Gloucestershire Local Safeguarding Children Board

Serious Case Review

"Ben"

November 2015 (Amended June 2016)

Lead Reviewers:

Jane Wiffin

Vicki Butler

Contents

1 Introduction 5

1.1 Why this case is being reviewed? 5

1.2 Family Composition 5

1.3 Succinct summary of case 6

1.4 Methodology 6

1.5 Family Involvement 6

2 The Findings of the Serious Case Review 7

2.1 Introduction 7

2.2 Appraisal of professional practice in this case – a synopsis 7

2.3 The importance of pre-birth assessments 7

2.4 The need to focus on Fathers in the antenatal period 8

2.5 Lead professional processes on the neonatal unit 9

2.6 Early Help Response 11

2.7 The importance of a comprehensive "at birth" assessment 11

2.8 How does this case act as a window on the safeguarding system more widely? 12

2.9 Summary of findings 15

2.10 FINDING 1: The principles of effective evidence based pre-birth and "at-birth" (perinatal) planning need to be embedded in multi-agency assessment activity where there are known vulnerabilities – its absence leaves babies at risk of poor care and harm 16

2.11 How did the issue feature in this particular case? 16

2.12 How do we know this is not peculiar to this case? 18

2.13 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? 18

2.14 Finding 2: The culture of a primary focus on the needs and circumstances of Mothers in the antenatal and postnatal period needs addressing to ensure that Fathers are included and that the contribution they make, the stresses they experience, and the risks they may pose are assessed. 19

2.15 How did the issue feature in this particular case? 20

2.16 How do we know this is not peculiar to this case and what numbers of cases are affected? 21

2.17 FINDING 3: It is important that Lead Professionals' processes in neonatal units for vulnerable babies with vulnerable parents; their absence leaves parents without a point of contact and makes it harder to assess and follow up on concerns leaving babies needs unaddressed. 21

2.18 How did the issue feature in this particular case? 22

2.19 How do we know this is not peculiar to this case and what numbers of cases are affected? 23

2.20 FINDING 4: Professionals should be supported in their role to ensure that assessment, decision-making and support plans routinely take sufficient account of the additional vulnerabilities of premature babies, leaving parents better informed and premature babies safeguarded 23

2.21 How did the issue feature in this particular case? 24

2.22 How do we know this is not peculiar to this case? 25

2.23 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? 25

2.24 FINDING FIVE: The rhetoric that safeguarding is a shared responsibility with all agencies taking their part is not consistently matched in practice, seeing children's social care continuing to see themselves, and be seen as the only agency to hold primary responsibility for decision making in cases. 26

2.25 How did the issue feature in this particular case? 27

2.26 How do we know this is not peculiar to this case? 28

2.27 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? 28

2.28 FINDING 6: Arrangements, roles and responsibilities for managing early help to families in Gloucestershire needs to be much clearer, to ensure there is effective planning and decision making for children and their families. 29

2.29 How did the issue feature in this particular case? 30

2.30 How do we know this is not peculiar to this case? 31

2.31 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? How do we know this is not peculiar to this case? 32

2.32 FINDING 7: Practitioners across agencies have not been supported to be able to identify the potential for non-accidental head injury NAHI ("shaken baby" syndrome) and there is no mechanism in place to raise awareness or to take preventative action leaving babies at potential risk of physical injury..... 32

2.33 How did the issue feature in this particular case? 34

2.34 How do we know this is not peculiar to this case? 34

2.35 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? 34

Appendix 1: Methodology 36

Appendix 2: Timeline 39

Appendix 3: References: 41

1 Introduction

1.1 Why this case is being reviewed?

This Serious Case Review was commissioned due to the nature of the child's death.[1] When Ben was 9 months old he was brought to hospital by ambulance having collapsed whilst in the sole care of his father, Jack. At hospital he was found to be very unwell. His parents reported that he had been unsettled for the last two weeks, with increased crying and poor sleeping patterns. This had coincided, in part, with his Mother, Antonia's return to work three weeks earlier. Jack said that over the previous two days Ben had been crying constantly and had seemed unwell. Ben died two days later of brain damage and the cause was assessed to be a non-accidental head injury. Jack was subsequently arrested and police inquiries are ongoing[2]. It is mandatory[i] in these circumstances to carry out a Serious Case Review.

1.2 Family Composition

Anonymised Name	Relationships	Age at time of critical incident
Ben	Subject of this review	9 months – his adjusted age[3] for prematurity is 6 and a half months
Antonia	Mother of Ben	21
Jack	Father of Ben	23
Daisy	Half-sister and first child of Antonia	4
Sally	Great Maternal Grandmother/ Special Guardian of Daisy	Not known

[1] All names have been anonymised in this report

[2] Since the report has been finalised, criminal proceedings have concluded and Jack has been found guilty of manslaughter

[3] Babies who are born prematurely have two ages: their chronological age which is the age of the baby from the day of birth and their adjusted age the age of the baby based on his due date, so if a baby is 6 months old, but was born two months early, his or her adjusted age is 4 months. http://www.bliss.org.uk/common-medical-terms

All family Members are White/British

1.3 Succinct summary of case

This case is about Ben and his parents, Antonia and Jack. Antonia had a difficult childhood, and was emotionally abused by her stepfather. She had problems with alcohol in her early teens, left home at 15 and was pregnant with her first child, Daisy at 16. Antonia continued to misuse alcohol/drugs and there were significant concerns from Swindon Children's Services about Antonia's neglect of Daisy, despite considerable support. This led to Daisy going to live permanently with her Maternal Great Grandmother, Sally. Antonia met Jack when she was 19. She was homeless at the time and a month later she was pregnant with Ben. She sought maternity care immediately and she reported to professionals that she was happy to be pregnant and wanted to make a fresh start. Little was understood by professionals about Jack and his family. Ben was born prematurely at Gloucester Hospital (at 30 weeks gestation) and he was initially very unwell and was moved to Bristol Hospital; he made good developmental progress and moved to Great Western Hospital Swindon. Staff at this Neonatal Unit became aware that there had been historic safeguarding concerns; there were some issues regarding late visiting by the parents on the ward and the Neonatal Unit Consultant Paediatrician made a referral to Gloucestershire Children's Social Care (GCSC). A brief assessment was completed and no ongoing concerns were raised. Ben was discharged home after 6 weeks of being in hospital (three different hospitals). Early support was provided and the parents were visited regularly at home and they were observed to be loving and caring parents.

1.4 Methodology

This review has been undertaken using the Learning Together systems model developed by the Social Care Institute for Excellence[ii]. More details are included in Appendix 1, alongside information about the two reviewers who led the review process. A group of senior professionals came together to provide strategic information about their own agencies, and to help with the collection and analysis of data which has led to this final report, details are provided in Appendix 1. The practitioners who worked with the family were also involved; they provided data and sensitive critical reflections on the practice under review. This is not an easy thing to do and we are grateful to them for their honesty and openness.

1.5 Family Involvement

Antonia was invited to meet with the lead reviewers and although arrangements were made, she eventually found it too difficult to do so.

2 The Findings of the Serious Case Review

2.1 Introduction

The Findings section begins with a synopsis of the appraisal of practice. This sets out the view of the Review Team and Case Group about how effective the professional response to Ben and his family was during the time under review. Where possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the detailed findings. This is followed by "What is it about this case that makes it act as a window on practice more widely?" which explains the ways in which features of this particular case are common to other work that professionals conduct with children and families, and therefore how this one case can provide useful organisational learning to underpin improvement. Finally, the report discusses in detail the 7 priority findings that have emerged from this Serious Case Review.

2.2 Appraisal of professional practice in this case – a synopsis

This section summarises the appraisal or judgement that the professionals involved in this review made of practice in this case. Care has been taken to avoid hindsight bias and to focus on what was known and knowable at the time.

2.2.1 All the professionals who were involved with Ben and his parents became aware, almost immediately, of the complex maternal family history and Antonia's strongly stated desire to make a fresh start, change her circumstances and resume care of Daisy. This knowledge was not matched by curiosity regarding Jack's family history and background; there remains little knowledge about his past or family circumstances. Antonia did manage to achieve change in her life, and the care provided by both parents to Ben in the period before his death was observed to be very warm and caring and Ben developed well, despite his prematurity and early health difficulties. There was nothing to indicate to any professional that Ben would be harmed and the news of his sad death was a shock to them all.

2.3 The importance of pre-birth assessments

The first contact Antonia had with professionals in Gloucestershire was when she was in the early stages of her pregnancy with Ben. The midwife who saw Antonia for the first pregnancy appointment perceived her to be very positive and open. Antonia told the midwife that she had an older child who was being looked after by Sally, her Maternal Grandmother because of neglect; that she had had a difficult and abusive childhood and had abused alcohol as a result. When she was asked about domestic abuse, Antonia said that she this had been an issue in the past, but not now and she said this was a different relationship. She said she wanted to be a

better parent this time, and she had hopes that Daisy would eventually return to her care. Antonia attended all her midwifery appointments either alone or with Jack; she had minor pregnancy related health issues that she sought help for.

2.3.1 The midwives did recognise that Antonia was vulnerable, but her openness, her positive approach, determination and action to change her circumstances, along with her compliance with appointments, reassured the midwifery professionals that there were no current concerns. This was overly optimistic practice. There should have been a pre-birth assessment at this stage to consider the balance across the strengths, of which there were a number, with the risks, of which there were more – either undertaken under the auspices of an early help response (Common Assessment Framework) or via a referral to Gloucestershire Children's Social Care (GCSC). Although Antonia was open about the past, there were issues about her present context which she did not share and about which she does not appear to have been asked. Antonia's Mother's current partner died on the day that she discovered she was pregnant, and she was having to provide support and help to her Mother who was having increasing numbers of panic attacks requiring hospitalisation. She also did not say that she had been homeless until she met Jack and became pregnant a month later. These were issues that she shared with the Paediatrician at Gloucester Hospital after Ben died.

2.3.2 Professionals noted the information about Antonia's past, but did not sufficiently consider the potential impact of the past on the present or future parental care. The importance of in depth pre-birth/at birth assessments is addressed by Finding 1.

2.4 The need to focus on Fathers in the antenatal period

There was little focus at this time on Jack, and information about his personal circumstances or his family was not sought. Therefore the midwives did not know that Jack's own father had had a heart attack at the same time that Antonia had discovered she was pregnant, and as a result of taking time off to support his father, Jack had lost his job. An additional potential stress factor for Jack was that there was a family history of heart failure. The impact of these stress factors was not known. Jack had never been a parent and had not had the opportunity to attend parent education classes, something which would have helped with the transition to new parenthood; this should have been considered as a further potential risk factor. The requirements of the Healthy Child Programme[iii] are that fathers should be centrally involved as partners in the pregnancy and the transition to parenthood. This need for a focus on fathers in the antenatal and immediate postnatal period is addressed in Finding 2.

2.4.1 Ben was born prematurely at 30 weeks gestation at Gloucestershire Royal Hospital (GRH). He was extremely unwell and there was a deterioration in his health which was life threatening. Consequently he moved between GRH and St Michael's Hospital, Bristol. Antonia and Jack coped well during this stressful time and engaged with staff and in providing care to Ben. Ten days after he was born Ben was moved to Great Western Hospital, Swindon (GWH). The Hospital were made aware that Antonia had had social work support in her childhood and had Alcoholic Pancreatitis at age 15, but it was not clear that her older child did not live with her.

2.5 Lead professional processes on the neonatal unit

In the early days of Ben's admission to the GWH Swindon neonatal unit Antonia talked about feeling "down" and told nursing staff she had suffered from depression in her first pregnancy. Antonia was advised to visit her GP, which she did not do, and no member of staff was given the responsibility of following this up, despite it being discussed in the ward round. The ward staff also had concerns about the parents' irregular pattern of visiting, which was often late at night, and although this was discussed with them by a number of people, the cause or meaning of this unusual behaviour was never established and no one member of staff was given responsibility for addressing these concerns directly with them. A week after Ben was admitted to GWH, Swindon, Antonia's past history was discussed and another member of the nursing staff was asked to make contact with agencies to establish further information; no timescales were agreed, and because of the pattern of shifts on the ward this did not happen for two weeks. This delay impacted negatively on the discharge planning process, leading to a lack of planning between hospital staff and the professionals who eventually supported Ben in the community. When further information was sought, this was done thoroughly and appropriate advice was sought from specialist safeguarding professionals in the hospital. The lack of a Lead Professional process on the neonatal unit meant that no one person was responsible for addressing the concerns or liaising with professionals in the community. This is addressed in Finding 3.

2.5.1 A member of the nursing team made contact with midwifery services and Children's Social Care in Swindon and Antonia's past history was shared in full. Information about Jack's circumstances was not sought. An initial discharge planning meeting was held four weeks after Ben was admitted to hospital. This was outside the expectation of the GWH discharge planning policy which recommends that discharge planning starts as soon as possible after admission, and in plenty of time to ensure links are made with professionals in the community who will provide support. The initial discharge planning meeting was attended by the Consultant Paediatrician, the Health Visitor, ward staff and the parents. There was

agreement that the hospital would start the discharge process and there would be a referral to GCSC. The inconclusive nature of this meeting was not acknowledged and the need for a further discharge planning meeting once the referral had been made to consider any emerging issues was not considered. This meant that the expertise of the hospital regarding Ben's prematurity was not available to the professionals who were to support Ben and his parents in the community. When Ben was discharged home Antonia was provided with a lot of information about caring for a premature baby by GWH, but this information was not shared or discussed at the subsequent Team around the Child meeting. The issue of the importance of an awareness of the needs of premature babies in the community is discussed in Finding 4.

2.5.2 The Consultant Paediatrician contacted GCSC and made a full referral sharing all known information about Ben and his parents. GCSC agreed to undertake an initial assessment. As part of the assessment contact was made with Swindon Children's Social Care and all historical information was shared. The assessment consisted of two home visits, one where the parents were interviewed about their circumstances. The Social Worker was impressed by Antonia's openness and her positive attitude. Jack shared that his father had recently died and they were living in his flat. The accommodation was considered as appropriate, but the Social Worker was surprised that the living room had been made into a sort of bedsit – despite there being a number of bedrooms. The parents explained that they liked watching television late at night, and this would make feeding Ben easier. As a result of this first home visit the Social Worker discussed the case with his manager, and both agreed that because there were no concerns it was appropriate for Ben to be discharged home, with immediate support from the children centre and the Health Visitor. The Hospital professionals waited for GCSC to decide whether Ben could be discharged home, and when this was agreed there was no awareness from any professional that this should have been a collaborative process with a discharge planning meeting to consider the outcome of the assessment and the support needed for a vulnerable premature baby. Finding 4 addresses the lack of awareness in the community of the needs of a premature baby and Finding 5 looks at the tendency of professionals to leave GCSC with the sole responsibility of making decisions for children, and the acceptance of this by GCSC staff.

2.5.3 The Health Visitor and Children's Centre worker visited Ben and his parents on the first and second day after discharge. They were both impressed by Antonia and Jack and the care and warmth they demonstrated to Ben. They were surprised by all the furniture being in one room and discussed this with the parents, who provided the same explanation they had given the Social Worker.

2.6 Early Help Response

A Team around the Child meeting was convened by the Social Worker when Ben had been at home for three days. This was attended by the parents, the Health Visitor and a professional from the Children's Centre. No one who attended understood that this was a Team around the Child Meeting, and there was no discussion of the need for a Lead Professional or issues of confidentiality, relating to information sharing. This meeting, delivered as part of an Early Help response, should have been collaboration between the parents and the professionals, with a plan of action agreed between all parties, outcomes set and a review process agreed. None of this happened, and the parents were told what services they should accept. Their reluctance to attend groups was acknowledged. A brief plan was outlined, which included visits from the Children's Centre and the Health Visitor, Ben to be taken regularly to health clinic and the parents to attend groups, but the purpose of this proposed plan of action was not made clear and no account was taken of the particular needs of a premature baby. Although this was called a Team around the Child meeting, and should have been seen as a formal early help response, there was no sense that this was understood by anyone present. This is addressed through Finding 6.

2.7 The importance of a comprehensive "at birth" assessment

An Initial Assessment[4] was completed four weeks later and the case closed to GCSC. This was an Initial Assessment which is defined as a brief process with the aim of establishing whether a child and their family needs services or whether further assessments are necessary. This assessment was, by its nature, superficial and did not address the central issues necessary to answer the question of whether two parents with such a range of social stressors, vulnerabilities and risk factors would be able to overcome these and be successful parents; particularly how they might cope in times of difficulty. The importance of "pre-birth/at birth" assessments is explored in Finding 1.

2.7.1 The Children's Centre worker visited the family once a week and encouraged Antonia and Jack to attend groups. The purpose of these visits was unclear and coupled with there being no concerns, the Children's Centre decided to end their involvement after a month. They phoned the Social Worker primarily to inform him of the decision, but also to check that it was an appropriate one. The Social Worker agreed that the case could close to the Children's Centre, despite his involvement having already ceased and that he had had no involvement with Ben or his parents since the Team around the Child meeting. This confused exchange was caused by

[4] An initial assessment is defined as a brief assessment of each child referred to social services with a request for services to be provided. webarchive.nationalarchives.gov.uk/20130401151715/https. This has now been replaced by a single assessment process in Gloucestershire.

the lack of clarity regarding the Team around the Child Plan, and the absence of a lead professional. This also points to mixed messages regarding who takes responsibility for vulnerable children and their families. This is addressed in Finding 5.

2.7.2 Eight weeks after Ben returned home, during a holiday period, GCSC received a referral from the NSPCC National Centre. This had been posted anonymously online and made allegations that Antonia was neglecting Ben. The referral was considered by the Duty Manager. She looked at the electronic records and saw that the case had recently been closed to GCSC, that there was a plan in place for regular visits by the Health Visitor and Children's Centre (it had not been recorded that the Children's Centre had ceased their involvement) and that Ben was to be taken to clinic weekly for weighing. She noted that there had been no other reported concerns. The Duty Manager believed she could not share information about this referral with the Health Visitor because she did not have the parent's permission to do so. She was confident if there had been concerns these would have been raised by the Health Visitor and so she closed the case without Ben having been seen. This referral should have warranted a visit by either a Social Worker or the Health Visitor given the age of the baby and the known history. If the issue of consent to information sharing had been addressed at the original Team around the Child Meeting this would have been a straightforward decision, but uncertainty about consent should never be a barrier to assuring the welfare of a child. Mother was unaware that this referral had been made.

2.7.3 Ben was seen by a number of professionals over the next few months. The Health Visitor was heavily involved and provided additional support to the family. This was not due to her having any concerns about the welfare of Ben but being a student Health Visitor was in a position to provide additional support and visits. Antonia was seeking help appropriately and Ben was thriving and was well cared for. Antonia told the Health Visitor that she had found a job and was very happy. She saw this as part of the changes she had made over an 18 month period and she hoped it would mean that she could consider seeking to have Daisy coming back to live with her. This was the last time the family were seen, before Ben was taken to hospital with a non-accidental head injury – and this is discussed in Finding 7

2.8 How does this case act as a window on the safeguarding system more widely?

The central purpose of a Serious Case Review is to learn lessons about how to improve the safeguarding system for the future. In essence the review looks back at one case in order to look forward to what would improve the practice in the wider safeguarding system. Although this case was unique to those involved, there

are aspects that are familiar to all professionals who work with vulnerable children and their families, and therefore this one case can provide useful organisational learning to underpin improvement more widely – it does act as a window on the safeguarding system in Gloucestershire.

2.8.1 This case highlights the balancing act faced by professionals when a parent has previously had a baby removed from their care because of neglect, there is a new pregnancy and decisions need to be made about the capacity of parents to provide appropriate care to the new baby. This is an important decision because babies are vulnerable, and particularly so, when they are born prematurely. This decision making is made more complex by a parent having been abused in childhood, and engaging in negative behaviours such as substance misuse, which have their roots in coping with early abuse. Part of the balancing act is weighing up whether parents stated intention to change in these situations is realistic and evidenced over time. Therefore this case has the potential to highlight through the Findings elements of effective practice. In this review all of the Findings are overlapping. They all have something to say about the vulnerability of young babies, particularly when they are born prematurely and their parents have historic and current factors which may impact on the quality of care they can provide. These Findings point to the importance of good quality evidence based assessments, planning and decision making which is multi-agency and includes fathers. This case also highlights the potential complexity of cross border working. The family were known to two local authorities, and three hospitals. However, this proved not be an influential issue in this case.

2.8.2 The Review Team has prioritised 7 findings for the LSCB to consider. They relate to one of the six categories of underlying patterns (see Appendix 1). Each finding is set out in a way that illustrates:

- How does the issue feature in this particular case?
- How do we know it is not peculiar to this case?
- What can the Case Group (those who worked with the family) and Review Team (the senior managers from each agency appointed to help with this case review) tell us about how this issue plays out in other similar cases/scenarios and/or ways that the pattern is embedded in usual practice?
- How prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern?
- How widespread is the pattern? Is it found in a specific team, local area, district, county, region, national?
- What are the implications for the reliability of the multi-agency child protection system?

2.8.3 The evidence for the different 'layers' of the findings comes from the knowledge and experience of the Review Team and the Case Group, from the records relating to this case, and other documentation from agencies, and from relevant research evidence.

2.9 Summary of findings

FINDING	CATEGORY
FINDING 1: The principles of effective evidence based pre-birth and "at-birth" (perinatal) planning need to be embedded in multi-agency assessment activity where there are known vulnerabilities – its absence leaves babies at risk of poor care and harm.	**Patterns of communication and collaboration in longer term work**
FINDING 2: The culture of a primary focus on the needs and circumstances of Mothers in the antenatal and postnatal period needs addressing to ensure that Fathers are included and that the contribution they make, the stresses they experience, and the risks they may pose are assessed.	**Patterns of communication and collaboration in longer term work**
FINDING 3: It is important that Lead Professionals processes are embedded in neonatal units for vulnerable babies with vulnerable parents; their absence leaves parents without a point of contact and makes it harder to assess and follow up on concerns leaving babies needs unaddressed.	**Patterns of communication and collaboration in longer term work**
FINDING 4: Professionals should be supported in their role to ensure that assessment, decision-making and support plans routinely take account of the additional vulnerabilities of premature babies leaving parents better informed and premature babies safeguarded.	**Patterns of communication and collaboration in longer term work**
FINDING 5: The rhetoric that safeguarding is a shared responsibility with all agencies taking their part is not consistently matched in practice, seeing children's social care continuing to see themselves, and be seen as the only agency to hold primary responsibility for decision making in cases.	**Patterns of communication and collaboration in longer term work**
FINDING 6: Arrangements, roles and responsibilities for managing early help to families in Gloucestershire needs to be much clearer, to ensure that there is effective planning and decision making for children and their families.	**Patterns of communication and collaboration in longer term work**
FINDING 7: Practitioners across agencies have not been supported to be able to recognise the potential for non-accidental head injury NAHI ("shaken baby" syndrome) and there is no mechanism in place to raise awareness or to take preventative action leaving babies at potential risk of physical injury.	**Patterns of communication and collaboration in longer term work**

2.10 FINDING 1: The principles of effective evidence based pre-birth and "at-birth" (perinatal) planning need to be embedded in multi-agency assessment activity where there are known vulnerabilities – its absence leaves babies at risk of poor care and harm

2.10.1 Pregnancy and the first year of life are one of the most important stages in the life cycle[iv]. It is the point at which the foundation of future health, development and well-being are laid down. The long term outcomes for children are strongly influenced by the factors that operate during pregnancy and the immediate postnatal period. It is therefore imperative to ensure that babies in utero and the early stages of their lives receive the best possible care and that any vulnerabilities are recognised early and addressed quickly. This requires good quality multi-agency pre-birth or at birth assessments to be undertaken[v].

2.10.2 Those assessments need to be based on the best evidence about what causes babies to be vulnerable to poor care or abuse. There is good quality research which outlines the factors which make abuse and neglect more likely[vi]. Those factors are connected to the circumstances of both parents/carers, particularly parents own experiences of being cared for, their experiences of being abused and neglected and the sense they made of this; their previous abuse of children and how much they take responsibility and feel empathy for the affected children. Issues such as parental mental illness, substance misuse are possible risk indicators as are the quality of parental relationships and current and historical family relationships. Family context is important, including socio-economic stresses and social isolation. The Parent-Baby relationship is critical; understanding the extent to which both parents have the capacity to understand their babies' emotional state, feel empathy for them and respond appropriately when they make demands on the parent. Research suggests that some vulnerable parents find these demands difficult and they can evoke strong feelings in parents about their own current or past difficult circumstances which can cause them to respond negatively as a result. All these factors should form the basis of a good quality evidence based pre-birth or at birth assessment when there are known vulnerabilities. It is important that these assessments are undertaken as early as possible to address concerns, provide support and build early relationships of care between the baby and parents.

2.11 How did the issue feature in this particular case?

Ben was born prematurely and spent some time in the Neonatal Unit at GWH Swindon. Professionals responsible for Ben's care became aware that there were historic concerns regarding Antonia and appropriately it was agreed that further inquiries should be made. These were delayed and information was not sought

until some weeks into Ben's stay on the ward. Extensive inquiries were undertaken with external agencies, but these inquiries were not matched by interviews with Antonia or Jack and the task of an assessment was passed to Children's Services.

2.11.1 Children's Services recognised the need for an assessment quickly, but this was not undertaken using an at birth/pre-birth framework - instead the much more superficial framework of the Initial Assessment[vii] was used. This focussed almost exclusively on Antonia, rather than Jack, and looked at her past circumstances and family history. Concerns about Antonia's experience of being abused as a child and the connection to her significant alcohol misuse were acknowledged. Her feelings about this in the context of caring for her own child were not discussed nor what feelings the care needs of the baby might evoke in her. Given that she had used alcohol in the past to cope with stress there should have been more reflection on the fact that she might use alcohol to cope with stress again.

2.11.2 Jack talked about the death of his father, which had been recent, and that they were living in his father's flat, but this significant loss was not explored, and the worries that Jack had regarding his own health because of the family history of heart disease only emerged after Ben died. His work circumstances were not explored either, and the fact that he had recently lost his job did not emerge, and therefore the impact on him or the family unit was not explored.

2.11.3 The parental relationship was not explored at all - although its newness was acknowledged. The parent – child relationship was described as very positive and that *"the parents seem to have a very strong emotional bond with Ben*". This assertion was made on the basis of one visit to the home, in the context of a professional's meeting, when Ben had been home for three days. This description was premature. There was some indication that both parents were coming to terms with balancing their own needs with those of a premature baby. They had moved all their belongings into the living room including Ben's cot, and explained that as they liked watching television this would enable them to do this and feed Ben. They also needed to be reminded of the importance of not smoking, particularly in the context of Ben's prematurity. These are small examples, but could indicate some contradiction between a stated strong emotional bond, and the realities of looking after a small baby. This needed further exploration and could have formed part of a plan to monitor how they were managing their own needs and the needs of Ben over time. The issue of Ben's prematurity and the impact of this on the early days of looking after him was not considered in the assessment and this is addressed in Finding 4.

2.11.4 Finally the issue of family support was not sufficiently explored or analysed. Antonia said that relationships with her own family were improving after what had been a difficult past. She did not mention that her mother's partner had recently died or that she had had to accompany her mother to mental health support because of her long standing problems with anxiety. It is unclear if these tensions were asked about, but the conclusion was that Antonia's Mother would be "*actively involved in providing support*" despite living some way away was over optimistic.

2.11.5 An at birth/pre-birth assessment needs to consider the impact of any parents past circumstances and make a judgement about the potential impact on the care of a vulnerable baby in the present and future; weighing up both potential risks and actual evidence based strengths. There was some attempt to do this within the Initial Assessment, but the core elements of an evidence based at birth/pre-birth assessment were missing.

2.12 How do we know this is not peculiar to this case?

The Case Group and Review Team who were such an integral part of this review reflected on the provision of pre-birth and at birth assessment. Although they felt that the need for these assessments to take place in a timely way was recognised and did happen locally, they were of the view that these were not undertaken using any kind of evidence based framework. This replicates the national picture where there have been concerns regarding the quality of pre-birth assessments. This is something that the NSPCC are prioritising as part of their "All Babies Count Campaign[viii]" and they have developed a specialist pre-birth assessment tool which they are trialling nationally.

2.13 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

Gloucestershire has a significant child population (22.95 of total population) and many are under 1 year old. Nationally there is recognition that Under-1s are a key group of concern for services. Almost a half (45 per cent) of all serious case reviews in England involve a child under 1, and a substantial proportion of such cases involve babies of three months or younger. Between 8 and 12 per cent of all children subject of a child protection plan are aged under 1. In both England and Wales, neglect is the most common category of abuse for under 1s subject of a child protection plan. Compared to all children under 18 in England, boys and girls under 1 are nearly three times as likely to be subject of a child protection plan due to physical abuse, over two times as likely to be subject of a child protection plan for neglect and 1.3 times as likely to be subject of a child protection plan for emotional abuse[ix]. There is nothing to suggest that the local picture is different and

therefore there is likely to be a number of babies who need to be subject of specialist pre-birth/at birth assessments.

FINDING 1 : The principles of effective evidence based pre-birth and "at-birth" (perinatal) planning need to be embedded in multi-agency assessment activity where there are known vulnerabilities – its absence leaves babies at risk of poor care and harm

Research has highlighted the increased vulnerability of young babies to abuse and neglect and the significant effect this can have on their wellbeing in the present and future. In order to make good quality decision making and plans regarding vulnerable babies it is essential that evidence based pre-birth and at birth assessments are undertaken in a timely way. In this case the assessment was neither timely or evidence based.

Considerations for the Board and member agencies

- What is known within the LSCB about practice regarding pre-birth/at birth assessments?
- What work has been carried out by the LSCB and its partner agencies regarding pre-birth/at birth assessments?
- Is there a structure and a template for these assessments outlining what should be covered and if this exists is it evidence based?
- How would an improvement in practice in this area be known about?
- What training is available?
- Could the LSCB link with national work being undertaken by the NSPCC?

2.14 Finding 2: The culture of a primary focus on the needs and circumstances of Mothers in the antenatal and postnatal period needs addressing to ensure that Fathers are included and that the contribution they make, the stresses they experience, and the risks they may pose are assessed.

"*The involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long wellbeing and outcomes of the child (regardless of whether the father is resident or not). Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of children." (NSF, 2004)*[x].

2.14.1 There is good evidence that the involvement of fathers in antenatal and postnatal care has benefits for children and their mothers[xi]. In recognition of this there has been a national drive towards an increased recognition of the role of fathers and

encouraging fathers' involvement in children's lives. It is 25 years since Professor Michael Lamb described fathers as the "forgotten contributors to child development"[xii] and in this time organisations like the Fatherhood Institute[xiii] the Royal College of Midwives[xiv], the Departments for Health and Education, the NSPCC[xv] and many others have provided valuable research, guidance and best practice examples to encourage services to work better for fathers - the "forgotten fifty per cent" of parents. The Healthy Child Programme (HCP[xvi]), the national programme for children and families, has a major emphasis on parenting support, including supporting both fathers and mothers to provide sensitive and attuned parenting, in particular during the first months and years of life; supporting strong couple relationships; ensuring that contact with the family routinely involves and supports fathers, including non-resident fathers and supporting the transition to parenthood, especially for first-time fathers and mothers. Research has highlighted that the involvement of fathers at an early stage of their children's lives (including before they are born) is vital because levels of father involvement established early on tend to endure[xvii] .

2.15 How did the issue feature in this particular case?

It is striking across the whole period under review how little was known about Jack's past and present circumstances, his family history, family relationships and social circumstances. He attended, some, but not all maternity appointments, and although Antonia provided a lot of information about her past during this time, nothing was recorded about Jack. This situation was replicated in the neonatal unit who had regular contact with Jack over a 4 week period.

2.15.1 During the assessment carried out by GCSC little information was sought about him and this was the same in the work carried out by the Children's Centre and the Health Visitor. This was despite him being present at most of the meetings and home visits that were carried out. What was known was that he was a new (and youngish) parent, that he had not had the opportunity to access parent education classes, his father had died during Antonia's pregnancy, they lived as a family in his father's flat and he was reluctant to engage in services. He was also observed to be a caring and supportive father. The focus was entirely on Antonia and her past circumstances. There appears to have been a lack of professional curiosity about the parents' relationship, which was known to be recent, and how they planned to parent together, their views about parenting and how they were coping as a couple with the care of a premature baby.

2.16 How do we know this is not peculiar to this case and what numbers of cases are affected?

The Review Team and Case Group considered that although the inclusion of fathers in all areas of practice had improved locally over the last few years, this remained an area of practice development, particularly in the context of antenatal and postnatal services. This affects many vulnerable families who need additional support.

Finding 2: The culture of a primary focus on the needs and circumstances of Mothers in the antenatal and postnatal period needs addressing to ensure that Fathers are included and that the contribution they make, the stresses they experience, and the risks they may pose are assessed.

The critical role played by fathers in children's lives, both positive and negative, has been recognised by national and local serious case reviews. If practice is to improve in this area it must begin during pregnancy and in the early days of a child's life, creating early emotional bonds between fathers and their children. Research suggests that this time is important, but there have been challenges in changing perceptions from "women centred care" to "Think Fathers" to parent centred care.

Considerations for the Board and member agencies

- Do the LSCB recognise this as a local issue?
- What work has the LSCB already completed regarding the involvement of fathers in Safeguarding practice?
- Could the LSCB link with the national Think Fathers agenda – and make use of available tools and resources?
- How would the LSCB know it had made improvements in this area of practice?

2.17 FINDING 3: It is important that Lead Professionals processes are embedded in neonatal units for vulnerable babies with vulnerable parents; their absence leaves parents without a point of contact and makes it harder to assess and follow up on concerns leaving babies needs unaddressed.

"Having a baby in neonatal care is naturally worrying for parents and every effort should be made to ensure that they receive the information, communication and support they need[xviii]*."*

"The concept of family-centred care has advanced in recent years and become recognised internationally. The underlying philosophy puts parents and the family at the centre of health care and promotes "individualised, flexible care," underpinned by appropriate information, support, and effective communication[xix]***."***

2.17.1 Having a baby in a neonatal unit can be anxiety provoking for all parents and particularly so for those parents with additional vulnerabilities. Research suggests[xx] that ensuring families receive consistency and continuity of care when their baby is in neonatal care is essential for the wellbeing and outcomes for babies, as well as their parents. This has been referred to as "family centred care" and means that there is someone whom parents can talk to about their concerns, seek advice from and plan the future, particularly the transition from hospital to home. It is essential that parents and families know who they can talk to, but it is often the case that the staffing arrangements on hospital wards means that parents can come into contact with large amounts of professionals, with large gaps between one meeting and another. This has led to some parents feeling isolated, unclear who to turn to in times of crisis, and ultimately unsupported[5]. These early days of parent-child care are critical to building emotional bonds for the future. It is essential that parental concerns are addressed quickly, their worries and anxieties addressed, and vulnerabilities picked up. Research suggests this is best achieved through consistency of care and building relationships between professionals and parents. There is no one model of key working arrangements nationally, but it is essential that all neonatal units consider how best to provide key working processes.

2.18 How did the issue feature in this particular case?

Ben was in neonatal care in GWH, Swindon for a number of weeks. During this time there were concerns about historic safeguarding issues regarding Antonia and uncertainty about Ben's half-sibling Daisy. These were recognised early on, but there was a delay in actioning any inquiries, because no one person was responsible for the care plan for Ben. There were also worries about the parents visiting pattern and behaviour on the unit. These were discussed within the ward round, and although the parents were present, there is no evidence that a member of staff spent time individually with them to understand the nature of the problem, or the meaning for the future care of Ben. Antonia shared with a member of staff on the neonatal unit early on that she was feeling low and had previously suffered from depression. She was advised to visit her GP, but there was no follow up regarding this.

2.19 How do we know this is not peculiar to this case and what numbers of cases are affected?

Nearly 1 in 10 – babies are born prematurely and many will spend time in a neonatal unit[xxi]. It is not known how many of these babies will have additional vulnerabilities because of their parents/family circumstances, but research suggests that there are increased risk of abuse and neglect. Work around the implementation of the Family Centred Care Initiative suggests that parents and families do not always receive continuity of care.

FINDING 3: It is important that Lead Professionals' processes are embedded in the neonatal unit for vulnerable babies with vulnerable parents; their absence leaves parents without a point of contact and makes it harder to assess and follow up on concerns leaving babies needs unaddressed.

1 in 10 babies are born prematurely, and many are likely to start their lives in a neonatal unit. This is a critical time for parent–child relationships, and it is essential early stresses and vulnerabilities are addressed. This can only be achieved through consistency of care and effective parent-professional relationships. Research suggests that parents need to know who they can approach for help and advice, and who will provide continuity of support.

Considerations for the Board and member agencies

- Does the LSCB recognise that this is an issue locally?
- What work has already been undertaken to develop key worker processes in neonatal units?
- Could the LSCB link with the Poppy Campaign regarding "Family centred care?
- How would the LSCB know that action in this area has had an impact on children's lives and improved practice?

2.20 FINDING 4: Professionals should be supported in their role to ensure that assessment, decision-making and support plans routinely take sufficient account of the additional vulnerabilities of premature babies, leaving parents better informed and premature babies safeguarded

"Premature birth is a significant stressor for parents and may adversely impact ….parenting behaviour[xxii]*"*

Premature babies are defined by the World Health Organisation[xxiii] as those born before completing 37 weeks in the womb. This is an important issue as the rate of

development for babies accelerates over the last few months and weeks of pregnancy and the gestation of between 37 and 40 weeks is important to prepare babies for life in the outside world. Babies born between 33 and 37 weeks are defined as mildly premature and these babies who have nearly completed the usual time of gestation often do not need much support, either at birth or as they grow and develop. Babies born between 28 and 32 weeks are defined as very pre term. These babies are usually born with some difficulties which can require hospitalisation.

2.20.1 There is some evidence that premature babies can cause stress for parents, and that in the early days it can be harder to develop good parent- child relationships[xxiv]. It is therefore important to ensure that the right support is in place, particularly where parents/carers have additional vulnerabilities. When very pre-term babies return home from hospital it is important to consider how near to their actual birth date they are – as this may also impact on their vulnerability. Pre-term babies can come home with a range of needs, but they are vulnerable to infection, particularly if they come home between October and March. Professional advice is that parents take things slowly, to avoid situations with lots of very young children such as playgroups and to ensure that anyone who comes into contact with the baby washes their hands thoroughly. Parents are told that they should not smoke at all because babies who have been in special care can have fragile lungs and can become unwell if they come home to an environment where people have been smoking.

2.20.2 Babies who have been in special care will have had a fixed routine on the ward regarding feeding and sleeping and it can take parents some time to adjust to this. Adjusting to sleep at home can be difficult for very premature babies and parents are advised to do things such as providing a quiet, dimly lit environment. Although most very pre-term babies will develop well, it may take them up to two years to catch up to their expected birth date. In recognition of this premature babies have two birthdays and two ages – their chronological age which is the is the age from the actual date of birth -- the actual number of days, weeks, or years old the baby is and their adjusted age which is the age of the baby based on his or her due date. So, if a baby is 6 months old, but was born two months early, his adjusted age is 4 months. This can help parents to understand developmental milestones.

2.21 How did the issue feature in this particular case?

Ben was born at 30 weeks gestation and so was born very prematurely. He was very unwell in the first week of life and he was transferred between hospitals for specialist care. He spent six weeks in hospital overall and returned home a month before his actual due date of birth. A discharge planning meeting was held six days

before he returned home. This is outside the expectation of Swindon Hospital Discharge planning process for vulnerable babies which suggests that discharge planning should start at admission or as early as possible. The discharge planning meeting, attended by hospital professionals and the Health Visitor, discussed the historical issues regarding Antonia and the current concerns about the visiting patterns of both parents. There was agreement that there was to be a referral to Gloucestershire Children's Social Care and plans were made regarding the discharge process at the hospital. There was no discussion about Ben's prematurity at this point or what the implications might be for any plans made when he returned home. The hospital provided Antonia and Jack with advice on discharge, and gave them a great deal of literature about caring for a premature baby at home; this was never shared with the team who supported Ben in the community, either by the hospital or by the parents, and this information was never sought.

2.21.1 The Assessment completed by GCSC did describe Ben's prematurity, but specialist input regarding the implications of this for decision making and planning was not sought and there was insufficient analysis of Ben's needs. If his prematurity had been considered, the fact that the parents had moved all the furniture into one room in order to be able to watch television and feed Ben might have been of concern because premature babies come home having been in a fixed routine. Ben's prematurity was not discussed at the Team around the Child meeting and the support plan recommended that Antonia and Jack take Ben to groups at the Children's Centre, something which was not in line with advice about the needs of premature babies. There was no acknowledgement that Ben might be more difficult to care for because of his vulnerability and that because Antonia had experienced difficulties parenting her first child and Jack had no previous experience of parenting, more support might need to be put in place. There was no recognition that Ben had returned home before his due date of birth and that there were implications for the care provided by Antonia and Jack over the next two years – given that it might take that time for him to catch up developmentally.

2.22 How do we know this is not peculiar to this case?

The Review Team and Case Group confirmed that there was a lack of awareness and knowledge regarding the needs of premature babies by professionals in the community.

2.23 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

In 2012, slightly more than 52,000 babies in England and Wales – nearly 1 in 10 – were born prematurely[xxv]. Research suggests that very pre-term babies can cause parents additional stress and there may be concerns regarding building parents –

child relationships[xxvi]. This would indicate that all professionals providing support to parents should be aware of the needs and circumstances of premature babies and ensure that assessment, decision making and support plans take this additional risk factor into account.

FINDING 4: Professionals should be supported in their role to ensure that assessment, decision-making and support plans routinely take sufficient account of the additional vulnerabilities of premature babies, leaving parents better informed and premature babies safeguarded

This case highlights the gap in knowledge between those who provide specialist care to premature babies in acute settings, and those who provide support in the community. This is an important issue given the vulnerability of premature babies and the enhanced risk of abuse and neglect. In this case professionals in the community had little knowledge of the needs of a premature baby and were hampered in their ability to provide effective plans for support and safety.

Considerations for the Board and member agencies

- Does the LSCB recognise this as an important issue locally?
- What can the LSCB do to improve the knowledge of professionals in the community and how can they harness existing knowledge and skills held by those working in acute settings?
- What training is available to LSCB staff in this area?
- How will the LSCB know any action they take has been successful?

2.24 FINDING FIVE: The rhetoric that safeguarding is a shared responsibility with all agencies taking their part is not consistently matched in practice, seeing children's social care continuing to see themselves, and be seen as the only agency to hold primary responsibility for decision making in cases.

"*The support and protection of children cannot be achieved by a single agency …Every service has to play its part. All staff must have placed on them the clear expectation that their primary responsibility is to the child and her/his family*"[xxvii]

Public Inquiries such as the Victoria Climbié Inquiry[xxviii] and numerous serious case reviews[xxix] have highlighted the importance of all agencies recognising their shared responsibility for safeguarding children and the importance of this being seen as a collaborative process. The Laming Inquiry highlighted the number of times when

agencies left decision making regarding child safety and wellbeing to the local Children's Services department, and there was a lack of any shared multi-agency discussion or planning. Since this time there have been large changes to policy and guidance. Section 11 of the Children Act 2004 "places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children[xxx]".

2.24.1 Safeguarding and promoting the welfare of children is defined in guidance[6] and Working Together to Safeguard Children (2015[7]) as:

- protecting children from maltreatment;
- preventing impairment of children's health or development; and
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

2.24.2 This makes clear the requirements for agencies to work together to ensure the wellbeing of children. There is good evidence that children's outcomes are improved when agencies take a holistic approach to their needs. This requires all agencies to take an active role in joint decision making for children and young people. This collective responsibility also needs to be viewed in the context of demands on Local Authority children's services which has been rising continually over the past seven years. In 2013–14 the number of referrals to children's social care services nationally increased by almost 11%, the number of child protection investigations rose by 12% and the number of children and young people becoming looked after rose by 1%.

2.24.3 Despite large scale national changes, there is evidence that the detail involved in ensuring that all agencies recognise that "safeguarding is everyone's business" has been more difficult to achieve in practice – turning rhetoric into reality. The Annual Report of Her Majesty's Chief Inspector of Education Children's Services and Skills, 2009–11 concluded that "*inspection has identified both strengths and areas for development in the interface between ….all services and the broader child protection system"*.

2.25 How did the issue feature in this particular case?

There were a number of examples in this case where GCSC were left with the sole responsibility for making decisions about Ben, and accepted the requirement to do

[6] Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004
[7] Working Together 2015

so. When Ben was in hospital, a referral regarding his safety and wellbeing was made to GCSC by GWH, Swindon. At this point the medical view was that Ben was medically well enough to be discharged home to his parents care. An assessment was completed and on the basis of this the Social Worker was asked to make the decision about whether Ben could be discharged home. There was no collaborative decision making or discharge planning with the longer term consequence that the expertise of the hospital regarding the needs of a premature baby was lost**.**

2.25.1 After a month of working with Ben and his parents, the Children's Centre decided to cease home visiting because they assessed that Antonia and Jack were coping well, there were no concerns and the visits were not purposeful. This was appropriately discussed by the Children's Centre worker with her manager in supervision. Despite the case having been closed to GCSC this decision was checked with the previous Social Worker. This Social Worker had had no recent contact with the family, so had no information about how well the parents were coping and he was not the case holder (the confusion regarding the early help plan and the lack of a lead professional meant that there was no one agency who had oversight of progress for Ben) . Despite this, he took responsibility for the decision that the Children's Centre could cease visiting and the agreed plan amended. The lack of collaboration at this point meant that the decision was made by an agency that had no recent contact, and this decision was not shared with the other agencies who were involved with Ben and his parents.

2.26 How do we know this is not peculiar to this case?

Although the recent section 11 Audit carried out in Gloucestershire showed high levels of multi-agency awareness and action regarding safeguarding roles and responsibilities, the Case Group confirmed that in frontline practice there was still a tendency for Social Workers to be viewed as having sole decision making responsibility regarding safeguarding and to naturally accept the responsibility without collaboration with others.

2.27 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

The need for a more collaborative approach to decision making regarding vulnerable children will impact on many cases. 41% of children in Gloucestershire live in the urban districts which have areas in the most deprived 10% nationally. There were nearly 20,000 contacts made by agencies regarding children and young people to Gloucestershire CSC in 2012/13 and 28.2% were accepted as a referral requiring action. At the end of 2013/14 93.4% of referrals went on to an Initial Assessment of which 25.3% resulted in no action. At the end of March 2014 there were 444 children subject of a Child Protection Plan, which means that

approximately 36 out of every 10,000 children and young people in Gloucestershire are suffering or likely to suffer significant harm.

FINDING 5: The rhetoric that safeguarding is a shared responsibility with all agencies taking their part is not consistently matched in practice, seeing children's social care continuing to see themselves, and be seen as the only agency to hold primary responsibility for decision making in cases.

A shared multi-agency approach to assessment, planning and decision making is essential for effective safeguarding practice. It is important that the national and local policy regarding "safeguarding being everyone's business" is reflected at all levels of practice. In this case despite there being an intellectual understanding of this shared responsibility, there was evidence that in actual day to day practice old established patterns of safeguarding being the sole responsibility of children's Social Care. This is unhelpful in a number of different ways. It causes confusion about decision making for individual children and undermines their safety; it causes resentment across professional groups and ultimately it puts undue pressure on one agency to manage an increasing workload.

Considerations for the Board and member agencies

- Does the LSCB recognise this as an issue locally?
- Has the Board done any work regarding this issue with front line practitioners?
- What could the Board do to address this issue?
- How will the Board know it has been successful?

2.28 FINDING 6: Arrangements, roles and responsibilities for managing early help to families in Gloucestershire needs to be much clearer, to ensure there is effective planning and decision making for children and their families.

Early help is an approach which offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending[xxxi]*;*

Research, policy and practice have identified the importance of offering help at an early stage to children and their families. Early help is defined as "*providing support as soon as a problem emerges at any stage of a child's life*". This is intended to

address the multiple disadvantages facing some children and families, to stop problems becoming entrenched, and therefore more difficult to address. There is good evidence that support is often offered too late to children and their families with enormous consequences for children's short and long term outcomes, the wellbeing of families as well as creating pressures on specialist services later down the line. As Munro highlighted in her review there are three imperatives for offering an effective early help response; a moral imperative for minimising adverse experiences for children and young people, a "*now or never*" imperative given the long term damage caused by early adverse experiences for children and a cost imperative – early help saves money.

2.28.1 The early help response has developed nationally as a consent based process, working with families in partnership to improve children's outcomes. The need to balance a style of working which makes sense for children and their families and is inclusive of them has led to some confusion about how structured and formal the process of early help needs to be. The Guidance makes clear the importance of a structured approach, with parents and children seen as equal partners. A good quality assessment using assessment tools such as the Initial Assessment, the CAF or the family Health Needs Assessment is essential for understanding children's needs and developing effective plans. These assessments can be undertaken by any agency in contact with the family, but must be done with the formal consent of the children (where old enough) and their parents and with issues of future consent and information sharing addressed at the start. The early help process is dependent on good working relationships between professionals, children and their families and the role of the Lead Professional was developed to ensure that there was one professional that children and their families could link with. Professionals are usually brought together by the Lead Professional in a TAC meeting (Team around the Child) and those professionals with the full inclusion of children and families are tasked with developing a package of support in partnership with children and their families which seek to address the identified needs. Effective early help plans should make clear the actions to be taken, by whom, services to be provided, the timescales, and what action will be taken if the plans are not working. The Lead Professional is also responsible for coordinating the delivery of the plan and reviewing progress against agreed goals on a regular basis. Research suggests that this structured approach is not always evident and so it was in this case.

2.29 How did the issue feature in this particular case?

Ben was not immediately recognised as a baby who might have additional needs because of his parents' circumstances. The opportunity for an early help assessment before he was born was not taken, and this is addressed in Finding 6. When he was in hospital "assessment activity" was undertaken which led to a plan

of alerting Children Services to his circumstances. Children Services appropriately undertook an assessment. This led to a Team around the Child meeting being convened, although the Health Visitor and Children's Centre professionals did not realise that this was a TAC (Team Around the Child Meeting). In part, this confusion was caused by the Children's Centre believing that a TAC only happened after a CAF (Common Assessment Framework) not after an Initial Assessment. The meeting agreed a brief plan of visits by the Health Visitor and the Children's Centre; this plan did not outline what the needs of Ben were based on the assessment, or what services would meet those needs, what outcomes were intended and there was no process of review built in.

2.29.1 The plan focussed particularly on Antonia and Jack taking Ben to groups, something that both parents were not keen to do. Despite the intention for the TAC plans to be a collaborative process, the parents' wishes were not taken into account, their objections were not explored or alternative approaches discussed. No Lead Professional was agreed or discussed, and this left the parents without a point of contact, and there was no reviewing process for the plan. The lack of clear needs and outcomes meant that the Children's Centre visited Ben and his parents as agreed, but without knowing exactly what they were hoping to do or achieve. The visits were brief, and after a month the lack of a clear purpose and no emerging problems meant that they were discontinued. The Health Visitor pursued Ben and his parent's attendance at groups, because this was what had been agreed, the parents continued to query why this was necessary or important, and ultimately it never happened.

2.29.2 The Health Visitor and the Health Visitor student provided intensive support to the family. The issue of consent and information sharing was not considered in the TAC meeting, and this meant that when concerns were raised about Antonia's care of Ben three months after the TAC it was unclear who information could be shared with and who was actually responsible for the plan. This left these concerns unexplored. Overall the potential for an effective early help response in this case was missed.

2.30 How do we know this is not peculiar to this case?

The Case Group and Review Team considered that there was general confusion about the details of the process of the early help response in Gloucestershire. National research has highlighted that there has been inconsistency in the implementation and application of an early help response and there is nothing to suggest that this is not replicated locally.

2.31 What numbers of cases are affected, and how widespread is the pattern – local, regional, national? How do we know this is not peculiar to this case?

The early help response is targeted at vulnerable children and their families who live in circumstances of personal and situational deprivation in order to improve children's outcomes and their future life chances. In Gloucestershire there are pockets of deprivation characterised particularly by rural poverty. A recent national research review highlighted the extent of poverty and deprivation in Gloucestershire and the impact on adult and child wellbeing, meaning there are many families who will need to access an early help resource. Part of the importance of the early help response is to address problems early, leaving specialist services to address more serious problems. There has been a 10% increase in referrals to Children's services, a 12% increase in Child Protection inquiries and Children subject to Child Protection plans nationally. These increasing pressures on specialist services have been felt by Gloucestershire and therefore the need for an effective early help response is even greater.

FINDING 6: Arrangements, roles and responsibilities for managing early help to families in Gloucestershire needs to be much clearer, to ensure there is effective planning and decision making for children and their families.

It is clear that an effective multi-agency early help response for children and their families is essential to reduce disadvantage, improve children's outcomes, address parental/family difficulties before they become entrenched and help services move to a proactive rather than reactive approach. This has benefits for children, their families and professionals.

Considerations for the Board and member agencies

- Does the Board recognise that more work needs to be done locally regarding the early help response?
- What work is the Board already undertaking to improve practice regarding the early help response?
- What else could the Board do?
- How would the Board know it had been successful?

2.32 FINDING 7: Practitioners across agencies have not been supported to be able to identify the potential for non-accidental head injury NAHI ("shaken baby" syndrome) and there is no mechanism in place to raise

awareness or to take preventative action leaving babies at potential risk of physical injury.

Babies under one are particularly vulnerable to abuse and neglect[xxxii] In England and Wales, they are around 8 times more likely to be at risk of homicide[xxxiii].The risk is greatest in the first three months of life and perpetrators are almost always parents. There is as yet no definitive explanation for this high incidence, though frailty and total dependence are important. The very real demands and stresses placed on a family by a new-born baby are almost certainly a factor. Non-accidental head injury (NAHI) is the most common cause of infant death or long term disability from maltreatment[xxxiv]. It represents one of the most severe forms of child abuse, with 13–30 per cent mortality rates and significant neurological impairments in at least half of the survivors[xxxv]. The picture in the UK is consistent with available data from other European countries, where infants are also more at risk of fatal injury, physical abuse and neglect than older children, indicating that it is essential to intervene early to prevent child maltreatment, death and disability[xxxvi].

2.32.1 Research into non-accidental head injuries indicates that when parents shake or otherwise inflict injuries on their babies, it is often a reaction to excessive crying. The other factors that can trigger NAHI are a lack of empathy or understanding of a baby's needs, and where a baby's crying triggers unresolved issues for the parent/carer[8]. Babies at increased risk are those aged under one year old and those who are born prematurely. Parental risk factors include a young age, unstable family environment, low socio-economic status, poor early childhood experiences including abuse and neglect, feelings of inadequacy in adulthood, social isolation and depression.

2.32.2 NAHI is a significant preventable public health problem which can be addressed by good quality assessment, education and routine awareness raising. In assessing the risk of NAHI to a baby, professionals should ask parents about the distress caused to them by their baby crying, or by caring for the baby's needs and the extent to which it is considered by the parents to be intolerable or the sense which they feel that the baby is behaving in a deliberately difficult way, which is designed to cause them distress. Professionals need to ask parents about how they cope with stress and help them to develop positive ways to deal with frustrations. All parents of

2.32.3 new-born babies should be given verbal and written advice about the appropriate handling of babies and the dangers of shaking them.

2.32.4 The evaluation of the NSPCC "Preventing non-Accidental head injuries Programme[xxxvii] indicates that the incidence of NAHI can be reduced and parents can be enabled to respond appropriately to the needs of babies.

2.33 How did the issue feature in this particular case?

Although we do not know what happened to Ben, there is evidence that he suffered a non-accidental head injury regarding which there are ongoing criminal proceedings related to Jack[9]. This case raises the importance of professional awareness and assessment of the risk of NAHI, particularly as many of the baby and parental risk factors were present in this case.

2.34 How do we know this is not peculiar to this case?

The Review Team and Case Group confirmed that professionals do not routinely assess the potential for Non Accidental Head Injury ("Shaken Baby" syndrome) and there is no mechanism in place to raise awareness or to take preventative action

2.35 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

There are no local statistics regarding the incidence of NAHI, but nationally Approximately 200 babies a year are affected.

FINDING 7: Practitioners across agencies have not been supported to be able to identify the potential for non-accidental head injury NAHI ("shaken baby" syndrome) and there is no mechanism in place to raise awareness or to take preventative action leaving babies at potential risk of physical injury.

Non Accidental Head Injury is a significant public health concern which can be addressed through awareness raising, assessment and support. There is poor professional awareness of what is an effective, preventative response to this issue. Effective programmes have been developed in the UK by the NSPCC and there is evidence of effective programmes in North America and Australia. Some areas have prioritised action, but there is an inconsistent national and local response, leaving babies at risk of harm.

Considerations for the Board and member agencies

- Does the Board recognise that this is a significant issue?
- What action could the Board take to address it?

[9] Since the report has been finalised, criminal proceedings have concluded and Jack has been found guilty of manslaughter

- Could the Board link in with the work being undertaken by the NSPCC?
- How will the Board know it has been successful?

Appendix 1: Methodology

Methodology

This serious case review has been undertaken using the SCIE Learning Together methodology. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper, underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them should contribute to improving practice more widely. Data comes from semi-structured conversations with the involved professionals, and the young person and their family who are the subject of the review, from case files and contextual documentation from organisations. A fundamental part of the approach is to talk with staff to understand what they thought and felt at the time they were involved in the case, avoiding hindsight as much as possible. It is vital to try and make sense of what factors contributed to their understanding at the time and to the decisions they made. This is known as 'local rationality'. Any appraisal of practice is then made in the context of those contributory factors.

The Review Team

The review was conducted by a team of senior representatives from local agencies who has had no direct involvement with the case. They shared in the conversations, the analysis of documents, the identification of key practice episodes and contributory factors. This report is the shared responsibility of the Review Team in terms of analysis and conclusions, but was written by the lead reviewers.

Named Nurse Safeguarding Children	Gloucestershire Care Services NHS Trust
Service Leader - Children's Safeguarding	Gloucestershire County Council
Paediatric Consultant and Named Doctor for Children's Safeguarding	Gloucester Hospital NHS Foundation Trust
Deputy Director of Nursing	Gloucestershire Clinical Commissioning Group
Detective Sergeant	Public Protection Bureau, Gloucestershire Constabulary
County Manager for Gloucestershire and Swindon Borough	4Children Children Centres
Business Manager	GSCB

The Case Group

The members of the Case Group are the professionals who worked with or made decisions about the family, and who had individual conversations with members of the Review Team. The Case Group comprised of 12 people (although not all attended Case Group meetings). Most were briefed on the methodology and then met with the Review Team on three further occasions to share in the analysis, the identification of contributory factors, and to comment and contribute to the report. Individual sessions were held with some professionals, either because they could not make the Case Group meetings or to clarify data.

Senior Family Practitioner	4Children Children Centres
Children's Centre Worker	4Children Children Centres
Health Visitor	Gloucestershire Care Services NHS Trust
Student Health Visitor	Gloucestershire Care Services NHS Trust
Team Manager	Gloucestershire Children's Social Care
Assistant Team Leader	Gloucestershire Children's Social Care
Social Worker	Gloucestershire Children's Social Care
General Practitioner	NHS England
Midwife	Gloucester Hospital NHS Foundation Trust
Social Worker	Swindon Children's Social Care
Paediatric Consultant	Great Western Hospital NHS Trust
	Great Western Hospital NHS Trust

Structure of the Review Process

The Review Team met on four occasions, including three times with the Case Group, and worked with them on the information from the conversations to the identification of the Findings and issues for LSCB consideration.

Sources of data

• The semi-structured conversations between members of the Review Team and 12 members of the Case Group;

• Documentation: All necessary documentation was made available to the review ranging from case files, procedures, and assessments. This meant that the reviewer did an in depth review of all the relevant information held during the period under review.

The Lead Reviewers

This review was undertaken by Jane Wiffin (Independent Lead Reviewer) and Vicki Butler.

Jane Wiffin was the Independent Lead Reviewer. She is a qualified Social Worker who has extensive experience of working in safeguarding. She is an experienced serious case review author and chair, having undertaken 18 reviews. She was accredited as a SCIE Learning Together Reviewer in 2011 and has undertaken a number of reviews using this methodology. She is currently engaged in work developing tools and frameworks for addressing childhood neglect and she is an experienced auditor and safeguarding trainer. She is independent from all the agencies involved in this review.

Vicki Butler was the second lead reviewer. She is a qualified social worker who has extensive operational safeguarding experience and has been a senior social care manager for 6 years. Vicki was accredited as a SCIE Lead reviewer in 2013 and has undertaken previous reviews using this methodology. She is currently the Deputy Director of Safeguarding and Care in Gloucestershire.

Appendix 2: Timeline

BEN AGED	EVENT
Early Pregnancy	Antonia has first pregnancy appointment with midwife and all further appointments attended
Ben Born at 30 weeks gestation: Gloucester Royal Hospital	
Three days old	Ben transferred to St Michaels Hospital, Bristol
Eight days old	Ben transferred back to Gloucester Royal Hospital
Two weeks old	Ben transferred to Great Western Hospital, Swindon
Three weeks old	Main Ward round held at Great Western Hospital – concerns regarding Antonia's past discussed and further inquiries to be made
Five weeks	Hospital staff make contact with Health Visitor, Social Worker and midwife. Information shared. Contact made with Named Nurse for Safeguarding
Six weeks	Discharge Planning Meeting agreed referral to Gloucestershire Children's Social Care (GCSC)
Six weeks	Consultant Paediatrician makes referral to GCSC. Initial Assessment agreed
	Initial Assessment commenced next day and home visit undertaken by the Social Worker
	Next day Social Worker telephoned Great Western Hospital and said he was happy for Ben to be discharged
Six weeks	Ben discharged home. Home visits over the next two days by Children's Centre and Health Visitor
	Three days after discharge Team around the Child Meeting held
	Children's Centre visit weekly for first four weeks. Decide to cease home visits and parents to attend regular clinics as no concerns
	Home visit by Health Visitor – Ben developing well
10 weeks	Initial Assessment completed
11 weeks	Home visit by Health Visitor no concerns – Ben developing well
12 weeks	Home visit by Health Visitor no concerns – Ben developing well
12 weeks	GCSC received anonymous referral from NSPCC on line service. Allegations of neglect. No action taken

13 weeks	Children's Centre inform Antonia and Jack of the end of their involvement. Parents to continue to attend regular baby clinic
15 weeks	Home visit by Health Visitor - routines discussed. Agreed student Health Visitor would be visiting
15 weeks	Paediatric outpatient appointment attended by Antonia and Ben. Good progress made
16 weeks	GCSC send Antonia and Jack a letter regarding referral received a month earlier and that no action was to be taken
17 weeks	Home visit by Health Visitor- good interaction between Ben and Antonia noted
19 weeks	Home visit by Health Visitor - Antonia has some health issues. Ben developing well
37 weeks	Ben is admitted to Swindon hospital with NAHI

Appendix 3: References:

[i] Department for Education (2013) 'Working Together to Safeguard Children' https://www.gov.uk/government/publications/working-together-to-safeguard-children

[ii] Fish, S., Munro, E and Bairstow, S. (2008) Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews. SCIE. LONDON

[iii] Health Child Programme : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

[iv] Cuthbert, et al (2011) 'All babies count: prevention and protection for vulnerable babies: a review of the evidence' NSPCC http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/all_babies_count_pdf_w df85569.pdf

[v] Calder, M.C. (2003) Unborn Children: A Framework for Assessment and Intervention. In: Calder, M.C. and Hackett, S., eds. Assessment in Child Care Using and Developing Frameworks for Practice. Dorset: Russell House Publishing

Corner, R. (1997) Pre-Birth Risk Assessment in Child Protection. Social Work Monographs, Norwich: University of East Anglia

Hart, D. (2010) Assessment Prior to Birth. In: Horwath, J., ed. The Child's World, Assessing Children in Need. London: Jessica Kingsley Publishers

[vi] Cuthbert, et al (2011) 'All babies count: prevention and protection for vulnerable babies: a review of the evidence' NSPCC

[vii] An Initial Assessment is defined as a brief assessment to consider the needs of a child and is underpinned by national guidance: Department of Health (2000) 'Framework for the Assessment of Children in Need' London HMSO

[viii] http://www.nspcc.org.uk/services-and-resources/research-and-resources/all-babies-count/

[ix] Cuthbert, et al (2011) 'All babies count: prevention and protection for vulnerable babies: a review of the evidence' NSPCC

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Children/index.htm

[xi] Burgess A. (2007). The costs and benefits of active fatherhood. Fatherhood Institute: Abergavenny. See: www.fatherhoodinstitute.org/index.php?id=0&cID=586. (accessed 1 October 2008)

[xii] Michael E. Lamb (Editor) (2010) The Role of the Father in Child Development, 5th Edition: Wiley

[xiii] http://www.fatherhoodinstitute.org/

[xiv] RCM, the Department of Health, the Royal College of Obstetricians and Gynaecologists and the Fatherhood Institute (2011) Reaching Out: Involving Fathers in Maternity Care**.** https://www.nspcc.org.uk/services-and-resources/research-and-resources/all-babies-count-dad-project/

[xvi] Department of Health (2009) 'Healthy Child Programme; Pregnancy and the first five years of life' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Heal th_Child_Programme.pdf

[xvii] McAllister, F., Burgess, A. & Kato, J. & Barker, G., (2012). Fatherhood: Parenting Programmes and Policy - a Critical Review of Best Practice. London/ Washington D.C.: Fatherhood Institute/Promundo/MenCare

[xviii] http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/baby-special-intensive-care.aspx

www.poppy-project.org.uk/resources/Poppy report for PRINT.pdf · PDF file
Family-centred care in neonatal units A Summary of research results and recommendations from the POPPY Project POPPY Parents of Premature babies Project

[xx] Family centred care model for neonatal http://www.poppy-project.org.uk/research.html

[xxi] According to the Office for National Statistics, 52,160 babies - 7.3% of live births – in England and Wales were born prematurely during 2012: http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2012/index.html

[xxii] Bilgin, A. and Wolke, Dieter. (2015) *maternal sensitivity in parenting preterm children: a meta-analysis.* Pediatrics, 136 (1). e177-e193. ISSN 0031-4005

[xxiii] http://www.who.int/mediacentre/factsheets/fs363/en/

[xxiv] http://www.who.int/mediacentre/factsheets/fs363/en/

[xxv] According to the Office for National Statistics, 52,160 babies - 7.3% of live births – in England and Wales were born prematurely during 2012: http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2012/index.html

[xxvi] Bilgin, A. and Wolke, Dieter. (2015) *Maternal sensitivity in parenting preterm children : a meta-analysis.* Pediatrics, 136 (1). e177-e193. ISSN 0031-4005

[xxvi] Wolke, Dieter, Eryigit-Madzwamuse, Suna and Gutbrod, Tina. (2014) *Very preterm/very low birthweight infants' attachment : infant and maternal characteristics.* Archives of Disease in Childhood - Fetal and Neonatal Edition, Volume 99 (Issue 1). F70-F75. ISSN 1359-2998 (In Press)

[xxvii] Laming (2003) The Victoria Climbie Inquiry: report of an inquiry by Lord Laming. DfE https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming

[xxviii] Laming (2003) The Victoria Climbie Inquiry: report of an inquiry by Lord Laming. DfE https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming

[xxix]Brandon et al (2009) Building on the learning from serious case reviews: https://www.gov.uk/government/publications/building-on-the

[xxx] Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004

[xxxi] Early Intervention: Smart Investment, Massive Savings; The Second Independent Report to Her Majesty's Government Graham Allen MP

[xxxii] Cuthbert, et al (2011) 'All babies count: prevention and protection for vulnerable babies: a review of the evidence' NSPCC http://www.nspcc.org.uk/services-and-resources/research-and-resources/all-babies-count

[xxxiii] Smith, K. (ed.) et al. (2011) Homicides, firearms offences and intimate violence 2009/2010: supplementary volume 2 to crime in England and Wales 2009/2010, London, Home Office.

[xxxiv]Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: a handbook for professionals. Chichester: Wiley.

xxxv Dias, M. (2005) 'Preventing abusive head trauma among infants and young children: a hospital based parent education programme', Paediatrics, 115 (2005): e470–e477.

xxxviWorld Health Organisation (2007) Preventing child maltreatment in Europe: a public health approach

xxxvii Coster, D with Bryson, C and Purdon, S (2014) Preventing non-Accidental head injuries programme: NSPCC www.nspcc.org.uk/globalassets/documents/evaluation-of-services