Serious Case Review

Overview Report: Anna

Author: Amanda Clarke

Date: 1st April 2022

Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Contents

1. The reason for the Serious Case Review

1.1 In late 2017 a serious injury occurred to Anna. When aged one year, Anna's mother said Anna was loosely strapped into a highchair. Anna was said to have then stood up, falling out of the chair onto the floor where she lay unresponsive. Mother attended a walk-in centre with the child and was transferred to hospital. A significant brain injury was diagnosed with abusive head trauma suspected as being a possible cause.

1.2 A serious case review (SCR)[1] referral was made to the local Safeguarding Children Board (now Safeguarding Children Partnership). It was concluded that the criteria for a SCR was met. An independent author (to be known as Author) was commissioned to work with a multi-agency panel of local senior professionals (the Panel) to identify any learning from the circumstances to improve arrangements to safeguard and promote the welfare of children.

2. The children and their family

2.1 Anna and her siblings as detailed below no longer reside with their parents. The names used in the overview report will be used to protect the true identity of the children. Mother and Father were from the Baltic States, Eastern Europe but all four children were born in the UK.

Name to be used in the review	Age at significant incident (late 2017)
Anna	1 year
Siblings	
Ava	1 year
Sophie	2 years
Thomas	3 years
Mother (to all four children)	Mid 20s
Father (to all four children)	30 years

[1] Serious case reviews are now known as child safeguarding practice reviews, Working Together 2018

3. Legal framework and methodology for the review

See Appendix A for information.

3.1 After consideration of criteria in *Working Together to Safeguard Children 2015* (the guidance in use at the time) and after Panel members had been identified the first meeting of the Panel and Author took place in June 2018.

3.2 The Author, is an independent safeguarding advisor with no connections to the local area or any of the organisations involved in the review. Her career history includes working as an investigator within police public protection and conducting inspections and audits for the NSPCC. She currently chairs a Safeguarding Adults Board and a Safeguarding Children Partnership in the north of England. She also provides safeguarding advice and support for a Diocese in the Midlands. She has authored several case reviews and domestic homicide reviews.

3.3 At the time of the first Panel meeting a criminal investigation and family court proceedings were ongoing. These formal processes continued for a substantial period of time delaying the opportunity to hold a practitioners' event for professionals who had offered support to the family leading to the significant incident. Meeting the parents as part of the review was not possible in the early stages due to them both being part of the criminal investigation

A Panel meeting was held in February 2019 to discuss emerging learning themes from the review and any action required as it was clear the SCR would not be completed in expected timescales. Further delay was caused by the impact of the Covid 19 pandemic.

The Panel reconvened in spring 2021, meeting virtually due to Covid 19 restrictions. It was decided that holding a practitioner event after such delay was inappropriate. Similarly, a Panel decision was made not to try to involve the parents of the children to contribute to the process, as information available showed they had moved on with their own lives. All four children were still too young to participate in the review.

3.4 The Panel therefore re-examined the journey of the children and family, identifying key learning themes to be highlighted in an overview report and demonstrating the current position for the local area in terms of safeguarding, almost four years after the significant incident. The decision to proceed in this way was considered proportionate under the circumstances.

3.5 The terms of reference for the review were developed at the first panel meeting and are attached at Appendix B. The timeframe for the review was agreed as January 2016 to December

2017; the start and end dates were when significant episodes occurred in the lives of the children, but Panel members and the Author were clear that other relevant incidents relating to the children and family occurring prior to the timeframe must also be considered. Non recent events in the lives of families are often significant and can impact upon and shape what occurs in the future.

4. Overview of what happened, key circumstances and background

4.1 The parents (to be known as Mother and Father) were not British and had been in the UK for part of their adult lives. Father had been known to UK services as a possible domestic abuse perpetrator in a different relationship in 2011 and 2012.

In 2014, prior to the review timeframe Mother was late booking the pregnancy of the first child, Thomas, being 21 weeks pregnant when booking occurred. When Thomas was a baby an assault incident took place in his (Thomas') presence. The assault was on Father, by a group of men in the family home. Mother was believed to be two months pregnant with Sophie at the time.

A Section 47 investigation took place in early 2016 (the start of the review timeframe) regarding minor injuries to both Thomas and Sophie with parents not seeking appropriate medical attention. An assessment resulted in no further action.

In autumn 2016 Mother attended hospital reporting pain to her legs. During treatment it transpired she was in labour with twins but said she was unaware of the pregnancy. Initially she did not want her partner, Father to be told about the babies. Whilst Mother was giving birth Father was unaware, at home with their other two young children.

The twins, Anna and Ava required care in the neo natal unit. A referral was made to children's social care due to the circumstances of a possible concealed pregnancy. After two days Mother informed Father about the babies and he was described as "shocked but not angry". The twins remained in hospital, with visiting by Mother and Father described as limited, said to be due in part to having two other young children and little family support.

Discharge was being discussed in late 2016 just prior to a domestic abuse incident taking place, with Father assaulting Mother. A section 47 investigation led to an initial case conference where all four children were placed on child protection plans for emotional abuse. During the assessment period Anna and Ava were discharged home, and their parents appeared reconciled.

Through early 2017 poor weight gain was noted for the twins and at times a lack of basic hygiene. A further domestic abuse incident by Father on Mother was reported to the police which the children witnessed. Mother informed the core group that she and Father had separated and within days she had retracted the domestic abuse allegation.

A period in hospital followed for the twins for them to be monitored for their lack of weight gain. Signs of physical neglect were queried particularly regarding hygiene. At a discharge planning meeting at the end of the hospital admission it was reported that no underlying medical condition had been identified which would cause poor or slow weight gain.

A legal gateway meeting took place and a further hospital admission for the twins. At discharge again there "was no medical indication for faltering weight". A review child protection conference had concluded that all four children should remain on child protection plans (category of neglect) in the care of Mother.

Within days of discharge unexplained bruising was noted to Ava's eyes. The health visitor referred to the on-call paediatrician as per the local policy (at the time) for bruising in a non mobile infant. A short period in foster care was arranged before the children were returned to Mother; the origin of the bruising was not known but not considered to be caused non accidentally

Father was trying to contact Mother around this time but his actions were reported to the police. Independent domestic violence advocate (IDVA) feedback was that Mother was accepting support.

Pre proceedings had commenced and in early summer 2017 growth pattern/ weight was still an issue for the twins. This was noted as improved after a month and a step down from pre proceedings was discussed at a core group. All children remained on child protection plans when reviewed mid summer 2017.

In autumn 2017 Ava sustained a serious injury to her lip requiring stitches. The cause was given by Mother as accidental but Mother's delayed response to the injury was challenged. Some positive progress however had been noted regarding Mothers parenting leading to an end of pre proceedings. The children remained on a child protection plan. At this point it was noted that Father's whereabouts were unknown.

In late 2017, two weeks after the review conference, the incident occurred resulting in Anna's serious head injury. Mother gave an accidental explanation for the incident but abusive head trauma and a possible delay in seeking treatment was suspected.

4.2 In June 2021 a decision was made that there would be no criminal proceedings relating to Anna's injuries and the police investigation was closed. The family court judgement was that the injuries were found to be non-accidental.

All four children have been adopted and at the time of writing the report Anna was said to be doing well, making good progress. As a result of the significant incident she has a permanent brain shunt and is registered as partially sighted. She also has long term impact upon her mobility.

5. Key themes of the review

5.1 When the Panel reconvened in 2021, key themes from the review timeframe were identified as follows:

- Concealed and denied pregnancy
- Interface between community and acute health professionals regarding advice and support given to new parents
- Failure to thrive as a form of neglect
- Response to minor injuries in children
- Managing language and cultural differences

(i) Concealed and denied pregnancy

Mother said she did not know she was pregnant with the twins despite having had two previous pregnancies and births. On contact with clinicians immediately prior to the pregnancy being detected neither Mother nor health professionals seemed to have realised that Mother was having a baby, let alone twins. Anna and Ava were thought to have been born at around 30 weeks therefore Mother had not reached full term. She may not have 'appeared pregnant'. However, the circumstances for Mother when first at hospital and her response immediately after the birth, not wanting Father informed and asking to relinquish the twins, prompted the hospital referral of a possible concealed or denied pregnancy. This was appropriate.

The local safeguarding children partnership has updated a document titled *Concealed and Denied Pregnancy Guidance, February 2021*. Despite this guidance not being in place at the time of the births a timely referral was made from hospital. Other aspects covered by the protocol were not relevant as there was limited opportunity for professionals to suspect Mother was pregnant and take appropriate action in advance of the births.

The outcome of an assessment after the referral to children's social care was that the pregnancy was assessed as not concealed and a decision was made to take no further action. The Panel felt this outcome was questionable due to the previous support needs of the family and the additional pressure that caring for premature twins might bring, alongside already having two other young children. Assessments should examine the whole journey of a family and in this case there were additional indicators of risk and need leading up to the births impacted by possible cultural challenges faced by Mother and Father. This will be explored later.

The arrangements within children's social care have since changed locally. The initial child and family assessments at the time of the review were being completed by a private company, which the local authority had commissioned. This arrangement ended in 2017 and all referrals since then meeting threshold for assessment are undertaken by children's social care within the local authority.

Learning point 1

Regardless of the unusual circumstances of the case and whether the twins' pregnancy was concealed the re- promotion of the *Concealed and Denied Pregnancy Guidance* may be useful, particularly to increase awareness of the reasons why a woman may conceal or deny a pregnancy, which include childhood trauma, domestic abuse, shame/fear of cultural expectations.

(ii) Interface between community and acute health professionals regarding advice and support given to new parents

Abusive head trauma was a suspected cause for the injury to Anna in late 2017. Often referred to as 'shaken baby syndrome' abusive head trauma can cause catastrophic injuries or death. The condition occurs most commonly in children younger than two years of age with an estimated

prevalence of 1: 3000 in babies younger than six months[2]. The persistent incidence of abusive head trauma in the UK is 20 to 24 per 100,000 children[3].

Many local safeguarding children partnerships (previously known as boards) have introduced education programmes for parents and carers of babies, and for professionals supporting them, to raise awareness about appropriate responses to crying babies, which is when abusive head trauma can often occur. ICON[4] an evidence based, multi-agency programmes is now in use across the safeguarding children partnership area where the incident occurred.

In 2016 key safety messages including responding to crying babies and safe handling were provided by professionals to expectant mothers and some fathers when pregnancies were known and women were receiving routine ante natal care. However due to Mother's pregnancy being unknown and undisclosed she would not have received her pre-birth visit from a health visitor where such messages would have been shared.

Post birth the twins remained in hospital for the first three months of their lives which meant on discharge they were outside of the timeframe for midwifery support once home. The community midwife did visit Mother at home in the days after the birth but there is no record of key messages being reinforced to Mother regarding crying and safe handling of babies. The Children and Family Wellbeing Service (CFWS) had been involved with the family when the older two siblings had been born in 2014 and 2015. Records show Mother attended two Bump, Birth and Beyond sessions in 2014 where key messages are delivered and both parents attended three baby clinic sessions in 2015. Their understanding and impact of receiving the information delivered for Sophie and Thomas, and retention of the advice for when the twins were born is unknown.

Hospital recording for the twins showed the visits by Mother and Father were mostly short and irregular whilst it was understood there were challenges due to them having two other very young children and limited family support. Notes indicated that the twins would not be discharged until the parents had received training and were competent in understanding oxygen equipment/bathing babies and caring for them for longer periods of time. Prior to their discharge

[2] CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014

[3] Abusive Head Trauma: The Case for Prevention- Dr Suzanne Smith PhD, Winston Churchill Memorial Trust Travel Fellowship, 2016

[4] ICON: I-infant crying is normal and will stop, C- comfort methods can soothe and the crying will stop, O- ok to walk away if the baby is safe and the crying will stop, N- never shake or hurt a baby
ICON is co-ordinated and supported by a national steering group based in Hampshire, iconcope.org

records did show that Mother received the required education as above but information specifically relating to safe handling of babies (similar to the ICON programme) is not recorded as provided.

The health visitor who attended the discharge planning meeting took over the support for Anna and Ava (and Mother) once they were at home age approx. three months. There is no record that specific safety messages relating to abusive head trauma were provided.

Learning point 2

In cases where it is has not been possible to provide guidance and support in the antenatal period and/ or if a newborn baby requires a prolonged stay in hospital there must be a formal arrangement between health partners in acute, community and primary care settings regarding the provision of advice and support to parents. Furthermore, it should be an expectation that when advice such as in the ICON programme has been given, a clear record must be entered in the child's notes. Other professionals, for example support workers, social workers who may be involved with families who have not received information as routine should also continue to take opportunities to reinforce key messages.

(iii) Failure to thrive as a form of neglect

Throughout the timeline there was evidence of the twins' failure to thrive particularly in relation to their weight. Once discharged home at around 3 months old they returned to hospital for two planned admissions in the spring of 2017 to monitor and investigate their weight loss for which no medical reason was found. When they were under the care of the hospital they gained weight. When they returned home they lost weight. Records also noted Mother being advised after the twins were observed being prop- fed (where a bottle is 'propped up' /positioned not requiring a baby to be held whilst being fed)[5]. Teats were also found to have been widened/ cut on feeding bottles (which may provide a faster flow).

In relation to the two planned periods in hospital a doctor reported no underlying medical condition which would cause poor or slow weight gain. However, the same doctor reported the children were thriving which was challenged by the health visitor. It was positive that professional discussion took place around why the twins may not be thriving, despite a cause not being found.

[5] Bottle feeding advice: never leave a baby alone to feed with a propped-up bottle as the may choke on the milk. www.nhs.uk

There may have been an element of over optimism in Mother's parenting capacity under the circumstances. Mother, once the twins were brought home at three months was a single parent, with limited family support. She had been unprepared for the birth of the two babies and was already a parent to two other very young children (toddlers). She was a survivor of domestic abuse and records indicate she may have been suffering from mental health issues herself. Her experiences in her earlier life were not fully known as she only entered the UK as a young adult. Despite a package of support being put in place the pressures Mother faced cannot be underestimated. Over a third of 538 cases examined by the Child Safeguarding Practice Review Panel in 2018 to 2019 were identified as having a practice theme of 'optimistic thinking[6]'.

Observations shared about Mother in core groups and other professional forums did not demonstrate significant concern for Mother or her capability as a parent of four very young children. As a consequence the level of concern for the children's wellbeing, apart from them remaining on child protection plans, was not identified or voiced by all professionals involved. Other ongoing issues, for example minor injuries sustained by the children throughout the timeframe (to be explored later) had little impact on the assessment of Mother and whether she was coping and whether the children were safe. Furthermore, records showed evidence of other possible signs of neglect for the twins on more than one occasion regarding their cleanliness and presentation. This was noted but does not seem to have been taken as an indicator of continuing neglect.

The definition for neglect includes the phrase "persistent and severe failure to meet a child's needs". This does not mean circumstances and the environment have to get progressively worse; the threshold for neglect can be met by the concerns not getting substantially better despite, as in this case, continued professional intervention. The long term impact of neglect on children should not be disregarded. Overall, there was little positive progress made for all four children during the period that they were subject to child protection plans for neglect.

It was encouraging that the home conditions were never reported as a significant concern. In addition to a child's home setting being assessed, the wider aspects of neglect and differing impacts on particular children do not seem considered, for example the age of the children involved and any additional needs.

[6] Annual report 2018-2019, Child Safeguarding Practice Review Panel

In April 2019 the local safeguarding children board (as it was known then) launched a refreshed multi-agency strategy to assist practitioners in tackling neglect more robustly. Also developed was a reference guide to the indicators of neglect and a neglect toolkit, created by Action for Children. The toolkit contains factors that may contribute to neglect many of which were relevant to Anna's family. There are helpful prompts and examples regarding different areas of a child's care. However, there is limited information in the current strategy to support practitioners in identifying a baby's failure to thrive as a form of possible neglect. NICE guidance regarding faltering growth[7] was published in September 2017 (when the twins were almost one) and NICE faltering growth quality standards[8] have since been published, in 2020.

At the time of publication of this report (spring 2022) a review of the neglect strategy is underway. This has found a need for greater consistency in the identification and assessment of neglect, as a result of which the local authority has purchased a licence for the Graded Care Profile 2[9] neglect assessment tool. This involves a significant commitment to training partnership staff which will be delivered over the course of the next 12 months. A revised neglect strategy is also envisaged to be published during this period.

Learning point 3

It would be beneficial for the local Partnership to include failure to thrive as an area of neglect for consideration especially in 0 to 1 year old babies. The Partnership should ensure guidance is available to enable clear understanding of non-organic failure to thrive, including thresholds and referral pathways, when concerns are identified in relation to the weight and growth of infants.

(iv) Response to minor injuries in children

Throughout the review timeframe and before, there were several minor injuries noted to all four children and a significant injury to both Ava (the mouth injury) and Anna (the abusive head trauma).

Minor injuries to the children included bruising, bite marks and scratches. When injuries were noted or reported initial action taken including by the nursery and the health visitor was usually

[7] National Institute for Health and Social Care Excellence (NICE) – Faltering growth: recognition and management of faltering growth in children, NICE guideline (NG75) 27 September 2017.
[8] National Institute for Health and Social Care Excellence (NICE) – Faltering growth, quality standard (QS197), 28 August 2020.
[9] Graded Care Profile 2 (GCP2) is an assessment tool which helps practitioners take a strengths based approach to measure the quality of care a child is receiving, learning.nspcc.org.uk

appropriate. The health visitor used guidance regarding bruising to pre mobile babies and the nursery kept detailed notes.

Records do indicate a delay in presentation and request for support by Mother for some injuries, including the two separate serious incidents involving the twins. All four children were on child protection plans for neglect when most of the injuries (minor or serious) occurred, but injuries were still managed mostly in isolation and did not lead to further investigation about Mother's ability to keep them safe. The vulnerabilities of babies in particular should never be underestimated. In the NSPCC Learning Brief of the Child Safeguarding Practice Review Panel's Annual Report 2018 to 2019[10] over a quarter of rapid reviews undertaken involved the death or serious harm of a child under 1 due to non accidental injury

The local area's neglect tool (mentioned early) which was launched after the timeframe for this review contains information about care and safety including for babies. For Ava and her siblings there was insufficient professional curiosity regarding the number of injuries across the four children who were all on child protection plans. When collated with other indicators of neglect for the family and the challenges which Mother herself faced the concerns for the children increased and should have been re-assessed.

A serious case review[11] in the local area completed in 2017 reinforced the need for practitioners to be professionally inquisitive with families. "It is crucial to ascertain whether explanations of injuries (however minor) are plausible. It is also important for professionals to view minor injuries collectively with other information about a child which together could give cause for greater concern".

The local area, as part of its multi agency arrangements does not currently have a procedure relating specifically to assessing unexplained injuries in immobile babies and children.

Learning point 4

The local area should consider the development and launch of a procedure for use across the partnership to support staff in responding well to unexplained injuries in immobile babies and children.

[10] 27 % of rapid reviews, NSPCC Casper Briefing on the CSPR Panel Annual report 2018 – 2019, March 2020
[11] SCR Child LB, learning brief published 2017

(v) Managing language and cultural differences

Both Mother and Father were not British and were thought to have entered the UK whilst adults[12]. All four children were born in the local Partnership area in the UK. The multi agency chronology is conflicted regarding the language capabilities of Mother. Some agencies noted a "language barrier" for Mother whilst other records show she was assessed as "speaking good" or "ok English" but that she sometimes "has difficulty communicating". Father's language skills and understanding are not well reflected in any agency records. English was described as "not the first language" for the older two children albeit they were very young themselves (not school age) and seemed to understand English.

There is limited evidence of use of interpreters with Mother who was the main carer of all four children. Given the complex circumstances from the unexpected birth of the twins to their lack of consistent weight gain it was imperative that Mother fully understood the expectations regarding her family and the ongoing safeguarding processes, including at one point pre proceedings.

A briefing issued by the NSPCC[13] highlights learning for practitioners which is relevant to this case. The learning includes awareness of language issues, recording the first language and use of professional interpreters.

As said earlier neither parent was from the UK in terms of their background. Little seems to be known regarding their upbringing. A separate NSPCC briefing[14] states "professionals sometimes lack the knowledge and confidence to work with families from different cultures (and religions). A lack of understanding of the cultural context of families can lead to professionals overlooking situations that may put family members at risk; whilst the desire to be culturally-sensitive can result in professionals accepting lower standards of care". In the Child Safeguarding Practice Review Panel third national review (September 2021)[15] practitioners are encouraged to try "to seek to understand every individual within the context of their own histories, backgrounds and culture" not just simply record ethnicity and cultural background.

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[12] There were approximately 92000 Latvian nationals residing in the United Kingdom in 2020, an increase from the 29000 Latvian nationals residing in the United Kingdom in 2008. The highest number of Latvian nationals residing in the United Kingdom was in 2017 with 117 thousand nationals, www.statista.com
The population of the UK at mid-year 2020 was estimated to be 67.1 million, www.ons.gov.uk

[13] NSPCC Learning from case reviews briefing - People whose first language is not English, March 2014

[14] NSPCC - Culture and faith: learning from case reviews, June 2014

[15] The Myth of Invisible Men - Safeguarding children under 1 from non-accidental injury caused by male carers, Child Safeguarding Practice Review Panel, September 2021

Learning point 5

Practitioners need to be professionally curious about families' cultural and religious context when undertaking assessments, planning interventions and support, whilst retaining focus on children. Involving interpreters is important to ensure there is full understanding of the service being delivered and expectations, with records completed to demonstrate language and understanding has been properly explored.

Good practice

It is clear many professionals and services worked hard to support the children and their parents. Good practice is highlighted when practitioners or a team or department are considered to have excelled 'over and above' what is expected of them and their service.

An episode during the timeframe which was agreed by the Panel as being good practice was the support provided by hospital staff after the domestic abuse incident just prior to the twins being discharged from hospital. This included emergency accommodation being offered for the older children and Mother.

6. Conclusion/what needs to happen

Anna suffered life changing injuries after an incident in her home in late 2017. At the time she was subject to a child protection plan for neglect, as were her three siblings. The injuries occurred just after her first birthday; it is known that children around this age are extremely vulnerable[16] [17].

Cumulative concerns existed for the family including a traumatic and unusual start to life for Anna and her twin followed by low weight gain and failure to thrive on discharge from hospital. There was recurring domestic abuse on Mother by Father, possible parental mental health issues and several minor injuries recorded for all four children during the review timeframe and before. Mother's response to her children's needs and to offers of support understandably fluctuated as for much of the period under review she had sole responsibility for four very young children, with little or no family support. Both Mother and Father were from a different country; understanding

[16] Children under 1 are the most likely age group to die through abuse or neglect - Child deaths by abuse and neglect, NSPCC Statistics briefing, September 2020

[17] Children under 1 have been consistently a high proportion of subjects of serious incident reports and serious case reviews- Child Safeguarding Practice Review Panel annual report, 2018-19

of their culture and previous experiences was not fully explored or assessed and language capabilities not formally documented.

An element of optimism appears to have existed for what Mother could achieve by herself as a parent, even with intervention, with limited progress made on the child protection plans. At times, there was a lack of professional curiosity and challenge regarding Father's involvement with the family and associated risks, including the impact of the children living in an abusive environment. Father at one point was said to have returned to his home country but this was later found not to be the case.

Unfortunately, the review process was delayed due to criminal and other court processes with further delay due to the Covid 19 pandemic. The Panel and Author have revisited the circumstances keeping in mind that many changes have occurred within the local area's Safeguarding Children Partnership since the incident with Anna was referred.

The original terms of reference from 2017 were re-examined and key learning themes identified. Reviewing practice, whenever this occurs, will always provide an opportunity to reflect on ways in which services can be developed and further enhanced. As a result of the significant incident(s) which occurred in the lives of Anna and her siblings, learning points have been agreed by the Panel based on analysis and findings from the case. These are repeated below for consideration and action by the local Safeguarding Children Partnership.

Learning points

1. The re- promotion of the Concealed and Denied Pregnancy Guidance may be useful, particularly to increase awareness of the reasons why a woman may conceal or deny a pregnancy, which include childhood trauma, domestic abuse, shame/fear of cultural expectations.
2. In cases where it is has not been possible to provide guidance and support in the antenatal period and/ or if a newborn baby requires a prolonged stay in hospital there must be a formal arrangement between health partners in acute, community and primary care settings regarding the provision of advice and support to parents. Furthermore, it should be an expectation that when advice such as in the ICON programme has been given, a clear record must be entered in the child's notes. Other professionals, for example support workers, social workers who may be involved with families who have not received

information as routine should also continue to take opportunities to reinforce key messages.

3. It would be beneficial for the local Partnership to include failure to thrive as an area of neglect for consideration especially in 0 to 1 year old babies. The Partnership should ensure guidance is available to enable clear understanding of non-organic failure to thrive, including thresholds and referral pathways, when concerns are identified in relation to the weight and growth of infants.
4. The local area should consider the development and launch of a procedure for use across the partnership to support staff in responding well to unexplained injuries in immobile babies and children.
5. Practitioners need to be professionally curious about families' cultural and religious context when undertaking assessments, planning interventions and support, whilst retaining focus on children. Involving interpreters is important to ensure there is full understanding of the service being delivered and expectations, with records completed to demonstrate language and understanding has been properly explored.

7. References

- Working Together to Safeguard Children 2018
- Working Together to Safeguard Children 2015
- Concealed and Denied Pregnancy Guidance (Local Safeguarding Children Partnership), February 2021
- CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014
- Abusive Head Trauma: The Case for Prevention- Dr Suzanne Smith PhD, Winston Churchill Memorial Trust Travel Fellowship, 2016
- ICON, iconcope.org
- Bottle feeding advice, www.nhs.uk
- Child Safeguarding Practice Review Panel Annual Report 2018 - 2019
- National Institute for Health and Social Care Excellence (NICE) – Faltering growth: recognition and management of faltering growth in children, NICE guideline (NG75) 27 September 2017
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- Graded Care Profile 2 - learning.nspcc.org
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- NSPCC - Culture and faith: learning from case reviews, June 2014
- The Myth of Invisible Men - Safeguarding children under 1 from non-accidental injury caused by male carers, Child Safeguarding Practice Review Panel, September 2021
- Child deaths by abuse and neglect, NSPCC Statistics briefing, September 2020

8. Appendix A – Framework & Methodology

A serious case review was commissioned by Local Safeguarding Children Board, following agreement at the Serious Case Review Sub Group in accordance with Working Together to Safeguard Children (Department for Education 2015), which was the version of Working Together relevant at that time.

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1)(e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter- agency working, the LSCB must commission an SCR.

Methodology

The methodology used initially was based on the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead, it is an effective learning tool for local safeguarding children boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken

of the case is not the focus of the reports which are succinct and centre on learning and improving practice.

However, because a review has been held, it does not necessarily mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of safeguarding boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the boards may identify additional learning issues or actions of strategic importance.

Organisation	Role
Independent	Lead Reviewer
Panel Chair	Deputy Designated Nurse for Safeguarding Children
Children's Social Care	Quality and Review Manager
Children and Family Wellbeing Service	Locality Manager
Early Years	Early education Safeguarding Officer
Lancashire Care foundation trust	Specialist Safeguarding Practitioner
Lancashire Constabulary	Review Officer
Southport and Ormskirk Hospital NHS Trust	Named Nurse Safeguarding Children
NHS Chorley and South Ribble CCG, NHS Greater Preston CCG and NHS West Lancashire CCG	Deputy Designated Lead Nurse Safeguarding Children
Lancashire Safeguarding Business Unit	Business Co-ordinator
Lancashire Safeguarding Business Unit	Business Support Officer

These may be included in the final review report or in an action plan as appropriate.
Due to delays in parallel processes and the Covid 19 pandemic the review methodology was amended; the final stages of the review were completed as explained in the body of the report above.

9. Appendix B – Terms of Reference

Introduction

This Review is being commissioned by the Chair of Lancashire Local Safeguarding Children Board (LSCB) in accordance with the learning and improvement framework for LSCBs described in Working Together to Safeguard Children guidance (HM Government 2015). The Serious Case Review will be undertaken using methodology based on the Welsh Child Practice Review Model in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSCB will conduct the review and report progress to the Board through its Chair.

Membership will include an independent Lead Reviewer and representatives from key agencies with involvement.

Timeframe for the review

The review will cover the timeframe of **16/01/2016 to 19/12/2018.** Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

Subject(s) of the review

XXX– DOB: 2016

XXX – DOB: 2016

Significant others

XXXX - Sibling of xxx

XXXX - Sibling of xxx

Mother of xxx

Father of xxx

The purpose of the review is to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB;
- Examine the effectiveness of information sharing, case handovers/transfers and working relationships between agencies and within agencies;

- Determine the extent to which decisions and actions were focussed on the subject children;
- Examine inter-agency working and service provision, including quality of assessments, for the child/children and the parenting capacity of all possible carers within the family;
- Explore the consideration and use of early help processes, and whether this was effective;
- Explore responses to the concealed/ denied pregnancy and whether assessments relating to the circumstances were robust;
- Examine the interface between community and acute health provision regarding advice provided to parents/carers of new born babies;
- Examine to what extent safe handling advice and support was provided to the carers;
- Establish whether all injuries, including minor injuries, sustained by the children were responded to appropriately by parents and professionals;
- Determine the impact of possible parental mental ill health within the family and whether appropriate services were considered to assist the mental wellbeing of the parents;
- Examine responses to, and the management of, children not being brought to appointments, and non-engagement with services by family members;
- Explore responses to concerns relating to the children's failure to thrive and neglect, including whether existing policy/guidance is effective;
- Explore whether all risk factors within the family were properly considered and were responses appropriate;
- Determine the extent to which professionals identified domestic abuse, what actions were taken to support the family and was this appropriate to the circumstances;
- Scrutinise the child protection plans and connected processes regarding all children within the family to ensure actions and outcomes were relevant, clear and child focussed;
- Explore that language, culture and other aspects relating to diversity were appropriately considered in all service provision to the family;

- Examine the involvement of other significant family members in the life of the children, and family/community support provided to the subject family;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify any learning for the LSCB to consider in order that an action plan can be developed to support and improve systems and practice, where necessary.

Tasks specific to the review panel:

1. To set the time frame for the review, see above;

2. Agencies that have been involved with the child/children and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;

3. Other agencies/services may be asked to provide a timeline following review of the information provided;

4. Agency timelines will include an analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;

5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;

6. A full and accurate genogram of the subject family will be prepared for the panel and to assist the learning event;

7. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;

8. The Panel will plan with the Lead Reviewer a learning event for practitioners to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;

9. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any areas for the LSCB to consider for the development or improvement to systems or practice;

10. The Panel will receive and consider the draft SCR report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial hypotheses addressed and any additional learning is identified and included in the final report;

11. The Panel will agree conclusions from the review and learning considerations for the LSCB and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;

12. The Panel will plan arrangements for feedback to the family and the practitioners in attendance at the learning event and share the contents of the report following the conclusion of the review, and before publication;

13. The Panel will take account of any criminal investigations or proceedings related to the case;

14. The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SCR report for publication.