noted in the maternity services file. At this point,

[1] Hillingdon Community Healthcare. Clinical Standards for Antenatal Contact.

Mother had missed 8 out of 12 appointments. It appears that the referral was generated but not sent by maternity services. It is not clear as to why this happened. A further referral was sent on the 14th April 2015 when Mother was 32 weeks pregnant. This was acknowledged by children's social care on the 17th April 2015 and a case worker was allocated in order to complete a child and family assessment[2].

3.12 Following the eight missed appointments, two home visits were arranged by maternity services. There were concerns about the state of the home. Father was present during at least one of these visits, his changing role was not documented or any implications considered.

3.13 At this time, child and family assessments were carried out by a separate organisation commissioned by the Local Authority. The referral noted the lack of attendance at hospital appointments (the health visitor appointments that had not been attended were not included as no discussions had taken place between the services). Mother's previously identified history and subsequent risk factors were also noted.

3.14 The child and family assessment included several attempts to make contact via telephone and two un-announced home visits over 24 days before contact was finally made with Mother during a further un-announced visit.

3.15 The assessment report was written and subsequent recommendations made following this one visit with Mother. Father had not been contacted or interviewed. The specialist midwife was very concerned about the number of missed midwifery care appointments by mum, her level of alcohol abuse and the suitability of the home for a new-born baby, she subsequently made several calls to the assessing social worker. The view of the assessing social worker was that the unborn Baby W should be supported using the child in need process. This was upgraded to a child protection process after discussions with a team manager from the commissioned service.

3.16 An initial child protection conference (ICPC) was held on the 5th June 2015 which was outside the usual accepted time frame of 15 days after the start of

[2] A child and family assessment is undertaken of the needs of individual children to determine what services to provide and action to take. The purpose of the assessment is:

- To gather important information about a child and family;
- To analyse their needs and/or the nature and level of any risk and harm being suffered by the child;
- To decide whether the child is a Child in Need (Section 17) and/or is suffering or likely to suffer Significant Harm (Section 47); and
- To provide support to address those needs to improve the child's outcomes to make them safe. (Working Together to Safeguard Children 2015)

child protection enquiries[3]. The ICPC was delayed due to the social worker not being able to get in contact with Mother, despite several telephone attempts and additional time was required to complete the assessment before the ICPC was held. Four professionals attended, only one of which had met Mother previously. The GP did not attend the ICPC but did send a report for the ICPC which was read out by the child protection conference chair and noted in the ICPC minutes. The assessing social worker could not attend the conference and so a duty social worker attended the meeting. There is no record of Father being at the ICPC. The conference agreed to place Baby W on a child protection plan under the category of neglect. Minutes of this conference and the subsequent child protection plan were not distributed due to an administration error. An analysis of the minutes for review has raised concerns that the process of the child protection conference was not in line with expected practice. For example, within the conference, when professionals were asked to give a score to the level of risk, scores indicated a high level of concern. However, the subsequent discussions as set out in the minutes appear to have ignored those risks and were not challenged by the chair of the conference.

3.17 A discharge planning meeting was subsequently held on the 19th June 2015 to agree how Baby W and Mother would be supported at home. A newly allocated social worker from Hillingdon chaired and minuted this meeting as well as meeting Mother and Father for the first time. For a newly allocated social worker to do this was usual practice. The maternal aunt also attended this meeting. No professional attending this meeting had met or worked with Mother previously. Baby W was monitored after his birth and no signs of withdrawal from alcohol or drugs were noted.

3.18 The plan agreed during the discharge planning meeting noted the importance of finding out further information about Father who was now actively involved in the parenting of Baby W and living with Mother. It was revealed during the meeting that Father had another child which he was no longer in contact with. It was also revealed that Father had a history of violence.

4. ANTE NATAL PERIOD - EVALUATION OF PRACTICE

4.1 The Marmot Review into Health Equalities[4] highlighted the importance of giving every child the best start in life. The foundations for every aspect of human development are laid in early childhood. What happens during these very early years, starting in pregnancy, has lifelong effects on many aspects of health and

[3] London Child Protection Procedures
[4] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

well-being. The National Institute for Clinical Excellence guideline for antenatal care[5] recommends that pregnant women should receive a complete assessment (booking) by 12 weeks' gestation (12 weeks and 6 days), but ideally by the 10th week. Booking outside of these guidelines is considered 'late' by professionals and is a known risk factor for child protection concerns.

4.2 The term 'toxic trio' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people and are explicitly identified in the Hillingdon children services risk factors table.[6]

4.3 At the time of booking, the GP identified risk factors of substance misuse; domestic violence, alcohol dependence and mental health issues but did not make a referral to children's social care although the threshold would have been met[7] and despite guidance[8] outlining the importance for GP's to refer when an adult poses a risk to the safety or wellbeing of their child. The lack of time available for the GP to scrutinise the full records of Mother meant that they relied on information from Mother, which was not tested and did not take account of her previous extensive history. There were assumptions made that as Mother was accompanied to the visit she was well supported and therefore this mitigated any risk. The self-report information from Mother was accepted as fact, rather than a more cautious approach which questioned the possibility that circumstances may not be as good as Mother indicated.

4.4 The GP's decision not to refer and accept the self-report information from Mother appeared to be perpetuated within a system where the potential risks posed by Mother and subsequently Father, were subject to confirmation bias (the tendency to search for, interpret, favour, and recall information in a way that confirms one's beliefs or hypotheses, while giving disproportionately less consideration to alternative possibilities)[9]. The GP notes were accepted as a factual account and therefore not subject to any future tests. Had any professional scrutinised the previous history of Mother, it would have been clear that this was a vulnerable individual who had numerous previous difficulties and more questions would have been asked about the relationship between Mother and Father, especially given her previous poor decision making and putting herself at risk.

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[5] https://www.nice.org.uk/guidance/cg6
[6] http://hillingdonchildcare.proceduresonline.com/chapters/table_risk_protect.html
[7] http://hillingdonchildcare.proceduresonline.com/chapters/p_elig_thresh_formatted.htm
[8] http://www.gmc-uk.org/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf
[9] Frost, Peter, et al. "The Influence of Confirmation Bias on Memory and Source Monitoring." *The Journal of general psychology* 142.4 (2015): 238-252.

4.5 Despite the extensive history of Mother which was known at the time of booking, there appears to be little service provision to support Mother to prepare for her changing role as a parent.

4.6 There is a perceived ambivalence within the services that referring before 24 weeks into children's social care would result in no action from them. This appears to have resulted in a lack of referrals into the system and professionals who are aware of the risk factors not carrying out their safeguarding responsibilities to refer. It does not explain why, despite the risks identified by all professionals involved, it took until Mother was 29 weeks pregnant to be referred into the system.

4.7 Upon receipt of the referral, maternity services identified that this was a mother who required additional care. A referral to children's social care should have been made on receipt of the referral from the GP, based on the risk factors identified. Had the extent of Mother and Father's history been known this would have warranted an immediate referral to children's social care and would have met the threshold for child protection. Whilst this process did ultimately occur, GP, maternity and health visiting services all missed the opportunity to make a referral and therefore give children's social care the most available time to assess and intervene with the family.

4.8 The fragmented way in which maternity services are delivered means that the care of vulnerable and at-risk mothers is not case managed by the service. Each time a mother comes into the service they are likely to see a different person for their routine antenatal care. For Mother this meant she saw 13 midwives in 19 weeks. Information shared by mothers during these exchanges are not held in context as the previous history remains unknown. Information recording is largely factual about what care was delivered and does not review how a mother is presenting or any ongoing vulnerabilities identified. This was further evidenced by the lack of follow up when the original referral to children's social care was not sent.

4.9 The specialist midwife for substance misuse only operates from the hospital and therefore if a mother does not attend the appointments, there is a reliance on community midwives to undertake home visits. The role of the community midwife within this follow up is not clear and there is a perception of the safeguarding role during these visits being retained by the specialist midwife, despite the fact that they had not visited the mother. This creates risk, as information gained by the community midwife was not recorded or shared with the specialist midwife.

4.10 The safeguarding role of the consultant obstetrician with at-risk or vulnerable mothers is not clear. Despite the consultant leading on the care of a vulnerable

mother who had been identified as needing a higher level of care, the level of non-attended medical appointments was left to midwifery to resolve.

4.11 The role of the safeguarding team within maternity services does not currently appear to support effective practice. The role of the named midwife in overseeing the safeguarding team and scrutinising/supervising their work appears to be in conflict with the post holders' other role as line manager for the maternity service. There is not enough time or attention being given to the safeguarding aspects of their job particularly in supporting the specialist roles.

4.12 The safeguarding midwives work separately to the specialist midwife. The specialist midwife demonstrated effective care during their brief exchanges, however, there is too much reliance on this one role to provide safeguarding assurance to the system. There were examples of good practice between the sonographers and wider midwifery service with communication about mothers who do not attend being shared amongst the teams. In contrast, there is little evidence of working together across the wider safeguarding team including the specialist roles. This is important as had there been an effective safeguarding process in place, the delay of 14 weeks before Mother was referred to children's social care would have been unlikely to have occurred. The level of unattended appointments should have triggered action by midwifery services after two missed appointments in line with their "did not attend" policy.

4.13 The role of the health visitor in supporting the care of Mother was not clearly understood, this is despite the level of attention and recent investment into health visiting services nationally.[10] There were missed opportunities for the specific assessment skills brought by the health visitor to be used to inform both the antenatal care and the subsequent child protection plan. The lack of engagement with a vulnerable mother, the lack of input into the child protection process and the perception that others in the system will have the same skills as the health visitor and, therefore, be undertaking this role is concerning. The local guidance for health visiting missed appointments[11] is clear and was not followed. Decisions about the risk within this family relied on subjective perceptions.

4.14 The assessment undertaken by children's social care lacked depth and was based on one visit with Mother which would not be considered good practice. The reliance on self-report and the lack of information regarding Father meant it

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407644/overview1-health-visit.pdf

[11] Central and North West London NHS Foundation Trust. Clinical Standards. Missed two or more appointments and decline of the Health Visiting Service.

would not have met the standards set out by the service[12] and would not have been sufficient to understand Mother or Father's capacity to parent. There appears to have been a perception that a first time mother was unknown to children's social care and no proactive action was taken to fully consider how previous circumstances impact on parenting capacity.

4.15 The review has been informed that the personal circumstances of the assessing social worker impacted on their ability to undertake a full assessment. The contracted time frames assessments need to be delivered in, meant that delaying the process and reassigning the assessment to an alternative social worker was not considered.

4.16 The quality of the assessment was scrutinised by a social work manager within the commissioned assessment service but the personal circumstances of the assessing social worker appeared to dominate the thinking of the manager and were given a higher priority than the needs of the child. The opportunity to utilise supervision, or reflective practice, to understand how this thinking was influencing the assessment process was not readily available for the manager. The acceptance of the poor quality of the assessment by both the supervisor and the social worker who took the case over meant that decisions at the child protection conference were not well informed. Professionals attending the discharge planning meeting did not appear clear about the purpose of the meeting and this was evidenced from the lack of information contained within the discharge and subsequent child protection plan. There was little time for proper assessment to take place.

4.17 The quality of the child protection conferences held were impacted by a number of factors. The lack of professionals around the table who knew or had worked with the family was concerning. There was little evidence that professionals were fully briefed about the family circumstances and therefore lacked the information to effectively perform their role within the conference. There was little evidence of effective chairing to assess whether the professionals in the room were able to pass informed and, therefore, effective views.[13] The chair did not pass comment or challenge regarding the lack of appropriate professional input into the conference nor the limited information available with regard to Mother's background history or that no information was known about Father. There was evidence of inappropriate comments by the chair during the conference which minimised the impact of previous episodes of domestic violence and no other professional challenged this. This may have been

[12] http://hillingdonchildcare.proceduresonline.com/chapters/p_assessment.htm
[13] https://www.hillingdon.gov.uk/article/6761/Child-protection-case-conference

influenced by the personal style adopted by the individual chairing the conference.

4.18 At the time of the child protection conference, administration services and business support were undergoing a period of transition within the local authority. This change appeared to produce a period of unstable and ineffective administration. The lack of child protection conference notes meant that professionals had no plan to work to unless they had been fortunate enough to take their own notes. There were also errors in the recording of information with conference notes being recorded against incorrect dates. There also appears to have been a negative impact to the effectiveness of the conference due to the

4.19 The practice during a discharge planning meeting of the attending social worker meeting the family for the first time and chairing and minute taking the meeting appears to be too many conflicting roles. In order for the social worker to be effective in this meeting, they needed to be able to give their full attention to what was being said and, most importantly, what was missing.

4.20 The lack of information about Father and his changing role was accepted by all professionals and is concerning. The role of the father is a constant theme of serious case reviews and there was little evidence that professionals have put this learning into practice with this family. This is evidenced by the lack of confirmed information known about Father and his risk to Mother and Baby W at the point the injuries occurred. In this case, a history of domestic violence perpetrated by Father was uncovered and this would have impacted on how the risk of Father was viewed, had it been known.

5. POST-NATAL PERIOD: BACKGROUND

5.1 Baby W was discharged home on the 22nd June 2015. Within the hospital environment his parents were observed as being proactive and comfortably caring for him.

5.2 A further child protection conference was held on the 29th June 2015, fourteen working days after the initial child protection conference. At this point midwifery services had visited Baby W and his mother twice and although midwifery services attended the conference, it was not the same midwives who had visited or been involved in the care of Baby W.

5.3 The health visitor attending the conference was still yet to meet with the family and had scheduled a visit three days after the conference.

5.4 The social worker had been able to meet with both his parents and wider family on an unannounced basis once. The view of the meeting was that Baby W was

doing well and was being appropriately cared for by his parents. Specific information about Father was still unknown.

5.5 Between the 30th June 2015 and the 12th July 2015 Baby W and Mother were visited 4 times by midwifery services and once by the case social worker. Father was sometimes present at the visits but no concerns were documented. This is important as concerns about Father were present in professionals' minds based on conversation with Mother, but were not written down or disclosed to other professionals. The social worker had begun the process of confirming and checking Father's information.

5.6 The health visitor also completed a new birth assessment visit during this time. This followed the format of a standard assessment and was not adjusted to take into account the child protection plan. Baby W was noted as progressing well.

5.7 On the 12th July 2015, Mother reported to her social worker that she had been assaulted by Father and was staying at her mother's home. The incident involved Father head-butting Mother. The social worker advised her to call the police and explained that the duty of care Mother had to Baby W involved staying away from Father until the police had advised her further regarding the risks that Father posed. Father was refusing to leave the property and so Mother went to stay at her own mother's house.

5.8 On the 15th July 2015 the police attended the address of Baby W's grandmother to speak with Mother. Baby W was noted as sleeping during the visit. Mother gave further details about the incident and also advised the police that Father had made threats to harm the baby and blame it on her. The police raised a Merlin report[14] which was sent to children's social care and health visiting services. Baby W was deemed to be in a place of safety at maternal grandmother's home.

5.9 Also on the 15th July 2015 midwifery services made an opportunistic visit to Baby W's home. Father was at the house and reported that Mother and Baby W were staying at maternal grandmother's house. Father was waiting outside to gain access to his belongings and reported he was moving out following an argument.

5.10 On the 16th July 2015 the social worker visited Baby W at the maternal grandmother's house. He was noted to be content and feeding well. Mother advised she would not return to the home until Father had left. Mother was

[14] This is the Metropolitan Police's notification of a child coming to their attention

expecting Father to move out that day and the police had advised her that he was being arrested for the assault.

5.11 During this visit, Mother shared information about Father with the social worker. This included his drug taking, stealing from her and that he had wanted her not to proceed with the pregnancy. She described that her mother (Baby W's grandmother) was very supportive and the social worker left the home comfortable that Baby W was safe.

5.12 On the 17th July 2015 Mother advised the social worker that she had returned to the family home. Father had been arrested that morning for the assault and charged. Mother explained that she had invited Father to the home. The social worker advised Mother that a risk assessment needed to be undertaken before this happened.

5.13 On the 19th July 2015 midwifery services visited Mother, this time at the family home. Mother reported to the midwife that she regretted reporting the incident, she felt she had exaggerated the injuries and she wanted the relationship with Father to continue. The midwife advised Mother to talk to her social worker and made no attempt to contact the social worker herself. The midwife also did not share this information with the health visitor who was taking over the care of the family. Midwifery discharged Mother from their care.

5.14 On the 20th July 2015 health visiting services received the merlin report, assessed the risk to Baby W as green (low) and noted that they intended to discuss the incident at the next visit on the 23rd July 2015. On the same day Mother called children's social care to talk to them about how she could retract her statement against Father. She advised them that Father was wanting to change his ways and stop drugs and she wanted help for him. She admitted Father had been at the address and that he was using cocaine.

5.15 Children's social care advised Mother that Father should not have been at the address and that legal advice would be sought if this happened again.

5.16 On the 23rd July 2015 health visiting services made a home visit to undertake a mood assessment with Mother. The domestic violence was discussed and Mother repeated that Father was taking drugs. At this point no mention of the allegations of Father to harm baby W had been discussed by any professional with Mother. Mother reported that Father had bail conditions not to contact Mother.

5.17 On the 26th July 2015 Mother and Aunt attended the urgent care centre with Baby W. He was reported to have a swollen leg which started the day before. Baby W was triaged by an emergency nurse practitioner and a GP who noted the swollen leg. The notes record 'no' to the question of whether Baby W was

on the 'safeguarding list'. Baby W was sent to the hospital's paediatric team for further investigations due to concerns regarding his medical condition.

5.18 At the accident and emergency department, Mother reported that she thought Baby W may have a spider bite. A number of explanations were explored by the medical team and they noted Baby W was subject of a child protection plan as the hospital had put an alert on their system on 22nd June 2015. Mother told the team that she was no longer in a relationship with Father.

5.19 On the 27th July 2015 the x-rays were reviewed by the paediatric radiologist who confirmed Baby W had four fractures in his leg, including a femur fracture and a disal tibia fracture, both of which suggested non-accidental causation.

6. POST NATAL PERIOD - EVALUATION OF PRACTICE

6.1 The late referral of the family to children's social care and the subsequent delay within the assessment process meant that there was an inadequate amount of time between the initial child protection conference and the subsequent review child protection conference. The newly allocated social worker was therefore not able to complete their enquiries in appropriate depth to enable the conference to make informed decisions at that time. The review child protection conference outcome was for Baby W to remain subject to a child protection plan, however, the limited assessment information meant that the extent of the risks to Baby W were not fully known.

6.2 The role of the professionals within the child protection process[15] is to inform decisions regarding the strengths of the family, the concerns they have, the complications of the family and what are seen as safety or protective factors. The repeated attendance of professionals at the child protection conferences who had not met or worked with the family means that these questions could not legitimately have been under scrutiny. Only a social worker report and a health visitor report were received, the health visitor had not met the family. The lack of preparation from the chair and the lack of reports received for the conference should have been addressed through a quality assurance process within children's social care.

6.3 There were a number of missed opportunities by the safeguarding midwifery team to invite to the conference the community midwife, who had visited Mother on seven occasions, and was the most involved professional at this time. The way in which vulnerable cases are managed within maternity services means that where there is a specialist midwife involved with the family, they will be

[15] -case-conference https://www.hillingdon.gov.uk/article/6761/Child-protection

invited alongside the safeguarding midwife. The community midwife also had information and concerns which were relevant to the child protection conference but did not document these in a way that could inform the midwives who did attend. The role of the safeguarding team in responding to invitations to child protection conference and ensuring that the appropriate individuals attend is critical and needs to be reviewed. The health visiting service was unable to effectively contribute to the review child protection conference as the health visitor had not undertaken any antenatal contact. There appeared a lack of urgency regarding the need for the health visitor to assess the family, despite the concerns, and even when the paediatric liaison health visitor who attends the maternity safeguarding meeting alerted the health visitor that a social work assessment was taking place on the 28th May 2015, no change to the plan to visit was made.

6.4 The health visiting service had a further opportunity to contribute an effective report to the child protection conference, however the health visitor had yet to make contact with Mother and was not due to see her until after the review child protection conference on 29th June 2015. The allocated health visitor stated that as there were other health services involved with Mother, such as maternity, completing a visit in order to inform the conference was not a priority. The decision to visit after the conference meant that the health visitor was merely observing the process and could not comment effectively on the parenting capacity of Mother and this would not be in line with good practice.

6.5 Following the domestic violence incident, Mother's allegation was responded to by the police. No referral was made by the police to the Independent Domestic Violence Advisers **(**IDVA) because the Domestic Abuse, Stalking and Honour Based Violence Risk Model scored the incident as a standard risk (DASH, 2009)[16]. Only medium to high risk cases would be referred to IDVA and this incident did not meet the threshold for police to refer to IDVA. The opportunity to refer to IDVA or any other domestic abuse support service was missed by the social worker who was aware that Mother was a repeat victim of previous domestic violence and therefore was in receipt of more information than the police. This would not be good practice as set out in the London Safeguarding Procedures.

6.6 After the domestic violence incident, both midwifery services and health visiting services visited Mother and were given information by Mother which was not recorded or shared with the social worker. This is important as there was information which demonstrated that Mother was unlikely to stay away from Father and therefore increase the risk against Baby W. It is not clear why

[16] http://www.dashriskchecklist.co.uk/

midwifery services discharged Mother without ensuring this information was shared with the health visiting services who would take over the care.

6.7 One reason for the lack of contact was the perception within services that getting hold of a social worker is difficult and protracted. This has resulted in an apathy about even trying to make the call. Children's social care were not able to respond appropriately as they were not given the full information from other professionals. No calls were even attempted by professionals to reach the social worker.

6.8 The allegations from Mother about Father injuring Baby W and blaming the injuries on her should not have been ignored as this is subsequently what appears to have happened. This information was recorded by the responding officer on a Merlin report which is in line with protocol and shared with the social worker and the health visitor. Although Mother was subsequently visited by the social worker and the health visitor, these specific allegations were not discussed.

6.9 Mother was still regarded as providing a safe place for Baby W, however, had the full history of Mother and Father been known at this time, the ability of Mother to make an appropriate decision to keep Baby W safe may have been questioned more thoroughly. Mother called children's social care a number of times to explain her reluctance to pursue the domestic violence case against Father and this information should have been used to further inform Mother's capacity to keep Baby W safe.

6.10 As Mother began to share more negative information about Father, the view of his ability to parent effectively was not challenged. This was new information and did not seem to be appropriately analysed. The changing role of Father as a risk should have informed professionals, and Mother's ability to protect Baby W should not have relied solely on her self-report, especially once she had moved from her mothers' home to the house they had shared as a family. It would have been good practice to bring the core group meeting forward urgently.

7. FINDINGS

Finding 1:

Practitioners did not adequately assess the implications of mental health, drug and alcohol use and domestic violence ('toxic trio') on parenting capacity. This resulted in a late referral to children's social care and one which lacked appropriate risk information.

7.1 Mother had an extensive history of mental ill-health, drug and alcohol misuse, Accident and Emergency and GP history prior to her pregnancy. The professionals involved in Baby W's care were all experienced and qualified, with some having enhanced safeguarding roles within their service. The risk factors alone should have prompted an early referral to children's social care where her circumstances and capacity to parent could have been assessed in more depth.

7.2 Even when additional factors such as the late booking, the discrepancy over alcohol consumption and the lack of attendance at appointments were raising the risk, the ability for Mother to make appropriate decisions for her unborn child did not alter practice.

7.3 There is an assumption within the system that a first time mother is 'unknown' to services because she has no history of parenting. This assumption negated the relevance of previous information that was known within the system and would have been useful to inform Mother's parenting capacity and her ability to keep Baby W safe by making appropriate decisions.

7.4 There was no testing completed of the level of drug and alcohol abuse by either parent. Once Mother had told the GP she had stopped drinking this became an accepted fact within services.

7.5 The reasons for the lack of referral to children's social care from all professionals who came into contact with Mother during the antenatal period was that there was insufficient awareness about the type of behaviour that raises risk. In addition, behaviours such as not attending appointments, Father's changing role within the family and concerns about living conditions were not recorded clearly and understood as indicative of increased risk.

7.6 When the child and family assessment was carried out, the lack of depth and acceptance of self-report meant that no agency had really considered the risk of the family. Even when risk was raised for example, regarding Father's domestic violence history during the child protection conference, this was minimised and at points colluded with during the process.

7.7 The outsourcing of the assessment service to an independent provider by the local authority created immediate capacity issues for children's social care. There appeared to be a culture within the independent provider where delivery of the assessment was the primary goal and at times this overrode the need for appropriate depth and quality. In this case, despite the quality, issues were picked up by the independent provider, however the assessment was still handed over as a completed piece of work which created additional risk. Consideration had been given to the quality of assessments required by the local authority and a mechanism to refer back to the independent provider was

in place when standards were not met. This did not work in this case and the assessment was accepted by the case social worker despite the gaps.

7.8 The delay in referring into children's social care alongside the inadequate assessment meant that little time had passed between the referral and Baby W being born. The assessment was not completed in enough detail to appropriately assess the action that was needed after Baby W's birth.

7.9 The lack of appropriate information available from professionals who were working with or had known either parent meant that the assessment relied on assumptions and self-report by Mother.

7.10 Information was available but not requested by children's social care or any of the health services regarding both parent's previous history. This impacted the level of risk that professionals considered both parents to be and their assumed capacity to parent effectively. Domestic violence particularly appeared to evoke an apathy amongst professionals who had seen or encountered worse.

7.11 Whilst the violence against Baby W was unlikely to be predicted, direct threats were made against the baby and these should have been taken more seriously by professionals. Had the full context and history of Mother and Father been known, it is clear that there would have been a different response. Had the information been challenged and questioned by professionals working effectively together, there may also have been a different response.

Recommendation 1:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice where the 'toxic trio' have been identified as a feature of the case in order to establish:

- Information being shared by families both within and between agencies is being tested and challenged appropriately
- Referrals are being made to children's social care in an appropriate time frame
- Professionals' learning needs in relation to the 'toxic trio' and its' impact on parenting, especially relating to assessment and record keeping skills.
- That supervision is being effectively utilised by all agencies to support and challenge assessments and safeguarding decisions across the system
- Decisions **not** to refer to children's social care where the 'toxic trio' exist should be made with a member of the safeguarding team, not by an

individual professional within health organisations.

Recommendation 2:

The Hospital Trust should be asked to establish a system whereby records in relation to an individual are accessible to all departments within the hospital.

Recommendation 3:

Children's social care should review their assessment format in order to ensure that, where first time parents are being assessed, all of their previous contact with health, police and children's social care is sought. This should include mental health, drug and alcohol misuse, accident and emergency and GP attendance. Assessments need to be scrutinised to ensure that the role of the father and their background history is clear at the earliest possible time.

Recommendation 3a:

Children's social care should ensure that the quality of children and family initial assessments is reviewed to ensure that they meet the required standard.

Recommendation 3b:

Children's social care need to ensure that an appropriate amount of time is given to the process to enable a thorough assessment to take place. Where the decision to outsource this service is made, further consideration needs to be given to the use of quality indicators and assurance tools from the provider to ensure transparency regarding quality concerns.

Recommendation 4:

The clinical commissioning group (CCG) needs to review the time that a GP has available to identify and risk assess first time parents where the 'toxic trio' exists to ensure that appropriate referrals are being made to children's social care and other specialist services (if necessary).

Recommendation 5:

Hillingdon Safeguarding Children Board should ensure that all partners comply with the London Child Protection Procedures regarding practice where there have

been direct threats made against a child.

Finding 2:

Assessments were influenced by both parent's appearance, demeanour and apparent compliance which hindered an in depth exploration of relevant issues.

7.12 Comments made during the review process indicated confusion on behalf of professionals about who can pose a risk to a child and what mitigates that risk. This is despite the senior level of professionals involved with this family. This extended to professionals being influenced by the way in which Father was dressed, the positive and open manner of Mother and the assumed support that was in place because Mother was accompanied to appointments.

7.13 Professionals demonstrated a lack of understanding regarding disguised compliance (where an individual gives the impression they are following advice but in reality are doing something different) and assumption/positive bias (the tendency to search for and recall information in a way that confirms existing beliefs or hypotheses, while giving disproportionately less consideration to alternative possibilities). This meant that they accepted what was being told to them and did not question the information being given to them, even if that information was different or more negative than the previous view they had.

7.14 There were a number of examples where information was not being challenged or scrutinised based on what Mother and Father were reporting. Professionals should be able to understand their own responses to particular types of presentation and identify that where parents appear to be complying, that this may hide the true extent of their difficulties.

7.15 There are a number of concerns identified across agencies regarding fixed beliefs about who poses a risk and how that risk may be mitigated e.g. by the clothes someone wears. An up to date understanding of what represents a risk and the use of historic information to inform current parenting practices is needed. This is especially important for the way the system views first time parents where they are considered 'unknown' in their parenting role and therefore assumptions about the relevance of previous information are being made.

7.16 There was evidence of 'group thinking' during the child protection conferences because professionals had not been working directly with the family in most cases and therefore they did not have the evidence of findings to challenge

some of the information they were being given. Professionals tended to agree with each other as they had no alternative to argue. Supervision which could have been used to challenge some of this thinking was not available in some agencies or not being utilised effectively in others. This is further discussed in Finding 6.

Recommendation 6:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice to identify professionals' learning needs in relation to identifying on-going and changing risk; disguised compliance; positive bias and group think.

Finding 3:

Roles within the safeguarding system were confused and this led to a lack of information sharing and the information that was available not being scrutinised by appropriate professionals.

7.17 Safeguarding responsibilities were not understood well, particularly within health and were seen to be available for delegation. There was also evidence of this within the children's social care first assessment. Information sharing both within and between agencies was poor. Information shared at GP meetings with the health visitor was not written down and therefore unavailable to other professionals involved in the care of the family.

7.18 Frequently, information that was gained verbally by professionals and was critical for decision making was not recorded in a way that could be used to assess risk. Information was not shared with key professionals with assumptions being made about what they would already know. There was confusion about who was working with Mother and in what way and assumptions that the involvement of one professional negated the role of another.

7.19 There was evidence that historical information was available within the health records but this was not systematically reviewed and shared with children's social care in order to inform their assessment. Children's social care missed the opportunity to request more information relating to Mother and Father's histories, especially relating to Mother's mental health and Father's domestic violence history. There were clear indicators within the records that Mother would be likely to have difficulties making appropriate decisions to keep herself and her baby safe. No mental health assessment was ever requested.

7.20 The safeguarding system with health organisations did not identify discrepant information (missing information or information that was different to that being readily accepted) that professionals were relying on. Safeguarding leads within health were not used effectively to challenge professionals thinking and where decisions were made not to visit or not to write detailed records, this did not come to the attention of those professionals with a responsibility for safeguarding.

7.21 There were a number of instances where professionals saw their safeguarding role as sitting with someone else e.g. the primary worker. Any contact with the family was therefore not seen in a safeguarding capacity, but as carrying out a discrete piece of work with safeguarding sitting elsewhere.

7.22 The lack of urgency and the apathy with regards to sharing appropriate information meant that the real risk of this family to Baby W remained underestimated at best and unknown at worse.

Recommendation 7:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice to assure itself that where risks are identified and a referral is not made, the rational is appropriate and documented clearly within the records.

Recommendation 7.1:

Hillingdon Safeguarding Children Board should ask health organisations to provide evidence that there is a comprehensive understanding across all professionals regarding their individual professional responsibility within the safeguarding system.

Recommendation 8:

Maternity services should review the effectiveness of their current safeguarding arrangements as currently the system does not ensure effective supervision and challenge.

Recommendation 8.1

The role of the Named Midwife within the maternity services needs to be reviewed for job role conflict and ambiguity with the managerial role.

Recommendation 9: The lack of case management for high risk and vulnerable mothers within maternity services needs reviewing as it is creating risk within the system. There is too much reliance on single professionals to carry the riskier cases in the absence of an effective case management approach that is shared amongst the safeguarding team as a whole.
Recommendation 10: CNWL to reinforce the London Safeguarding Children Board Threshold Guidance and ensure that when the toxic trio has been identified the duty to refer is fully considered. Health visitors should access supervision and support for decision making dilemmas in this area.

Finding 4:

The child protection conference relied on professionals to share/challenge information about a family that they had not been involved with.

7.23 As is accepted good practice, children's social care relied on individual agencies to ensure that the most appropriate professional contributed to the process and attended the child protection conferences. There is an assumption within the system that the GP would not wish to be involved in the process and therefore the information they provide can lack detail. The GP often has ongoing contact with the family and a conversation between the social worker and the GP would have enabled the GP to be more informed in future meetings with Mother.

7.24 The lack of known information about Mother's capacity to parent and the risk of Father to Baby W meant that un-informed decisions were made by professionals who were not working with the family at Child Protection Conferences.

7.25 Professionals were consistently attending conferences without providing appropriate information or prioritising visits to gain that information. Professionals did not seem to be aware of the significance of their attendance at the conference and made no attempt collectively to ensure that the right people were around the table.

7.26 The opportunity to invite professionals who had worked with the family was missed by maternity services who should have selected the most appropriate person to attend.

7.27 Although the information shared at the conference was sufficient to identify risk, the quality of chairing of the child protection conferences was not adequate. The chair did not ensure that the right people were at the table, discrepant information was identified and information was not analysed in enough depth to assess the level of risk. Other professionals at the conference did not challenge the quality of chairing even though the minutes show that the chair was making inappropriate comments regarding domestic violence. It has not been possible to speak to the chair who no longer works in the UK. Since this time, quality assurance processes have been put in place to recitfy this issue. [17]

7.28 At the time of the conferences the administration service was being provided as a separate service within the local authority. The lack of internal administrators to the children's social care team appeared to create delays in requests to attend the conference being circulated, delays or non-sending of conference minutes, and a generalised lack of accuracy in the content of what was being recorded.

Recommendation 11:

The Hillingdon Local Safeguarding Children Board needs to ensure that the London Child Protection Procedures regarding good practice at child protection conferences is followed.

Recommendation 11a:

Children's social care should work with partner agencies to review the effectiveness of the quality assurance mechanisms for child protection conferences in order to ensure that they are having a positive impact on outcomes for children.

[17] Child Protection Conference chairs are observed by their line managers as part of the ongoing service improvement and continuous professional development. Feedback forms are provided to professionals who attend CP conferences.

Finding 5:

The arrangements for supervision within the system either did not exist or were not effective at enabling professionals to think about the needs of Baby W.

7.29 Despite the needs and complexity of this family, they were not discussed by any health professional in safeguarding supervision. The arrangements for safeguarding supervision in some agencies lacked appropriate scrutiny and/or trained professionals undertaking the supervision. Time on the job does not serve as a proxy for effective supervisor skills and more attention to the role of the supervisor as providing safeguarding assurance for organisations needs to be given.

7.30 Where arrangements for safeguarding supervision did exist, there was a lack of quality audit around activity to ensure that high risk families are being appropriately engaged with. If the professional does not bring a family into supervision even where there are significant risks, these families are not picked up elsewhere.

7.31 A number of the professionals spoken to by the lead reviewer working with the family were struggling with their own capacity to think. Whilst this was coming from conflicting workload demands and the general pace and tenor of the work, as well as emotional stress from outside of the workplace, these were not unknown to managers. There did not appear to be a connection made between the lack of ability to think and the increased safeguarding risks this might present. There was no evidence of restorative approaches to supervision to ensure that professionals could manage their risks and retain their capacity to think.[18]

7.32 The higher the safeguarding demand and responsibility within the system, the less professionals appeared to be supported by an appropriate level of scrutiny and supervision. Within health settings, where supervision arrangements were in place, the professional decides what cases are discussed. Risk is increased where the frequency of supervision arrangements does not match the changing demand of a case and therefore the need for more urgent supervision. Without the capacity to discuss all cases within safeguarding supervision there will always be cases that have not been discussed and a more risk based assessment of what is not discussed needs to be considered.

[18] Department of Health (2012) Using Restorative Supervision (Wallbank, 2009) to improve practice and safeguarding decisions. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209911/S15_Restorative_Supervision_Surrey_EISCS_V121211.pdf

Recommendation 12:

Hillingdon Safeguarding Children Board should develop a statement of expectation regarding the core elements of effective supervision underpinning safeguarding practice and seek assurance from all organisations that their arrangements meet these expectations. The statement should consider the findings of this review in relation to the need to ensure that professionals are supported to develop their capacity to think, challenge themselves and others and manage the emotional impact of the work.

Good practice

The review would like to draw attention to the excellent approach that the sonography team had within the hospital to the vulnerable mothers. They liaise closely with their midwifery colleagues about non-attendance and issues arising within the scan appointments and should be considered able to be more involved in the safeguarding process.

8. APPENDIX 1: THE REVIEW PROCESS

8.1 This serious case review process was based on the principles set out in Working Together to Safeguard Children 2015 namely the review:

- 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.

8.2 Hillingdon Safeguarding Children Board (HSCB) has developed a Serious Case Review Guide for Staff and Information for Families which should be made available to all relevant individuals engaged in any particular review.

8.3 Following agreement by the subcommittee that the case met the threshold for a serious case review, the chair of Hillingdon Safeguarding Children Board commissioned this review.

8.4 Dr Sonya Wallbank and Jane Wonnacott were appointed as the lead reviewers and report authors. Dr Sonya Wallbank is a Clinical Psychologist who has extensive senior experience working within the Health System including the Department of Health. She has a Doctorate in Clinical Psychology and has undertaken significant research on the impact of practitioner stress, burnout and compassion fatigue on their capacity to assess risk and make appropriate decisions. Jane Wonnacott qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in social work and also an MPhil as a result of researching the impact of supervision on child protection practice. She has over 20 years' experience of carrying out serious case reviews.

8.5 The lead reviewers worked with a small team of senior professionals from within Hillingdon who represented the organisations who had contact with Baby W and his family. This team consisted of:

- The Local Safeguarding Children Board Business and Development Manager
- Named Nurse Safeguarding Children for Central and North West London NHS Foundation Trust

- Designated Nurse Safeguarding Children, Hillingdon
- Named Nurse Safeguarding, The Hillingdon Hospitals NHS Foundation Trust
- Metropolitan Police Representative
- Associate Director, Safeguarding and Service improvement, London Borough of Hillingdon

8.6 The review process involved:

- Compilation of an integrated chronology
- Review team meetings to analyse information submitted and support the review in terms of identifying missing information, further lines of enquiry and the practitioners who would be asked to contribute through individual discussions
- Practitioner discussions
- Writing an agreed case narrative and identification by the review team of emerging findings and appropriate recommendations

8.7 The review team agreed that the questions that should be considered during the course of the review were:

Question
Risk assessment
What questions were asked to identify risk factors? What questions were not asked or professionals did not conteplate needing to ask?
How far was information about father explored and understood?
Did professionals feel able to ask difficult questions and if not, what were the perceived barriers?
What information was known about the risk factors e.g. maternal grandmother? Were the risks apparent and if not, why not?
Action/Decisions taken
How was the information responded to, shared and understood?
What information was available to professionals but not reviewed and therefore unknown?

What gaps were identified in information or understanding?
How far was discrepant information identified and/or challenged?
Had the full information been known to professionals what changes in practice or decisions would have taken place if any?
Why wasn't a referal made earlier? – what was driving this thinking? What was stopping this happening?
Child protection planning process
How far did the pre-birth assessment capture extended family history in order to assess risk? What stopped a more in-depth social work assessment?
Why is there limited evidence of the risk factors appearing within the child protection conference?
As part of the S47 enquiries what should have been found out? E.g. grandmother drinking risks.
What is in the child protection plan and was it effective?
Who was present at the conference? Do the minutes capture the concerns?
Broader context
How did responses/action match with relevant policies and procedures?
Did cross border sharing of information impede decision making?
How did the administration support of the conference impact what was recorded?

8.8 Individual chronologies were received and reviewed from:

- GP practice
- Accident and Emergency
- Alcohol support services
- Midwifery services
- Health visiting services
- Children's social care

- Metropolitan Police

8.9 The lead reviewer met with the following people in order to understand in more detail events leading up to Baby W's injuries:

- Mother's GP
- Senior Project Manager – Children's Social Care Assessment Team
- Senior Social Worker – Children's Social Care
- Social Worker – Children's Social Care
- Stenographer – Maternity Services
- Specialist Midwife – Maternity Services
- Named Midwife – Maternity Services
- Community Midwife – Maternity Services
- Safeguarding Midwives – Maternity Services
- Consultant Obstetrician – Maternity Services
- Health Visitor
- Police conference liaison officer- Metropolitan Police

8.10 There were six meetings of the review team:

- 9th November 2015
- 16th December 2015
- 29th February 2016
- 15th April 2016
- 22nd June 2016
- 16th September 2016.

8.1 Mother and father were invited to contribute to the review but at the time of writing have not taken up the offer to do so.

8.2 In order to make sure that lessons could be implemented as soon as possible it was agreed that the report should be presented to the Safeguarding Children Board before the conclusion of the criminal proceedings. The panel recognised that Mother and father's feelings regarding contributing to the review could change following conclusion of the criminal investigation they will be contacted again at that point.