Child Safeguarding Practice Review

Overview Report: Child C, D and E

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1. Introduction and Background

1.1. The background of the Child Safeguarding Practice Review (CSPR)

This CSPR was commissioned by Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP). The subject children of this review will be known as Child C, Child D and Child E throughout the report.

The catalyst for this CSPR was that in 2013, there were two separate child deaths from the same family within 7 months of each other. Both children died following breathing difficulties at home which had resulted in emergency medical responses prior to their deaths. The first child who died (Child D) was only 24 days old at the time of death, followed by Child C at the age of 21 months.

In the absence of any definitive medical cause for the children's deaths a level of medical uncertainty existed but did not progress until a number of years later when another child (Child E) started to experience breathing difficulties at home resulting in admission to hospital.

The pattern of hospital admissions relating to Child E followed breathing difficulties at home and this, in conjunction with the history of Child C and Child D and the adult male involved was recognised by paediatricians who initiated a short child protection investigation for Child E who was removed to a place of safety. These actions averted the probable eventual death of Child E.

A finding of fact hearing on behalf of Child E took place in the Family Court which found that the family context at the time of each serious incident corresponded with the breaking down of the adults relationship and that the same male had been in sole care of the children just prior to, or at the time of the respiratory collapse of each child. The finding of the court was that Child E had no medical condition or illness to explain the onset of a sudden respiratory arrest and that the male involved had probably been responsible for deliberately causing this.

This court hearing triggered a highly complex criminal investigation of the male involved who was arrested for the children's murder/ attempted murder in 2018 by which time there was a further murder charge relating to the death of his most recent partner. This woman was not connected to the children in this review and died at home as a result of deliberate drug poisoning.

A ten-week criminal trial completed in the latter part of 2021 found that the male involved was guilty of the murder of Child C and Child D and his then partner. He was also found guilty of the attempted murder of Child E.

The identity of Child E has been protected throughout this report for legal reasons.

During sentencing, the judge described the convicted male as being an, "exceptionally controlling, selfish and cruel man." He was sentenced for a minimum jail term of 40 years and following a review of the sentence was sentenced to a further 8 years. During the trial it was accepted that no one else with any caring responsibility for any of the children had been aware or suspected the involved male of any untoward actions at the time the incidents occured.

Child Safeguarding Practice Review - (previously known as a Serious Case Review (SCR)) is undertaken when a child dies or the child has been seriously harmed and there is cause for concern as to the way organisations worked together

Child Safeguarding Assurance Partnership (CSAP) – The safeguarding partners work together to agree on ways that they will co-ordinate their safeguarding services, act as a strategic leadership group in supporting and engaging others, and implement local and national learning.

1.2. Delay in carrying out this CSPR

On the commencement of the Police investigation it was decided that in view of this case highlighting probable child murder and attempted murder, that a Child Safeguarding Practice Review (CSPR) should be commissioned in line with the national statutory regulated practice guidance and the national child safeguarding practice review panel.

The review did not commence until after the criminal trial of the male involved had been concluded to ensure that the highly complex detail of the medical and pathological police evidence was fully protected.

The purpose of this review has been to recognise both historical and more recent child safeguarding practice arrangements and to highlight good practice and any progress or gaps in local safeguarding systems and practice. A number of recommendations have been produced which are based on the lessons learned from this review in order to improve safeguarding arrangements for children in the future.

1.3. Methodology

The review has been conducted in line with Working Together (2018) statutory guidance and the National Child Safeguarding Practice Review Panel: practice guidance 2019.

An Independent Reviewer with relevant expertise and experience was commissioned to conduct the review with terms of reference which sets out the scope and key lines of enquiry for the review (Appendix 1).

A Panel of managers and safeguarding leads from the agencies/organisations involved in the review have been actively involved throughout the process.

The Independent Reviewer virtually attended the summing up and sentencing of the male involved's criminal trial and has since met with the mother of Child C and Child D to hear her testimony and her feedback on services provided to her children and family which has been greatly appreciated.

Extracts from the comments made by the mother of Child C and Child D have been transcribed within the report and written in blue to promote her voice on behalf of herself and the children.

Working Together 2018 is interagency statutory guidance produced by the government which outlines how practitioners working with children and families should work together to safeguard and promote the welfare of children.

National Child Safeguarding Practice Review Panel - are an independent panel commissioning reviews of serious child safeguarding cases.

2. Overview of the family and context

The children who are the subjects of this CSPR were all white British and living in the north of England. The children had lived within an urban community and within easy reach of the adults' friends and family. The male involved **(MI)** was fully employed in a well remunerated construction job throughout the review period and the father of Child C and Child D.

2.1 Parental background

Historically, the Mother of Child C and Child D **(MCD)** was known to have experienced a troubled childhood and following the death of her own mother had been predominantly looked after by her older sister. The household MCD was brought up in had been chaotic and her school attendance was extremely poor. MCD entered into a platonic relationship with MI when she was 10 years old and became reliant on him and his family.

MI, also had a troubled childhood; he had experienced behavioural issues and was a victim of domestic abuse. He too had an extremely poor school attendance record. As a youth he was known to the Police for anti-social behaviour and he experimented with alcohol and drugs.

MCD became pregnant by MI at the age of 19 years. One month prior to the first pregnancy being confirmed there was a brief history of deliberate self-harm by MCD involving an overdose of prescribed medication. MCD was supported by mental health services at the time and remained under the care of her own GP for management of her mental health.

Professionals working with the family at the time were not aware of MI's drug dealing and gambling which resulted in him having debts amounting to thousands of pounds which impacted on the couple's relationship.

It was only after the couple finally split up that MCD became aware that she had been manipulated and controlled by MI throughout their relationship, the scale of which was only fully realised by MCD at the end of the criminal trial in 2021.

2.2 What happened – Child C and Child D

MCD's first midwifery assessment was at 8 weeks of pregnancy. The midwife appropriately took into account her psychosocial circumstances which resulted in MCD's maternity care being referred to a Caseload Midwife who is a midwife with a limited caseload to provide additional support and to promote continuity of care.

A Common Assessment Framework (CAF) was completed resulting in the family receiving the Early Start Programme which provided intensive parenting support during MCD's pregnancy and throughout Child C's first year.

The Routine Enquiry questions on domestic abuse were asked on a number of occasions throughout the antenatal period with no concern being flagged.

Common Assessment Framework (CAF) – is a process used to identify children and family unmet needs and support them.

Early Start Programme – is a local authority programme offered to support vulnerable families during pregnancy and infancy.

Routine Enquiry - involves asking women direct questions in relation to domestic abuse during pregnancy and child's early infancy.

Child C made good developmental progress and was appropriately taken to hospital on three occasions. Child C was 11 months old when professionals became aware that mother was pregnant with Child D.

There were no significant issues identified by the Caseload Midwife during this pregnancy and additional support from Early Start Programme was not required. MCD was encouraged to access local services at the children's centre.

Child D was born healthy and with no new family issues being identified. The child attended hospital on 2 occasions (age 7 days and 17 days) after having reported breathing difficulties at home. On both occasions the child quickly recovered and following a period of observation was discharged home.

The day following the second discharge from hospital, Child D was found to be not breathing at home by MI. A 999 call was made and MI commenced resuscitation as instructed. The child was taken to hospital but did not recover and died.

The Paediatrician was shocked by the child's death given that the child had been well on the ward just a few hours earlier. The cause of death reported by the Coroner was Bronchopneumonia.

Child C was 17 months old when Child D died. The child was reviewed and found to be developing normally with no safeguarding concerns. When the child was 20 months old, they had a sudden respiratory arrest at home requiring a short admission to hospital for observation.

Twenty days later Child C was found unresponsive in a pushchair at home and was taken to hospital where the child was later pronounced dead.

Paediatricians were surprised by the child's death and harboured some concern that something untoward had occurred to the child because there did not appear to be any medical explanation for the child's death. The cause of death reported by the Coroner was unascertained and an open verdict was concluded at the Coroner Inquest.

There were no other children involved at this point.

Bronchopneumonia - inflammation of the lungs, arising in the bronchi or bronchioles

Coroner Inquest – are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries

2.3 What happened – Child E

Two years following the death of Child C the mother of Child E **(ME)** attended midwifery services and following assessment was referred to a Caseload Midwife and the mental health assessment team, but ME did not engage with the mental health service.

The pregnancy and early neonatal period was appropriately managed by health teams as there were significant health risks established to be present for the baby and ME largely complied with these measures. In the event Child E was born healthy and there were no development concerns and the child was thriving.

When the child was 5 months old there was an alleged high-risk domestic abuse incident which was reported to the Police by MI. This was followed by a second incident reported to the Police the following day involving an altercation between ME and another adult who had been caring for Child E.

There was an appropriate referral to the Multiagency Safeguarding Hub (MASH) by the Police with a same day contact by Children's Social Care and the commencement of a child and family assessment.

One-week later Child E was admitted to hospital following a respiratory arrest. The child quickly recovered. ME informed the allocated Social Worker of the child's admission. The Social Worker contacted the Paediatrician who shared information about concern surrounding the deaths of Child C and Child D and MI's involvement with all three children and of an emerging pattern of possible Fabricated or Induced Illness (FII).

A discharge meeting involving the Health Visitor, Social Worker and Paediatrician was arranged for the following day which concluded that Child E was fit for discharge home with a plan arranged by Children's Social Care for ME, and child to stay with an aunt for support and supervision.

Three days following discharge, Child E was found to have a further episode of sudden respiratory difficulty requiring hospital admission. At the time of the episode Child E was in the care of MI.

A Strategy Meeting was held two days later where it was agreed that the threshold to undertake a section 47 investigation (child protection) had been met with a plan to secure the safety of Child E.

Child E was monitored in hospital until Children's Social Care obtained an Interim Care Order through Local Authority (LA) care proceedings. These ongoing family court proceedings led to a criminal investigation of MI resulting in his eventual conviction and incarceration.

Multiagency Safeguarding Hub (MASH) – brings together professionals from a range of agencies into an integrated multi-agency team and provides triage and multi-agency assessment of safeguarding concerns in respect of vulnerable children.

Fabricated or Induced Illness (FII) – is a rare form of child abuse and happens when a parent or carer, exaggerates or deliberately causes symptoms of illness in the child

Strategy Meeting – should take place where there are concerns about the safety and/wellbeing of a child or children. This is a statutory process as part of national safeguarding arrangements for children

Interim Care Order – a temporary order made by the Court at the beginning of Care Proceedings and places a child in the care of the Local Authority and gives them shared parental responsibility with the parent.

3. Key Learning Themes

Firstly, it must be stressed that this is a rare and highly complex review involving child murder by MI. It is recognised that much of the learning is based on historical information and the knowledge of hindsight from evidence produced firstly in the family courts and then by the Police which has been disclosed in the criminal court setting. The review highlights a number of positive changes to safeguarding practice and systems which have already been made locally.

Secondly, it is recognised that professionals working with children and their parents do so based on the principle that parents want what is best for their children and want to keep them safe.

In this case, the good work of all the agencies involved with the children and family resulted in recognising and responding to concerns at a dangerous point in the life of Child E which ultimately saved the child's life.

3.1 Key Learning Themes identified:

- Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) and Physical Abuse in children.
- Medically Unexplained Deaths in Children – including Sudden Unexpected Death of Children (SUDC) arrangements, Child Death Overview Panel (CDOP) arrangements and Criminal Investigation.
- Coercive Control and Domestic Abuse

Sudden Unexpected Death of Children (SUDC) arrangements – involves a rapid multiagency response by a trained team of local professionals who will support the parents and investigate the circumstances of the death and report back to CDOP and the Coroner.

Child Death Overview Panel (CDOP) – is a statutory requirement of Working Together 2010. The purpose of the CDOP is to ensure that when a child under the age of 18 dies there is a comprehensive and independent review of the circumstances.

Coercive Control – this is described as controlling behaviour designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.

Domestic Abuse - is violence or other abuse that occurs in a domestic setting, such as in a marriage or cohabitation.

4. Perplexing Presentations (PP), Fabricated or Induced Illness (FII) and Physical Abuse in Children

4.1 Introduction

Guidance on FII has been available from the Royal College of Paediatrics and Child Health (RCPCH) since 2009. Since then there has been significant developments in this area of medicine. The term Perplexing Presentations was suggested in 2013 with development around recognising, risk assessment and how to manage these types of presentations to improve safeguarding and child outcome.

A perplexing presentation is the essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible discrepancies and unexplained findings or parental behaviours (RCPCH 2021).

The guidance suggests that there had been uncertainty around the criteria for PP/FII and the threshold at which safeguarding procedures should be involved. There has been a helpful shift towards early recognition and intervention without the need for proof of deliberate deception by a care giver.

The challenge remains that paediatricians are faced with medical emergency /presentations which rely on accurate and truthful reporting from parents and care givers. Parents and carers who harm their children will fabricate stories to cover up their actions leaving the paediatrician with complex and emotionally stressful dilemmas.

4.2 Narrative following a review of the children's presentations to hospital in chronological order.

All three children attended the same hospital children's department and were treated by the same paediatricians which was a positive feature given that this alerted the paediatricians to the pattern of medical presentations and raised their concern for the safety of Child E which ultimately saved the child's life.

4.3 Child C – featured four admissions to hospital prior to the birth of Child D.

Child C's first hospital attendance (age 7 months) was for a Viral Upper Respiratory Tract Infection which was appropriately treated prior to being discharged home. There was a return visit the following day with concerns of a wheezy chest (possible asthma) and this was treated accordingly.

The third hospital attendance (age 9 months) came following a 999-emergency call by MI for medical assistance. The story from MI was that he had left the child playing unattended and, on his return, had found the child asleep and unresponsive on the floor with paracetamol next to the child. MI said that the child was "drowsy" when they came around. However, there appeared to be a flaw in this story because Paracetamol does not cause drowsiness even in large doses until a few days after administration and this should have alerted staff to inconsistencies in MI's account.

The child's observations and behaviour were normal on admission to hospital and a blood test for toxicology was negative for Paracetamol. The medical conclusion at the time was that the child had not taken any Paracetamol therefore no medical treatment was necessary and no checks about the child's home situation were made as part of the overall clinical assessment.

The reflection on learning here may provide an opportunity for paediatricians to consider the use of new assessment guidance for the evaluation, risk stratification, investigation and management

of children presenting to hospital with a Brief Resolved Unexplained Event (BRUE). The guidance / pathway is intended to replace the previous guidance on Apparent Life-Threatening Events (ALTE). (NHS Greater Glasgow and Clyde, 2018).

The guidance has been shown to be effective in recognising infants who are at risk of repeated BRUE episode or identifying an underlying disorder. Whilst the guidance helps the practitioner explore medical findings it also considers the wider socio-environmental factors which promotes more effective risk assessment and safeguarding.

Proposal following Learning 1

The CSAP via the Integrated Care Board and Acute Hospital Trusts should request that local paediatricians consider using a consistent assessment tool such as the BRUE model across the partnership to support their clinical practice and to improve the risk assessment of children admitted with brief resolved unexplained events.

Possible ingestion of substances is not an uncommon event for children. Parents are encouraged to err on the side of caution particularly with paracetamol because of its level of toxicity. However, the collapse history seems to have been lost/forgotten with the finding of normal blood tests. It is important to consider the presentation of the child and see whether the results explain that. Even if there had been paracetamol in this child's system it would not have explained an unresponsive child.

There were a number of features around this event which did not appear to be plausible and were not explored at the time. How could a 9-month-old child who was not yet walking manage to stand and get the Paracetamol packet off the mantle piece? Did the child have the manual dexterity to remove the tablets from the blister pack – even if using their teeth as was suggested? Why would anyone caring for a 9-month-old child leave them on their own without supervision for 20 minutes? Why was there a history of unresponsiveness and drowsiness when the child had been reported as ingesting paracetamol? Why would a child who had been collapsed, requiring resuscitation at home, be well on admission to the ward?

During discussion at the learning event, the paediatricians felt that it was common to see children admitted with drug/substance ingestions and at the time nothing raised any alarm that something sinister had happened.

Whilst paediatricians are not expected to be criminal forensic investigators there should be an expectation for them to be professionally curious when parental histories potentially do not match clinical findings with a view to promoting safeguarding.

Best practice would have been for the hospital staff to have made safeguarding checks with MASH and the Health Visitor to better understand the situation at home. A CAF was already in place for the child and this event should have been worthy of a multiagency "team around the child" meeting to consider how the family were functioning and to identify any future risks for the child.

A request for the Health Visitor to visit the home for health and safety checks was appropriately completed by the Children's Department Paediatric Liaison Nurse. The Health Visitor visited the child two weeks later for a pre-arranged appointment.

This visit was taken up by MCD being distressed because she had split up from MI recently and his family had made threats to take the child from her which indicted that there was increased tension within the family that had been worthy of further consideration.

Whilst the Health Visitor recognised the need for support around domestic arguments and advised MCD to attend women's domestic abuse and refuge services it did not lead to any additional assessment of family functioning as it should have done.

MCD told the Independent Reviewer that over this period of time she had been trying to get away from MI because she thought he was gambling again, *"but he would not let me go".* She had no money of her own and she was not happy in the relationship.

MCD recalled to the Independent Reviewer that on the day of the paracetamol incident she had told MI that she was going shopping and when she returned, he would have to leave. She had just reached the door of the supermarket when MI rang her to say that Child C had taken paracetamol and had collapsed and he was on his way to the hospital. MCD went straight to the hospital to meet with MI and Child C.

MCD reflected with the Independent Reviewer that when children (such as Child C) are admitted to hospital with a history which does not appear to match up *"there should be checks about what is happening at home".* Hospital staff had not fully considered the situation at home or the state of the parent's relationship which prevented them from seeing the bigger picture.

NSPCC learning from case reviews (2017) suggest that where there are vulnerable families with increasing stress and rising tension that children are at greater risk of abuse. There is therefore, validity in mother's proposal for checks at home for children where there are perplexing presentations even if concerns are only low level.

Professionals should be particularly alert to these types of presentations because they may be a precursor to something more serious happening in the future, as occurred in this case.

At MI's murder trial there was a suspicion in court that he may have fabricated the story about paracetamol and he himself caused the collapse of the child to deflect the situation of the couple breaking up.

Whilst the learning is both historical and heavily based on hindsight there is a lesson here about professional curiosity and information gathering/sharing and how hospital and community children services work together to assess risk to safeguard children when the child's presentation is perplexing or where elements of a given situation are inconclusive or doubtful.

Proposal following Learning 2

The new safeguarding policy for Perplexing Presentations / Fabricated or Induced Illness in Children which is in line with the RCPCH guidance (2021), should act to raise awareness of how to manage children where there are elements of uncertainty in the history of a child's medical presentation and establish pathways for gathering information about a child and family home and environmental factors as part of the clinical assessment.

Child C (11 months) had a further appropriate hospital admission for a minor urinary problem which was resolved with antibiotics. This presentation was unremarkable and appropriate.

4.4 Child D – featured 2 hospital admissions prior to the child's death

Child D (age 7 days) attended hospital with oral thrush and medication was appropriately given. The Health Visitor was notified and visited 3 days later with no concern identified.

Ten days later, Child D (age 17 days) required a 999-emergency response due to breathing difficulties at home and quickly recovered when the paramedic arrived. The child was admitted to hospital for 2 days with signs of an upper respiratory tract infection. Medical tests and observations were all normal prior to discharge and the child appeared well.

Following discharge home, the child had a cardio-respiratory arrest and died just a few hours later. The paediatricians had not found any perplexing features in any of Child D's hospital admissions. It was the suddenness of the child's death following discharge which the paediatricians found perplexing.

4.5 Child C – (continued) features 1 further hospital admission prior to the child's death.

When Child C was 18 months old (6 months after the death of Child D), MI made a 999-emergency call because the child was said to be having difficulty breathing. Full screening tests took place at the hospital which were all normal. The child remained well whilst in hospital.

MI requested to take the child home on "home leave" with an arrangement to return the following day to be seen again by the paediatrician. The child was not returned to the ward as arranged and the parents were not contacted by the hospital to check the reason for this. The discharge summary to the Health Visitor did not reflect that the child had not been returned for review as planned.

There is an issue here around "was not brought" (formally known as did not attend) procedures. Best practice would have been to alert the Health Visitor in the community that the child had not attended the hospital as planned. Paediatricians at the learning event did not feel that this was an issue because MI had not taken the child home against medical advice.

Professional curiosity around why the child had not been returned as planned should have been expected with a call to the parents to check on the circumstances to ensure a safe discharge from hospital.

Progress
New local arrangements are now in place within the hospital's Children's Department where the hospital children's nurses are available to contact parents/carers direct to chase up any issues and to share information with other services and agencies.

Three weeks following this hospital admission, Child C was brought into hospital and found to be dead. The nature of this death was perplexing in that this was a sudden and unexpected death of a child who had been otherwise healthy and developing well.

4.6 Child E – features 3 hospital admissions prior to the child being safeguarded.

By the time Child E attended hospital at the age of 9 weeks the child had already undergone extensive screening to exclude any cardiac, metabolic or genetic conditions all of which were normal.

Child E's first hospital attendance occurred at the age of 9 weeks because the child was sleepy and unsettled when awake following vaccinations and a low threshold to admit the child had been identified. The child was found to be well and was discharged.

The second admission occurred when Child E was 4 ½ months old. At this point at least two serious domestic abuse incidents had been reported to the Police by MI about ME's (mother of Child E) alleged violent behaviour and mental health issues (both of which ME denied) resulting in ME's arrest and a referral to MASH (Multi-agency Safeguarding Hub). A child and family assessment had been appropriately commenced with a focus on ME as a potiential perpetrator of domestic abuse.

Child E's third admission to hospital came via another 999-emergency response call with a history that MI had found the child with breathing difficulties. On arrival at hospital the child was alert, smiling, interacting and observations were all normal.

ME sent a text to the Social Worker involved with Child E to inform them that the child had been admitted to hospital which resulted in a professional's discussion between the Social Worker, Health Visitor and Paediatrician.

During the discussion, the Paediatrician reported that the child was well enough for discharge. There were no concerns at the hospital about the care of Child E provided by the child's mother (ME). The Paediatrician shared medical concerns about the circumstances of the deaths of Child C and Child D and MI's involvement with children including the possible features of FII.

The circumstances highlighted by the Paediatrician were serious enough to trigger a formal strategy discussion/meeting to include the Police prior to the child's discharge to ensure effective decision making to safeguard Child E but this did not occur.

The Social Worker raised a concern that Children's Social Care had limited information about Child C and Child D deaths and that careful decision making was needed around Child E's discharge home. This lack of available information will be discussed later in the report.

The safeguarding team at the hospital had not been informed of the child's admission or concerns raised by professionals on the ward at this point. Their assistance and expertise were not utilised to assist in the safeguarding process in line with the hospital's safeguarding arrangements. This lack of communication fell short of best practice expectation within the hospital safeguarding arrangements.

Progress
The hospital safeguarding team now have a safeguarding practitioner who is based on the ward during office hours. They complete safeguarding walk rounds on the ward and are available for advice and support. This safeguarding function is proactive in supporting clinical staff to safeguard children

The hospital safeguarding team were later informed of Child E's admission by the Children's Social Care team manager who asked for further information about Child C and Child D's deaths and shared concerns about the family history and current admission.

Information was ascertained from the ward that following the meeting between the Social Worker and the Peadiatrician the plan was for Child E to be discharged home with ME with supervision

from an aunt. Children's Social Care reported that they planned to speak with the police about previous deaths to ascertain information from the post-mortems following the deaths of Child C and Child D. This contact did not trigger any further risk assessment into the safety of the proposed plan for the child to be discharged prior to all reasonable checks being made and for the opportunity for a strategy meeting to be considered.

The following day, a different Paediatrician was covering the ward and was keen to discharge Child E to prevent exposure to infection. The initial Paediatrician had now remembered the deaths of Child C and Child D and felt there were concerns about Child E going home because there was a pattern of possible FII emerging which needed further exploration. Again, this should have triggered a multi-agency safeguarding strategy meeting prior to the child's discharge.

The appearance of a level of urgency by the Paediatrician to discharge Child E from hospital once the child was found to be medically well is a common feature of hospital-based practitioners. The perspective within hospital settings is often that a hospital children's ward bed is not a "place of safety" for children for Children's Social Care to use as an easy option placement. However, had Children's Social Care insisted on a strategy meeting prior to the child's discharge, this may have resulted in the child remaining on the ward for longer to allow for relevant multiagency checks to be made. This being the case, it may have enabled professionals to meet the threshold to investigate under section 47 (child protection) resulting in more effective risk assessment and planning at this earlier stage.

In the absence of a strategy meeting and the uncertainity around the allegation of domestic abuse against ME, Children's Social Care concluded that Child E could go and stay with ME at another family member's (an aunt) home who could provide support and supervise the child's care. The word 'supervise' may have provided a false sense of security that the child was to be protected by the collective family.

With the benefit of hindsight, the safeguarding risk assessment and planning was inadequate to protect Child E given that there were immediate concerns of FII taking into consideration the deaths of Child C and Child D and the involvement by MI.

At some point prior to the child's discharge, MI admitted to the Social Worker that he had lied about the risk ME may pose to Child E and agreed that the child should be returned to ME's care. MI admitting that he had lied to agencies over something so serious should have alerted the Social Worker to the increased level of risk.

ME told the Independent Reviewer that the Social Worker had a discussion with her and aunt prior to discharge. The arrangement was to have the aunt around in case ME needed any support with Child E at home. There was no actual supervision arrangement in place and ME said that *"no one told us there was any safeguarding concerns".*

It is the case that raising concern with parents/carers around FII can make the situation more dangerous because the parents/carer may do something untoward to the child to prove agencies wrong in their quest to provide evidence that there is some form of medical condition affecting the child.

Concerns of the emerging patterns of hospital presentations and FII by the Paediatrician were further discussed and the Social Worker requested chronologies of all three children. The Paediatrician declined to do this due to workload pressures and advised that Children's Social Care

should formally request the information from the hospital. However, following the hospital safeguarding team's involvement they began to collate the chronologies the next day. They emailed the Peadiatrician for information about the death's of Child C and Child D and asked for a copy of the internal mortality investigation to assist in the compiling of the chronologies in support of the case.

It is acknowledged that paediatricians are the lead agent in FII cases and this is a very time-consuming role. The work needed to make a diagnosis of FII would require a temporary work plan change to allow time for this work to be done if appropriate. It is important that paediatricians understand their role and responsibilities when managing concerns of FII and that there are clear procedures in place to support the Paediatrician in carrying out this important safeguarding function.

Progress and Proposal following Learning 3

The new Multi-agency Perplexing Presentations and Fabricated Induced Illness Guidance will require effective implementation and training. To ensure that all those working in this area understand their own roles and responsibilities as well as the nature, language and context of the guidance. There will also need to be a robust undertaking by hospital trusts to support their paediatricians in this work both practically and emotionally.

The day after discharge, the Social Worker visited Child E and ME and a Family Support Worker (FSW) was allocated.

Two days following discharge, MI made a 111 call to report that Child E had a worsening cough. Other adults caring for Child E were not told about this call.

The next day, Child E was allegedly found by MI to have stopped breathing resulting in a 999 call for emergency assistance.

On attendance by the ambulance crew the child had rapid breathing but the child quickly recovered and was transported to hospital where all observations appeared to be within normal limits.

Another adult contacted the Emergency Duty Team (out of hours social services) at ME's request to inform them that Child E was being taken to hospital again. The Social Worker was informed the following day and contacted the hospital for further information.

A strategy meeting was agreed in response to the identification of the high level of risk to the child and this was arranged to take place in two days' time. A same day urgent strategy meeting would be expected practice in line with safeguarding procedures. A further review strategy meeting could have been convened two days later to discuss information gathered.

Delay of the strategy meeting was put down to medical tests needing to be completed to enable the Paediatrician to provide or exclude a medical diagnosis. In acknowledgement of the greater level of concern for the child there was a move to nurse them on the main ward (instead of a side ward) for supervision. This was good practice to enable hospital ward staff to supervise the situation more closely.

The Hospital Named Doctor was informed of the serious case and the Named Nurse once alerted was able to be present at the Strategy Meeting to support hospital professionals. There would have

been merit in the Named or Designated Professionals being brought into the situation sooner to provide safeguarding guidance and expertise.

The strategy meeting was well attended by all the agencies. It was recognised that MI's story had some inconsistencies and that he had had time alone with Child C and Child D prior to their deaths. The outcome was a unanimous decision for a section 47 (child protection) investigation with a rationale that FII was an evident concern in the absence of any medical condition to cause to the child's sudden respiratory difficulties.

Proposal following Learning 4

The CSAP should conduct an audit in partnership with the Acute Hospital Trust around the effectiveness of safeguarding arrangements for facilitating strategy discussions/meetings in the hospital setting. The audit should include timescales, identify the attendance of the statutory agencies and consider the effectiveness of decision making.

There were some challenges for the paediatricians that came to light at the Strategy Meeting with a discussion about the risk of them being seen as being overzealous but with their overriding concern being around the potential dangers to the child. This provided an insight into the plight of medical professionals who often have to address dilemmas whilst protecting professional reputations.

Further medical specialist advice was taken by the Paediatrician about Child E's presentations to hospital, which was good practice and produced a working hypothesis that whilst a genetic condition could not be ruled out a deliberate induced event needed to be considered as a significant possibility.

Paediatricians are trained to diagnose and treat ill health in children and to work in partnership with parents on the basis of trust. The learning event raised an important issue around the negative emotional impact of paediatricians and other professionals being party to the removal of a child from their parents in care proceedings.

This highlights the importance of debriefing and supervision following distressing incidents and reinforces the importance of utilising the skills and knowledge of the Named and Designated Professional's expertise within the hospital setting.

Child E remained in hospital until the Local Authority was granted an Interim Care Order with a care plan to keep Child E safe.

Named Professionals – have a key role in promoting good professional safegurding practice within health trusts and provide advice and expertise to fellow professionals.

Designated Professionals – denotes dedicated professionals with specific roles and responsibilities for safeguarding children, including the provision of strategic advice and guidance to organisational boards across healthcare services and to local multi-agency safeguarding organisation.

5. Medically unexplained deaths in children

The Sudden Unexpected Death of Children arrangements, Child Death Overview Panel arrangements and Criminal Investigation

5.1 Introduction

NSPCC Child deaths due to abuse or neglect statistics briefing (2021). This briefing looked at what data and statistics were available about child deaths due to abuse or neglect.

It suggested that official measures are likely to be underestimations of the number of children who die due to a number of reasons, including:

- the legal complexity of proof of homicide
- misdiagnosed cause of death
- abuse not being the immediate cause of death, but being a contributing factor
- cause of death remaining unknown or unexplained.

However, based on the number of child homicides recorded by the police each year, there is on average, at least one child killed a week in the UK.

It is recognised that the incidence of two children experiencing sudden unexpected deaths from the same household is extremely uncommon and should be viewed as a high alert to guide further investigation into the possibility of deliberate harm to a child.

5.2 Narrative following review of SUDC and CDOP arrangements

Both Child C and Child D had died in the same year just 7 months apart and were siblings from the same household. Child D was only 24 days old when the child died and Child C was 21 months old. Both had historical hospital admissions which had been viewed as being unremarkable at the time. Both had been healthy before they suddenly and unexpectedly died in similar circumstances. It has only been with the benefit of hindsight following a criminal trial that we have been able to consider the learning around deliberate harm to the children.

5.3 Circumstances around the death of Child D

Child D had a respiratory arrest within 8 hours of returning home from hospital (age 24 days) whilst in the care of MI. The account provided closely resembled those often given in cases of sudden unexpected death in infancy.

The Rapid Response and Sudden Unexpected Deaths in Children (SUDC) processes at the time were well provided and the parents were supported throughout. The SUDC nurse was not available to support the process until the following day because their hours of working at the time was 9-5, Monday till Friday with no Bank Holidays and the child died on a Bank Holiday.

Progress

Following a review of the SUDC service in 2018, additional funding was made available to expand the SUDC nursing service which is now a 7-day service including bank holidays with working hours of 9-5. Outside of these hours the Consultant Paediatrician on duty carries out the tasks required at the hospital following the child death with the Police.

Communication and information sharing was good, although there was a delay with sharing the hospital medical records because the child died within 48 hours of hospital discharge resulting in the need for a Root Cause Analysis Review of the circumstances which concluded that all care had been appropriate and that the child had been well on discharge from hospital.

The initial findings from the post-mortem examination were recorded as unascertained. The final verdict of the Coroner inquest was that the death had been by natural causes with a final post mortem report recording acute bronchopneumonia.

The CDOP meeting closed the case within seven months and received relevant information that medical practice at the hospital had been reviewed and found to be appropriate at the time and that both parents had smoked which was an increased risk factor for SUDC. No further action was recommended by CDOP.

The paediatricians reflected at the learning event that they remembered that they had found the Coroner's verdict surprising given that Child D had been so well prior to leaving hospital. They recalled a discussion at the hospital mortality meeting (this meeting would have been separate to the CDOP process) that they raised low-level concerns about the child's death being attributed to bronchopneumonia and the paediatric view being that the death was unascertained.

This difference of opinion was not recorded or shared within the CDOP process which left a loose end of information which was lost other than to the memory of the doctors concerned at the time. The views raised by the paediatricians had been valid pathological/medical information and would have been useful information had it been shared within the CDOP or other Child Death processes.

Progress

Since 2018, there has been a new statutory requirement for multiagency attendance at a Child Death Review Meeting (takes place prior to CDOP) where all relevant information about the child and family is shared. These meetings are expected to be effectively recorded with appropriate information sharing via the "draft analysis form" to CDOP.

It is the case that had Child Death Review Meetings been in place at the time there would possibly have been a better opportunity for the concerns of the paediatricians to be shared, recorded and addressed.

Root Cause Analysis Review - is a systematic process for identifying "root causes" of problems or events and an approach for responding to them.

Bronchopneumonia – inflammation of the lungs usually caused by a bacterial infection or virus.

Proposal following Learning 5

The CSAP should be assured that the local arrangements for Child Death Review Meetings are well established and consistently applied across all areas of the partnership in line with Working Together 2018.

Any concern which has a bearing on the death of a child should be recorded as an opinion in the Child Death Review Meeting minutes even if this is not a unanimous view. Relevant information should be placed on the individual agency child's record for future information scrutiny. Individual agencies should take responsibility for the effectiveness of record keeping following Child Death Review Meetings and other associated meetings. Whilst Child Death Review Meetings were not available at the time the fact that Children's Social Care had very little information about Child C and Child D's deaths on their record management system when safeguarding concerns arose bears testament to a potential shortfall in effective record keeping.

Proposal following Learning 6

The CSAP should ensure that agencies attending Child Death Review Meeting's have effective processes for the transfer of important information being recorded on their agency's child and family record systems.

There were no feedback mechanisms at the time to share the differences of opinion raised by the paediatricians to the Coroner or CDOP. The benefit of having such feedback arrangements locally is that it provides a forum for further discussion and learning.

Proposal following Learning 7

The CSAP should consider with the Coroner their relationship and potential for feedback between the Child Death Overview Panel and Coroner when managing difference of opinion.

5.4 Circumstances around the death of Child C

Child C (21 months) had been found by MCD to be unresponsive at home in a pushchair having been out for most of the day with MI. A 999-emergency call was made and the child was found to be in cardiac arrest and despite appropriate resuscitation by paramedic's and other health professionals the child was found to be dead shortly after arriving at the hospital.

Following the death of the child, a Rapid Response Meeting was requested by the Police Senior Investigating Officer with Children's Social Care and Consultant Paediatrician at the hospital. It was recognised that this was the second child death from the same family which led to the Police taking a greater level of forensic attention of the home to identify any evidence of abuse of which none was found.

The medical history for Child C was provided and the parents were interviewed by the Police. Whilst the routine investigation which takes place within the SUDC process were robust, it did not extend to requesting a medical review of the two children's medical records together which would have been best practice. In hindsight, this may have drawn attention to a number of medical concerns which were surfacing of possible FII following the deaths of the two children.

Proposal following learning 8

The CSAP should ensure that where there have been two or more children dying suddenly and unexpectedly from the same family that these are viewed as indicative that the cause of death for the children is likely to be the same and further assessment of the children's cases together may provide either a diagnosis or an explanation. As such, all medical records should be reviewed by an experienced senior Paediatrician who should report on the child's medical history and present any findings to the Joint Agency Response Team and CDRM/CDOP.

On medical examination there were a number of small marks and bruises on Child C's face, back of neck, and legs and a small upper torn frenulum in the mouth. These were put down to accidental toddler injuries and the trauma of the resuscitation process which was a reasonable hypothesis. However, with the benefit of hindsight following the criminal trial these marks may have been pointing to something more sinister.

Keeping an open-minded approach during the SUDC process is essential in order to ensure that professionals are not ruling out areas of uncertainty too soon.

The initial post mortem results for Child C was recorded to be unascertained and samples were sent for toxicology testing and formal police statements were taken from the parents. The final post-mortem was undertaken by a Home Office Pathologist whose report confirmed that the child's cause of death was unascertained. The Coroner's final verdict was that the child's cause of death was unascertained and therefore an open verdict was recorded.

The CDOP review was closed after 14 months which was 6 months after the Coroner's final verdict. The reason for the delay is not known other than the workings of CDOP at the time. The meeting recognised that the child had previous hospital admissions with breathing difficulties possibly related to asthma. It was noted that the child's sibling had died earlier in the year and that both children had been in the care of their father prior to their death.

The concerns around the circumstances of the deaths of the two children were discussed at CDOP which was recalled at the learning event. Given the odd circumstances and absence of any clear medical cause for the children's deaths there were concerns about possible deliberate harm to the children but these concerns were not regarded to be supported by sufficient evidence to provoke a criminal investigation. Concerns and suspicion were not recorded in the CDOP minutes as it should have been for future information and scrutiny.

Both parents were still young and were now childless making it highly likely that there would be future pregnancies for them either together as a couple or individually as part of another couple.

Frenulum – is situated inside the mouth. It is a thin tissue connecting the upper lip to the upper gums just above the front teeth.

Issues around MCD's mental health, parental smoking, sleeping arrangements and parental supervision were all well recorded and good practice around bereavement support was acknowledged. There were no recommended actions for the safeguarding of any future children born to the parents as would have been expected.

Best practice would have been for the Joint Area Response Team to recommend a multi-agency Pre-Birth Assessment for any future pregnancies to provide a vehicle for sharing information, risk assessment and to safeguard any future children born to the couple.

Proposal following learning 9

The CSAP should ensure that where there are suspicious circumstances surrounding a child death, a recommendation should follow from the Joint Area Review strategy meeting, Child Death Review Meeting or Child Death Overview Panel for future pregnancies to ensure effective multi-agency Pre-birth Assessment. This should take place for the couple if they remain together or individually as part of other couples.

A lack of feedback from the Child Death processes back to individual organisations record created a gap in information connectivity. However, Child Death Review processes changed in 2018 and Child Death Review Meetings have supplemented other meeting structures such as hospital mortality meetings. They should have multi-agency representation to ensure safeguarding issues are appropriately managed and recorded within individual agencies with action plans being shared with Child Death Overview Panel.

Proposal following learning 10

The CSAP should review the effectiveness and consistency of the child death review arrangements across the area of the partnership to promote information sharing and risk management.

Whilst the Child Death Overview Panel is expected to maintain anonymity, this can be broken where a safeguarding or medical risk to a living or potential future child or family member is uncovered during the process and action taken to reduce that risk.

In conclusion to the SUDC and CDOP arrangements at the time, whilst they were found to be good and continue to be improved, it was not the engagement of these two processes which protected Child E. It was the good fortune that the child attended the same hospital and was seen by the same Paediatricians who remembered the deaths of Child C and Child D, including MI's involvement with them and the concerns they had at the time. From this, the pattern of FII more clearly emerged and Child E was safeguarded.

Children should not need to rely on good fortune in order to be protected. Children need their child death processes to be robustly applied to leave a record trail of relevant information to aid any future risk assessment to protect children.

Proposal following learning 11

The CSAP should be assured that those attending CDRMs and CDOP understand their roles and responsibilities and there are quality assurance arrangements in place to monitor effectiveness.

5.5 Criminal Investigation

There was no role for a criminal investigation beyond the child death processes (as previously described) identified by the Police until Child E's second admission to hospital when they were invited to a strategy meeting. Police were fully involved in the child protection investigation and were aware that Children's Social Care were developing a case for the Family Court for a Finding of Fact hearing.

There was relevant information sharing by email between Children's Social Care and Police about Child E's Care Proceedings and the expert reports being prepared for the Finding of Fact court hearing which contained serious concern that MI may have caused harm to all three children.

At the conclusion of the Care Proceedings best practice would have been for Children's Social Care to contact the Police directly to discuss the outcome of the court proceedings. The lack of effective communication at the time resulted in the delay of the Police being notified that the Judge had found that MI was culpable of the deliberate harm of the three children and that no-one else was involved in the incidents.

The court requested the Police to initiate a criminal investigation which commenced a short time later. At the time the Police were based at a different site to Children's Social Care and communication was less fluid than it is now.

Progress

The establishment of the new Multi-agency Safeguarding Hub (MASH) arrangements has developed lines of communication between the agencies to ensure effective information sharing.

The Police were provided with all the reports obtained within the family proceedings. The Police criminal investigation involved extensive gathering of medical information which included at least 12 medical and pathology expert reports which is to be commended. The magnitude of this investigation cannot be overestimated and much of the information gathering took place during the national COVID lockdown period making access to people and physical evidence more challenging.

The final Police file which was presented to the criminal trial had more than 800 pages of medical evidence which had to be fully referenced and crossed referenced. This along with the evidence given by expert witnessess in the court eventually delivered a verdict of murder and attempted murder by the male involved and brought justice to the deceased children and late partner.

Another positive aspect to this case was that evidence gathering was enhanced by the level of continuity of police work. The Independent Reviewer is aware that the Senior Police Officer for the case retired during the time but agreed to return to Police service to continue with the case and take it to it's eventual successful end.

Proposal following learning 12
The partnership should consider writing to the Police Chief Constable in recognition of the excellent work and outcome outlined in this review.

6. Coercive Control and Domestic Abuse

6.1 Introduction

Domestic violence and abuse can be defined as:

"Any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional". (Gov 2021).

NSPCC briefing on learning from serious case reviews (2017) identified issues raised in this review including adults who are in an abusive relationship may not realise they are being abused. As a result, they may underestimate the effects on themselves and their baby, which can have an impact on their ability to keep their child safe. Domestic abuse poses a significant risk to a baby's wellbeing. Professionals do not always understand the dynamics of domestic abuse and how it affects very young children.

There was a deeply toxic undercurrent within the relationships that MI created which was unknown to professionals and MCD at the time. Since, their relationship ended and with counselling undertaken with domestic abuse services, MCD has been able to recognise that she was a victim of coercive control and domestic abuse.

It is recognised in the review timeline that professionals appropriately covered Routine Enquiry questions with MCD about her relationship to detect and issues of domestic abuse. On all occasions MCD gave a positive report about the state of her relationship which is what she believed at the time.

6.2 There were two main incidents in the timeline which indicted domestic abuse as follows:

The first incident was when Child E was around 5 months old. MI contacted Police to report an alleged serious incident. MI said ME was missing and he was concerned about the state of her mental health. ME was found safe at another address and she denied the allegations made by MI.

The incident was recorded as high-risk domestic abuse and referred to the Multi-agency Safeguarding Hub for risk assessment. In view of the uncertainty, an agreement was made for Child E to remain with MI at the home of another adult until Children's Social Care had completed their assessment.

The following day ME and another adult attended where MI was staying and was begging to see her baby. A brief altercation took place between ME and another adult at the property and the Police were called to have ME removed from the house. ME was arrested for Assault.

One week later Child E was admitted to hospital (as previously discussed) during which time it was ME that the Social Worker viewed as a perpetrator of domestic abuse and not MI who had raised

the original concern. It was only just prior to the child's discharge that MI admitted that he had been lying about his concerns around ME's mental health. The enormity of this deception did not result in a change of plan for the child's discharge and the new information appeared to be accepted without further risk assessment.

This demonstrated the level of manipulation of professionals by MI who was intent on hurting ME by preventing her from caring for her baby when in fact she had done nothing wrong.

Professionals should be aware that controlling the actions of those who have a role to support and safeguard through manipulation is a common trait in coercive controlling behaviour. Practitioners assessing and intervening in these circumstances need to have appropriate levels of professional curiosity to explore the full range of explanations and hypotheses regarding the presenting behaviours of both adults concerned.

6.3 MCD's engagement with domestic abuse services

Following the final split of the parents of Child C and Child D, MCD effectively engaged with domestic abuse service practitioners, who were able to help her realise the abusive nature of the relationship and negative impact this had on her self-esteem and confidence.

MCD shared with the Independent Reviewer that most of the arguments the couple had were about money and MI's gambling which was putting the family in debt. It was at these points that MCD would give MI the ultimatum to leave but something always happened to prevent him needing to leave.

MCD told the Independent Reviewer at their meeting that when she was with MI, she thought he was *"perfect". "It was only later that I found out he was the perfect guy in disguise".* MCD said that they had a lot of history together and he knew how to support her and calm her down.

MCD reflected that she had been young and naive about how relationships should be at the time and following counselling she feels much wiser and would be able to spot the signs of controlling behaviour in any new relationship in the future.

The Independent Reviewer asked if MCD had one lesson to share with other women living in a controlling relationship and she said *"before he did what he did he was brilliant. When in that relationship it is so hard to see anything wrong with it".* It therefore needs the attention of family, friends and professionals to help women to see what is happening in their relationship and to seek the right advice and support.

Proposal following Learning 12
The partnership should consider how the local in-school programme on coercive control and healthy relationships can be expanded and delivered to young people in other educational settings and for those not in education.

7. Impact statement at the trial

MCD said that all she ever wanted was to be a mum and to *"give my children the opportunities I never had growing up".*

She said that *"when the children were born, they consumed my world" "I loved them every day I had them". "He was their daddy; he was one of the two people who was meant to love and protect them the most in the whole world". "Instead he did the opposite."*

8. Good Practice

A number of areas of good practice were recognised during the reviewing process:

- There had been good early assessment and good family support services being provided to support Child C.
- There was good bereavement support following the deaths of the Child C and Child D.
- The actions of the paediatricians who raised concern about FII and concerns for Child E.
- The actions of social workers following confirmation of possible FII.
- The Police investigation which was extremely challenging had a positive result.

9. Conclusion

This case has been called "the complex case of all complex cases" and whilst this case is historical and much of the learning is based on the benefit of hindsight there is learning here for professionals about the nature of and the unthinkable consequences of extreme coercive control in adult relationships and the devastating impact this can have on children.

10. Recommendations

1) The CSAP should review the implementation plan developed in support of the new local arrangements for Perplexing Presentations / Fabricated or Induced Illness in Children and consider the inclusion of the "proposals for learning" identified in this review.
2) The CSAP should request that local paediatricians consider a review of using an assessment tool such as the BRUE model to support their clinical practice and to improve the risk assessment of children attending with brief resolved unexplained events.
3) The CSAP should conduct a partnership wide audit with their Acute Hospital Trusts to review the effectiveness of the arrangements for facilitating strategy discussions/meetings in the hospital setting. The audit should include timescales, attendance by statutory partners and quality of decision making.
4) The CSAP should request the Integrated Care Systems across the partnership to review their Child Death arrangements and provide assurance that the "proposals for learning" identified in this review have been addressed.
5) The CSAP should consider writing to the Police Chief Constable to express recognition of the magnitude of the police investigation outlined in this review. The evidence gathered was enhanced by the level of continuity of police work, particularly by the Senior Police Officer who agreed to return from retirement to continue with the case.

6) The CSAP should consider how the local in- school programme on coercive control and healthy relationships can be expanded and delivered to young people in other educational settings and for those not in education.

Clinical commissioning groups (CCGs) were created following the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013. They were clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. As of 1 April 2021, following a series of mergers, there were 106 CCGs in England. However, they were dissolved in July 2022 and their duties taken on by the new **integrated care systems (ICSs).**

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12. Statement of Reviewer Independence

The reviewer, Kathy Webster, is independent of the case and of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership.

Prior to my involvement with this Local Child Safeguarding Practice Review:

- I have not been directly concerned with the child or any of the family members or professionals involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigorous analysis and evaluation of the issues as set out in the Terms of Reference.

This report has been produced in good faith and is based on the information provided.

Signature:

Name: Kathy Webster – Independent Reviewer

Date: November 2022

13. Appendix 1: Terms of Reference Child Safeguarding Practice Review

Introduction

This Child Safeguarding Practice Review (CSPR) was commissioned by Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) in accordance with "Improving Child Protection and Safeguarding Practice" Chapter 4 of Working Together to Safeguard Children guidance HM Government 2018. The CSPR will be conducted using a research evidence-based systems approach methodology.

A multi-agency Panel established by the local CSAP will conduct the review and report progress to the Board. Membership will include an Independent Lead Reviewer and senior / safeguarding representatives from key agencies who had been involved with the child and family.

The tasks specific to the review panel:

1. To set the time frame for the review.
2. Agencies involved with the child and family will provide information of their involvement for the preparation of a composite timeline which will be used to form hypotheses of themes.
3. A case summary should be included to provide any relevant additional background information from significant events outside the timeframe for the review. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate.
4. The Panel, through the support of CSAP and Independent Reviewer will consider contributions to the review from appropriate family members and provide feedback at the conclusion of the review process.
5. The Panel will take account of any criminal investigations or proceedings related to the case.
6. The Panel with the Lead Reviewer will plan a learning event for practitioners; Identifying attendees, preparing and supporting them prior to the learning event and feedback following the event.
7. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice.
8. The Panel will receive and consider the draft report/presentation prepared by the Independent 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/presentation.
9. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Independent Reviewer for presentation to the CSAP for consideration and agreement.

10. The Panel will plan arrangements for reporting to CSAP and feedback to the family and the practitioners at the learning event. The contents of the final report/presentation will be shared for wider learning.
11. The Chair of the CSAP will be responsible for making all public comments and responses to media interest concerning the review. It is anticipated that there will be no public disclosure of information other than the CSPR report/presentation for publication.

The key lines of enquiry for the review:

- Examine the effectiveness of the local safeguarding children arrangements for teenage pregnancy including use of CAF/Early Help processes.
- Establish the effectiveness of the use "Routine Enquiry" in establishing possible domestic abuse and coercive control.
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies.
- Establish any learning from the case about the way in which local services and professionals work together to safeguard children across the hospital and community divide.
- Explore the way that concerns around Fabricated and Induced Incidence (FII) were addressed and utilised.
- Explore the multi-agency response to the death of each child and the support provided to the family at the time.
- Explore the effectiveness of the Care of Next Infant (CONI) arrangements in this case.
- Explore how follow-on information about the deaths were utilised to manage any risks to future children.
- Explore the roles of SUDC processes and CDOP at the time and consider how any learning from the children's deaths were utilised locally to improve welfare outcomes for future children in the family and other local children.