Local Child Safeguarding Practice Review

Child Z

Lead Reviewer: Moira Murray

February 2021

Contents

1. Introduction

1.1 The issues for consideration in the review are as follows:

- What was Child Z's lived experience in the family environment?
- What was the multi-agency understanding of the risks to Child Z at the time of the first referral?
- What was the effectiveness of the response to the initial referral to MASH? What would need to be different?
- Was the quality of practice regarding pre-birth assessment of both Mother and Father effective? Did this practice follow agreed SSCB/SSCP procedures?
- Information Sharing: what information was known and subsequently shared about Father, his parenting capacity and possible risks to children?
- How effective was inter-agency communication between health and children's social care in the period before and immediately after Child Z's birth?
- Is there evidence that current practice around pre-birth assessments, has improved?
- What is the evidence that all workers are fully cognisant with timescales, procedures and vulnerabilities/risk factors associated specifically with unborn babies, particularly where there is a history of previous children having been removed?
- Were there errors in thinking that affected decision-making in this case?
- Were there wider-systemic issues across the multi-agency system that affected practice in this case?

2. Findings and Lessons Learned

Missed Opportunity to undertake assessments

2.1.1 Father's disclosure that he had previously had a child removed from his care prompted a safeguarding referral to be made to the MASH. This offered an opportunity for the reasons why the child was removed to be ascertained and should have led to a pre-birth assessment being undertaken of Child Z. In addition, a Child and Family Assessment should have been initiated into the contact arrangements in place for Father's son.

2.1.2 During the Practitioners Learning Event, it was explained that at the time the MARF was received, a restructuring process was taking place in the MASH. A new "threshold document" was introduced and the MASH changed to the Children's Single Point of Access (C-SPA Surrey) in April 2019. *"The Children's Single Point of Access is the umbrella term used to describe the front door to Surrey County Council services for children."*[1]

[1] https://www.surreylocaloffer.org.uk/kb5/surrey/localoffer/service.page?id=bicUUN93_U0

2.1.3 Guidance was introduced in May 2019 for the Request and Support Team, C-SPA, which specifically stipulated that when a contact is received where '*an unborn child of a parent who has had a child removed/adopted previously but are currently caring for other children with no current Children's Services involvement, [the contact] should be sent to the Multi-Agency Partnership'* and where *'Previous child/children have been removed from parental care or voluntarily accommodated such contacts will be sent to the Assessment Service in order for a Child and Family Assessment to be undertaken.*' (Source Children's Social Care, Information Report).

2.1.4 The review has been informed that since April 2019 work has been completed concerning policy and procedures relating to pre-birth assessments, which have been circulated to all staff. This is positive action and is to be welcomed. The lesson arising from this review is that where there is uncertainty about the safety of an unborn child's wellbeing, due to concerns about a child being previously being removed from a birth parent's care, a pre-birth assessment should be considered a first priority.

2.1.5 The question needs to be asked as to whether if a pre-birth assessment and a Child and Family Assessment had been undertaken, could there have been a different outcome for Child Z? The importance of robust, comprehensive investigations into the past history of a parent where there is a known child protection concern cannot be underestimated.

The dependence of practitioners on the information supplied by parents

2.1.6 Whilst it is standard practice for expectant mothers to be asked during antenatal appointments whether they have or are experiencing domestic abuse, midwives are dependent on the response given by the woman to this enquiry. This concern was raised at the Practitioners Learning Event, when those attending from maternity services highlighted that they are very reliant on the information provided by a mother. It was explained that in this and other cases, access to information from fathers' medical records is limited but more information about the father/significant male in a family could inform any risk assessment. This is a lesson learned and is reflected in Recommendation 1.

The importance of the role of fathers

2.1.7 The need for practitioners to thoroughly assess a parent's past history, not least when it is known that a child had previously been removed due to non-accidental injury, is a finding of this review. Father disclosed that a child had been removed from his care and this should have prompted a thorough investigation of his involvement in the child's removal. This review has already highlighted research findings concerning the incidence of fathers being responsible for abusive head trauma in children. The importance of the role that fathers and significant males play in the care of infants and

vulnerable children is a lesson learned from this and other Serious Case Reviews/Child Safeguarding Practice Reviews.

Information Sharing: the need to maintain accurate complete records

2.1.8 There has been difficulty in providing the review with definitive information from the midwifery service. This is because the system for recording information has changed from paper to electronic records. The review has been informed that since the introduction of digital patient records in April 2019 a significant amount of training has been rolled out to staff about the importance of documentation and domestic abuse screening. Audits have taken place to confirm that this training has been effective. Screening compliance has increased significantly and is being well recorded. (Source: Information Report, Maternity Unit, Hospital 1).

2.1.9 The review has been informed that discussions are planned to take place between the Named and Designated GPs for Safeguarding Children and the Named Safeguarding Midwives, Hospital 1 to ensure that robust and appropriate information is shared between Primary Care and Midwifery Services. The majority of women now book directly with the midwife and many have little routine contact with their GP during the antenatal period. As a result, consultation notes may not be immediately available to the next professional to see that individual. (Source: Information Report, CCG).

2.1.10 In this case, the removal of Father's son from parental care, would have been more robustly documented in the GP notes, if the midwife had informed the Practice directly of Father's history and the safeguarding referral to the MASH. This would have allowed an entry to be made onto both Mother and Father's frontpage summary of the GP records; resulting in the GP not having to search through previous entries in the notes to find such relevant information. The review has been informed that GP practices have a secure generic email address for the processing of safeguarding information. As a result of this review the Surrey GP practice secure generic email addresses have been shared with the maternity safeguarding teams for the purpose of safeguarding. Such information is flagged on GP records across Surrey. This is a lesson learned and is reflected in Recommendation 2.

Escalating Concerns

2.1.11 A newly updated and approved procedure for Escalating Partner Disagreement was issued and distributed by Surrey Safeguarding Children Partnership on 29 April 2020[2]. The procedure sets out the responsibilities and process for partner agencies to raise concerns about practice. Children's Social Care has informed the review that is hopeful that if a situation such as Child Z arose again that Health colleagues would use this

[2] https://surreyscb.procedures.org.uk/skyqox/complaints-and-disagreements/inter-agency-escalation-policy-and-procedure

procedure to challenge a decision not to undertake a pre-birth assessment following a safeguarding referral. This action is to be commended and it is hoped that practitioners have been fully informed and aware of the new procedure. Recommendation 3.

Special Guardianship Orders

2.1.12 The review has highlighted the lack of oversight of Special Guardianship Orders once an order has been made, as there is often no requirement for ongoing involvement by Children's Social Care with the child. However, this case has also raised awareness of the possible need for contact arrangements between birth parents and their children to be reviewed. This could be undertaken periodically to seek assurance that the Special Guardianship Order remains safe for the child. Such review could also seek to reassure the special guardian that the Local Authority is available to intervene in circumstances where undue pressure is being exerted by a birth parent to ensure that contact with their child takes place. Best practice guidance with regard to Special Guardianship Orders issued by the President of the Family Division, in June 2020 specifically addresses concerns arising from Special Guardianship Orders, which have also arisen in this review. Recommendation 4.

Professional Curiosity

2.1.13 The need for professional curiosity, also described by Lord laming (2003) in the Victoria Climbié inquiry as "*respectful uncertainty*" is a further lesson emanating from this review. By applying critical evaluation to any information received and maintaining an inquisitive approach, professionals can avoid linear and absolute explanations by exploring alternative, multiple perspectives, which can in turn influence the outcomes for children.

The impact of change on services and professional capacity

2.1.14 Children's Social Care in Surrey has experienced a period of uncertainty and change over the past five years since an Ofsted inspection, in June 2015 and again in May 2018, concluded that the service was inadequate. Such findings have a significant effect on senior managers and staff moral and as explained at the Practitioners Learning Event, a large number of senior staff left the employ of the Local Authority at the time the Child Z case came to the attention of MASH. Since April 2019, there have been considerable improvements in the provision of services to children, which have been exemplified in this review. It is commendable that the last of three progress reviews conducted by the Commissioner, appointed by the Department for Education, to oversee improvement in Surrey found clear signs in January 2020, that *"the*

performance and quality of help and protection practice are improving, and "front door" social care services and early help provision are also continuing to get better".[3]

3 Good Practice

3.1.1 It was good practice on the part of the midwifery staff to recognise the safeguarding risk to the unborn child when the parents attended antenatal appointments. But, the necessity to escalate concerns when the outcome of MASH inquiries became known is a lesson learned.

3.1.2 The Health Visiting Service recognised the need for Universal Partnership Plus level services to Child Z, although it does not appear that this level of service was undertaken.

3.1.3 Non-accidental injury concerns were promptly identified and referred resulting in good partnership working. Initially, it was uncertain as to whether Child Z would survive, and the presence of the Child Death Overview Panel (CDOP) Nurse at the Strategy Meeting encouraged deeper discussion and the involvement of Police, leading to the eventual arrest of the parents.

4 Conclusions and Recommendations

4.1.1 Child Z suffered significant and life-threatening injuries during the first seven weeks of her life spent in the care of her parents. She is now making good progress, however the long-term outlook for her full recovery is as yet not known. Whether a pre-birth assessment would have ensured a different outcome for Child Z is not known. However, if such an assessment had taken place, professionals would have been aware of the possible risks presented by leaving her in the care of her parents and arrangements could have been put in place to monitor her health and well-being.

4.1.2 Like many other statutory reviews this case has raised familiar issues and lessons for those involved in safeguarding children. It is acknowledged that safeguarding children is difficult, demanding and complex, however, the importance of maintaining professional curiosity to ensure that relevant information is assessed and reviewed is essential if small babies and vulnerable children are to be protected from significant harm.

[3] https://www.cypnow.co.uk/news/article/surrey-county-council-to-retain-control-of-children-s-services

Recommendations

The following recommendations are for consideration by the Surrey Safeguarding Children Partnership

Recommendation 1 **When a father is involved in the antenatal care/care of a new born baby, professionals should seek to ensure that issues of safety and wellbeing of the child are explained and the support mechanisms available are identified.** **For example: the NHS Dadpad covers the importance of babies safe-sleeping, co-sleeping, coping with crying and safe handling and is a digital resource to support fathers: https://thedadpad.co.uk/. ICON is an example of a suggested evidence based preventative program for abusive head trauma that prepares parents to manage crying infants https://iconcope.org/for-professionals/**
Recommendation 2 **Any agency, which is aware that a child has been removed from the care of a parent/s, including a child from a previous relationship, should inform the GP Practice. This would allow an entry to be flagged on both the Mother and Father's medical records and would ensure that the Practice is aware from the outset of safeguarding concerns.**
Recommendation 3 **Partner agencies need to seek assurance that awareness of the updated and approved procedure for Escalating Partner Disagreements has been made available to all professionals. The Safeguarding Children Partnership should ascertain that professionals in individual partner agencies are aware of the procedure and that it is being used when concerns require escalation. In addition, the identification of the person to whom the concern should be escalated needs to be clarified in the procedure in order to assist those raising the concern.**
Recommendation 4 **In the light of the recent best practice guidance with regard to Special Guardianship Orders issued by the President of the Family Division, partner agencies should be reminded that prior to seeking a Special Guardianship Order from the Court, parental contact with the child should be given careful consideration, in terms of:** **(i) The purpose of the contact.** **(ii) The form of contact, direct or indirect and the frequency.** **(iii) The professional input required to support carers** **(iv) The planning and support required to ensure the stability of the placement in the context of ongoing contact.** **Assistance in understanding the significance of these changes may be enhanced by a briefing note from Legal Services.** **Full detail of the Practice Direction can be found at:** https://www.judiciary.uk/announcements/message-from-the-president-of-the-family-division/

Appendix 1

Surrey Child Safeguarding Practice Review Terms of Reference

CHILD REFERENCE:	Child Z
DATE:	1 April 2020

1.	**INTRODUCTION**
	The aim of this review is to identify improvements that can be made to better safeguard children and to prevent, or reduce the risk, of recurrence of similar incidents. The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systematic issues, and whether and how policy and practice need to change. It should be noted that the review is not being conducted to attribute blame or hold individuals, organisations or agencies to account as there are separate processes for this. The focus of this review is learning for Surrey's multi-agency safeguarding children system in order to improve the quality of our practice with children and families.
2.	**REVIEW TEAM**
	Name of Lead Reviewer: Moira Murray **Membership of the Review Panel:** Surrey Police Independent Review Author QA Children's Service Manager, Surrey County Council Surrey wide CCG Designated Nurse for Looked After Children/ Deputy Designated Nurse for Safeguarding Surrey wide CCG Designated Doctor for Safeguarding Principal Lawyer, Surrey County Council Surrey Safeguarding Children Partnership
3.	**SCOPE OF THE REVIEW**
	Time Period to be Considered by the Review and Rationale: The period of the review from 1st March 2019 when Mother booked antenatally at 9/40 gestation to the 3rd December 2019 when Child Z was taken to A&E.

	Key Issues to be Addressed by the Review: (NOTE: These may evolve as more information becomes available during the review) What was the multi-agency understanding of the risks to Child Z at the time of the first referral? What was the effectiveness of the response to the initial referral to MASH? What would need to be different? Was the quality of practice regarding pre-birth assessment of both Mother and Father effective? Did this practice follow agreed SSCB/SSCP procedures? Information Sharing what information was known and subsequently shared about Father, his parenting capacity and possible risks to children? How effective was inter-agency communication between health and children's social care in the period before and immediately after Child Z's birth? Is there evidence that current practice around pre-birth assessments has improved? The current Guidance is very specific and stipulates that a contact on: "*an unborn child of a parent who have had a child removed/adopted previously but are currently caring for other children with no current Children's Services involvement"*, should be sent to the Multi-Agency Partnership (MAP). And where: *"previous child/children have been removed from parental care or voluntarily accommodated", such contacts will be sent to the Assessment Service in order for a Child and Family Assessment to be undertaken.* What is the evidence that all workers are fully cognisant with timescales, procedures and vulnerabilities/risk factors associated specifically with unborn babies, particularly where there is a history of previous children having been removed? Were there errors in thinking that affected decision-making in this case? Where there wider-systemic issues across the multi-agency system that affected practice in this case?
4.	**METHODOLOGY**

	To be confirmed with the Independent Review Author at the first Panel Meeting.
5.	**LEGAL CONSIDERATIONS**
	Parallel Investigations: There is parallel police investigation at this time.
5.	**OTHER CONSIDERATIONS**
	Were there any learning difficulties or cultural factors that made caring for Child Z challenging for these parents, especially father. If so, were these factors considered in any assessments.

Methodology

Reports were received from each agency involved in the review.

A learning event was held for professionals.

Regular Panel Meetings were held to discuss the progress of the review.

Partner agencies involved in the review

SCC Children's Services (QA Service Manager)

Surrey Police

Surrey wide CCG Designated Doctor for Safeguarding Children

Surrey wide CCG Designated Nurse for LAC/ Deputy Designated Nurse for Safeguarding Children

Surrey Safeguarding Children Partnership Team

Moira Murray, Lead Reviewer: Is a social worker by training and has undertaken numerous SCRs, Learning Reviews and CSPRs. She has been involved in safeguarding audits for the NHS, the voluntary sector and local authorities. She co-authored HM Government *Safeguarding Disabled Children Practice Guidance, 2009* whilst Head of Safeguarding at the Children's Society. She was a non-executive board member of the Independent Safeguarding Authority for 5 years, was Safeguarding Manager for Children and Vulnerable Adults, London 2012 Olympics and Paralympic Games; has undertaken safeguarding reviews for the Foreign & Commonwealth Office, the BBC post Jimmy Savile and Premier League Football. Until recently she was the Senior Casework Manager in the National Safeguarding Team, Church of England.