Serious Case Review

Overview Report: Child LS (Thomas)

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Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

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1. The Reason for the Serious Case Review

1.1 In autumn 2018 Child LS (to be known as Thomas) was born. Two weeks later Thomas was found with a serious head injury at home. His parents (to be known as Mother and Father in the review) were both present as was his half sibling aged three (to be known as Liam in the review). The parents both said Thomas was alone in a room with Liam when he became injured. Serious injuries were found to Thomas' skull and brain and a non-accidental cause suspected. Fortunately, Thomas survived but the injuries sustained have left him visually impaired.

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 the 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 Thomas and Liam no longer reside with Mother and Father. The names used in the overview report will be used to protect the true identity of the children. The children, Mother and Father were all white British and spoke English.

Name to be used in the review	Age at significant incident
Thomas	2 weeks
Half Sibling	
Liam	3 years
Mother (to the children)	Early 30s
Father (to Thomas)	Early 30s

[1] Serious case reviews are now known as child safeguarding practice reviews, Working Together to safeguard children, Gov.UK July 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 July 2018* (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 May 2019.

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 is independent chair and scrutineer of a Safeguarding Children Partnership. 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 involving both parents. These formal processes continued for a substantial period of time and were further delayed by the Covid 19 pandemic. The opportunity to hold a practitioners' event for professionals who had offered support to the family was considered by the Panel at the first meeting in 2019. Plans commenced for a practitioners' event, but this was postponed due to the parallel proceedings. At the point of the review resuming in Spring 2021 it was decided by the Panel that the substantial period of time elapsed since the significant incident made it not possible for the practitioners' event to be reinstated. Some staff had changed roles or left.

A Panel meeting had been held in February 2020 to ensure emerging learning themes from the review were identified including any urgent action required as it was clear then the SCR would not be completed in expected timescales, without the further delay caused by the impact of the Covid 19 pandemic.

Meeting the parents as part of the review was delayed in the early stages due to them both being integral to the criminal investigation. When the Panel reconvened in 2021 it was agreed to contact Mother and Father after such a delay would be inappropriate. Family court processes were still continuing at that time regarding the future of the children. The Panel were informed the couple had separated and Mother had moved to a different area of the UK.

A decision was made that the Panel would re-examine the experience of Thomas and his 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, three 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 December 2016 to November 2018; the start and end dates were when significant episodes occurred in the family. The 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 Mother had lived with her grandmother throughout much of her life. Records indicate Mother may have been abused as a very young child by another relative. Mother had learning difficulties and a history of other vulnerabilities including some substance and alcohol misuse, housing problems and debt. She had her first child as a very young adult. This child lived permanently with his father and was not part of the review.

Another child, the sibling of Thomas, (known as Liam) was born in 2015. Team around the family (TAF) support was ongoing with regular engagement from Mother and sometimes Liam's father (who was a different man to the first child's father). The TAF support closed in spring 2017.

When the relationship between Liam's father and Mother ended, Mothers relationship with Father (of Thomas) is thought to have commenced. This was believed to be in late 2017.

A domestic abuse incident occurred between Mother and Father in early 2018 in the presence of Liam who was a toddler at the time. Both adults received minor injuries but refused to make complaints to the police. Referrals were made to children's social care regarding the domestic abuse and the impact on the child (Liam) who was present. An assessment was undertaken then the case was closed.

Just prior to the domestic abuse incident Mother had asked for early help support but contact to commence the early help had not taken place. Mum was struggling emotionally due to her grandmother's recent death and needed help with housing and finances. It transpired that around this time Mother became pregnant with Thomas. The pregnancy was eventually 'booked' (reported formally) in spring 2018 at around 12 weeks. Mother did not attend all antenatal appointments throughout the pregnancy but was seen intermittently. She continued the relationship with Father, sometimes they lived together at the same address but sometimes not. Housing and risk of homelessness continued to be a problem for Mother and Liam. They often stayed at different temporary addresses with little stability.

Early help support was offered to the family in spring 2018. Mother was seen by a family support worker but eventually, due to a number of missed appointments the support was closed.

A re-referral for early help was made later in the pregnancy with two visits taking place prior to the birth of Thomas in autumn 2018. After the birth and discharge from hospital Mother and Thomas were seen by community midwifery and by early help support practitioners. Mother's housing situation and sleeping arrangements for herself, and the children continued to be problematic. The midwife last saw Mother with both children the day before the significant incident. A plan had been made to visit jointly with the health visitor but sadly Thomas was injured before the contact took place. He was two weeks old when the incident leading to the severe head and brain injuries took place.

Thomas has now been adopted and is said to be happy and settled, with his complex health needs being managed well.

5. Key Themes of the Review

When the Panel reconvened in 2021 key themes from the review timeframe were identified as follows (in no order of priority):

- Early Help
- Supporting Adults with Experience of Adverse Childhood Experiences (ACEs) and Trauma
- Impact of Domestic Abuse on Children
- Abusive Head Trauma
- Safer Sleep for Infants
- Identifying and Supporting Learning Difficulties of Parents and Carers.

Early Help

Records show that Mother whilst in touch with the health visitor for Liam agreed to a referral for early help support in early 2018. This was just prior to the pregnancy with Thomas being known. At the time she had multiple needs including housing and debt, bereavement and was also asking for help with nursery for Liam and with parenting generally. These needs were in addition to her earlier adverse experiences.

Several attempts by the support worker from the Children and Wellbeing Service (commonly known as the Early Help Service) to make contact with Mother were unsuccessful. A first joint visit with the health visitor eventually occurred five weeks after the referral. The domestic abuse incident in which Liam was present had occurred ten days before the early help service face to face contact. It is positive that weekly visits were made to Mother and Liam by the support worker during the following month, advice and signposting was provided for both parent and child, including support attempted relating to domestic abuse, see below.

Despite initial engagement with early help, Mother was then not seen for a period of six weeks regardless of the efforts of the support worker. Mother was pregnant at this point and was in intermittent contact with other health professionals for the pregnancy. The early help support was closed due to Mother's perceived non-engagement, with a re-referral in summer 2018 from the health visitor. Mother's needs were identified then as "pregnant and at risk of homelessness".

Mother and Liam were seen twice by the early help support worker prior to Thomas being born and once after the birth before Thomas was injured. Other contacts are on record as attempted. The significant focus for Mother in terms of early help support offered during that period was on housing. Some focus on Liam was evident in recording from visits including observations and guidance regarding nursery placements.

The support workers involved appeared to be offering assistance for a wide range of issues, under difficult circumstances including trying to locate Mother who frequently had to change her living arrangements. However, a formal plan of support with agreed actions and intended outcomes was not evident. Support appeared offered on an adhoc basis with focus on Mother's priority needs first.

The Author was told in the Children and Family Wellbeing Service since the remodelling in early 2021, when the Family Safeguarding Model[2] came into place, the service has introduced new practice standards and a new quality assurance framework. This is providing evidence that outcomes are improving as a result.

Supporting Adults with Experience of Adverse Childhood Experiences (ACEs) and Trauma

From what is recorded about Mother's own childhood and transition into adulthood it is clear her life included ACEs[3], as detailed in the overview of the case above. Different professionals were aware of some or all of Mother's ACEs, there was evidence of ACEs being identified and recorded, (albeit not specifically using ACE terminology) and some support was offered. What was less evident was the consideration of the impact of the ACEs on Mother as an adult and a parent, and any consequential impact on her children.

[2] Family Safeguarding works with the whole family using a strengths-based approach to identify families' strengths, needs and any changes to be made. The aim is to "support parents to become better equipped to meet the demands of parenting so families can stay together safely".

[3] Adverse childhood experiences (ACEs) are stressful or traumatic events that happen in childhood and can affect people as adults

Since the review timeframe the knowledge and awareness of ACEs and their impact has improved extensively. Information relating to trauma[4] is also now more widely available. Mother's documented history demonstrated some aspects of substantial trauma.

The local area has taken a proactive approach to improve responses to ACEs. A group of frontline practitioners have developed a resource[5] to inform practitioners about what ACEs are, their immediate effects and how they can affect children in the short-term and throughout their lives.

A more trauma informed workforce is the aspiration for the whole partnership and wider geographical area. Senior leaders have committed to a pledge of investing in the development of trauma informed practice. This includes encouraging the understanding of human experiences of the children, families and communities in the area, responding to these experiences and addressing the causes rather than just the presenting behaviours.

A local network is facilitating multi-disciplinary workshops aimed at different professional groups ranging from basic awareness, information for frontline staff and briefings for managers and leaders. The Child and Family Wellbeing Service are in the process of facilitating full day training/awareness sessions for all staff within the service in the local area. The Author was told the impact of the training will be examined.

Impact of Domestic Abuse on Children

Liam, in early 2018 whilst a toddler, was present and witnessed a domestic abuse incident between his Mother and the Father of Thomas. Police attending the incident recorded Liam's unusual response, in that he appeared outwardly unaffected suggesting this may have been a regular occurrence in the household. No formal complaints were made by either adult, with both alleged to have assaulted the other. The level of need applied initially was Level 4[6], with a child being recognised as at risk of significant harm.

It is believed that Mother had not yet conceived Thomas at the time of the reported domestic abuse incident. Pre birth assessment is explored below.

A child and family assessment took place regarding Liam, but Father was not part of the assessment due to Mother claiming at the time the relationship was over. A manager's case note suggested Father should have been included however this was not acted upon. Checks of Father had been undertaken when the referral was received with no recorded relevant history.

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[4] Trauma is a term for a wider set of experiences or events that can happen at any time of life and includes some of the adversities in childhood known as ACEs. Trauma describes the psychological impact of experiencing or witnessing a physically or emotionally harmful or life-threatening event. It may be a single incident or prolonged or repeating experiences.

[5] Resource- "The little book of ACEs"

[6] Local Area Continuum of Need and Thresholds Guidance, June 2016

After the assessment the case was stepped down to a lower level of need (Level 2- evidence of some unmet needs/ low risk). A request for early help support (regarding housing issues) was already in progress prior to the domestic abuse incident. The health visitor having received notification of the incident 3 weeks after it occurred informed the support worker, who was not aware of the abusive incident and who at the time had not yet been able to make contact with Mother.

There is considerable research relating to the negative impact and cumulative harm on children living in households where domestic abuse is present. In *Sowing the Seeds- children's experience of domestic abuse and criminality*[7], the importance of focusing on children is highlighted and it is recommended "identifying children who live in households with domestic abuse as victims in their own right".

The Domestic Abuse Act, April 2021 explicitly recognises children as victims if they see, hear or experience the effects of abuse. It is therefore imperative that all professionals are aware and respond accordingly to children as set out in the Domestic Abuse Act, when assessing risk and need, or when planning interventions.

The Author was told the response to domestic abuse in the local area in terms of information sharing and families receiving appropriate support was much improved. Domestic abuse was one of the key priorities of the Partnership area, alongside neglect, with three domestic abuse tactical groups covering the three areas of the wider Partnership. A Multi-Agency Safeguarding Hub (MASH) approach is constantly evolving, resulting in more efficient ways of working with partners to identify cases (such as this one) and enable an earlier response.

The local safeguarding children partnership's current training programme offers a multi-agency course with a specific focus on children affected by domestic abuse. Training has improved within the Child and Family Wellbeing Service with more support workers across the districts trained in the Freedom[8] Programme. This was not the position in 2018 and whilst some support was provided to Mother as part of the Early Help Offer, this was sporadic with limited impact. There are also plans now for the Child and Family Wellbeing Service to appoint a number of specialist domestic abuse workers.

[7] Sowing the Seeds- Dr Elaine Wedlock, Dr Julian Molina for the Victims' Commissioner (England and Wales), April 2020

[8] The Freedom Programme is a domestic violence programme primarily designed for women as victims of domestic violence, since research shows that the vast majority of cases of serious abuse are male on female. The programme examines the roles played by attitudes and beliefs on the actions of perpetrators and the responses of victims and survivors.

Learning Point 1

The Safeguarding Children Partnership should require all partners to evidence their organisational focus and response in relation to the Domestic Abuse Act 2021's requirement to recognise children who see, hear or experience the effects of domestic abuse as victims in their own right.

Pre-Birth Assessment

The pregnancy leading to the birth of Thomas became known to services in Spring 2018 when Mother was seen by community midwifery. She was assessed as being around 12 weeks pregnant. Mother told the midwife about the domestic abuse by Father, who she described as her 'previous partner'. After this contact, Mother did not attend two appointments and at almost 20 weeks pregnant, she was seen with Father and Liam. At this appointment she denied any involvement with 'Social Services'. There was no evidence of routine enquiry[9] being undertaken despite the disclosure of domestic abuse at the first appointment. It is unclear if this was due to the presence of Father at the 20 week appointment.

At this point, with Mother halfway through the pregnancy, there appears no consideration of a pre-birth assessment. Two routine, no access visits by the health visitor followed. When eventually Mother was seen, additional concerns were noted, including debt, homelessness, difficulty coping with Liam as a toddler and Mother's possible learning difficulties. The health visitor made a request for support to the Child and Family Wellbeing Service but notably the previous domestic abuse was not mentioned.

A different support worker was allocated in 2018 and it is unclear whether the different worker was aware of the previous domestic abuse incident. Some telephone contact had occurred between the worker and Father when he answered Mother's phone but there was limited professional curiosity attempted with Mother about the relationship when Mother was eventually seen. Father did not stay during the contact therefore there was opportunity for further exploration with Mother about the couple's history. Other pressing concerns during the visit, such as pending eviction and possible bleeding related to the pregnancy were managed well.

There is no evidence in any agency records that a pre-birth assessment was considered regarding Thomas. A multi-agency pre-birth protocol was in place at the time in the partnership area, updated and re-published in 2021. This provides clear guidance regarding when a pre-birth assessment should be

[9] The routine enquiry is an opportunity for health professionals to sensitively enquire with a woman about her experience of domestic abuse both present and past, regardless of whether there are indicators or suspicions of abuse. Should a response be received that domestic abuse is a concern then further safeguarding advice and/ or action must be taken. During pregnancy advice and action must include risks to the unborn child/ new baby as well as the mother being assessed- Domestic Abuse: A resource for health professionals, March 2017

considered, stating "requests for a multi-agency pre-birth assessment should be made as soon as concerns for the safety of the unborn child become apparent in the pregnancy". The updated protocol still includes helpful examples of pre-birth strengths and concerns. A number of the concerns relating to the position for Mother at the time were included in the protocol examples available when Mother was pregnant, but it is not known why a request for further assessment of the family's situation was not instigated.

Learning point 2

The Safeguarding Children Partnership should re-promote the local area's pre-birth protocol across all partners including the examples of pre-birth strengths and concerns to ensure all practitioners have a sound awareness of when and how to consider its use.

Routine enquiry and seeing women alone was scrutinised in the maternity themed review which followed this case, with assurance provided (see in Abusive Head Trauma below).

Abusive Head Trauma

Thomas was injured when he was less than one month old. Children under 1 have been consistently a high proportion of subjects of serious incident reports and serious case reviews[10]. Abusive head trauma was a suspected cause for Thomas' injury. 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[11].

Many local safeguarding children partnerships 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[12] an evidence based; multi-agency programmes is now in use across the safeguarding children partnership area where the incident occurred.

In the absence of the ICON programme being implemented in 2018 there was still an expectation that routine advice relating to safe handling of babies would be provided to expectant parents. There is no specific evidence that this guidance was provided during the pregnancy. It is acknowledged that Mother, did not or was not able to attend all appointments, or meet with professionals who were trying to support her. Therefore, opportunities to provide the information to help prevent abusive head trauma were less

[10] Child Safeguarding Practice Review Panel Annual Report, 2018-19.
[11] CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014.
[12] 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, iconcope.org

than with some other families. Immediately prior to the birth and in the first weeks after Thomas was born Mother's housing situation worsened and the chances to share important advice were minimal.

Mother's understanding and ability to retain advice was never properly assessed, see below, meaning that advice, if provided may not have been fully understood. It is noted that Mother disclosed being dyslexic and not being able to read. The local area has arranged for the ICON advice leaflet in easy read version to be added to the Partnership website. This is helpful to some people with language and literacy issues but other parents who cannot read or have difficulties understanding certain information may still find accessing the guidance is a challenge.

It is not known which carer, was responsible for causing the head injury to Thomas or under what circumstances or context. With case recording not evidencing Mother as receiving any advice or support regarding safe handling and responding to crying babies it is less likely that Father received any similar guidance. Research suggests that around 70% of babies who are shaken are shaken by men[13]. Any education and prevention programme should include male parents and carers even those who are hard to reach as in this family's case. The local area's ICON materials are currently for anyone in a caring role so targeted at parents/ carers, but dependent on the service delivery of messages as to how fathers are included.

There is increasing awareness of the need to involve fathers including in preventative messaging. The Child Safeguarding Practice Review Panel's National Review – The Myth of Invisible Men, September 2021 has been a catalyst for the local partnership to try to strengthen work relating to males.

The Author was told in the local NHS Foundation Trust Hospital a themed review[14] took place which included Thomas as his case was one of 4 similar cases having occurred over a short period of time in 2018. A detailed action plan was developed which included a focus on domestic abuse, routine enquiry and seeing women alone, and strengthening safeguarding supervision. Weekly audits were completed as part of the identified actions. Assurance was provided to the (then) local Safeguarding Children Board in February 2020 that actions had been completed to address the areas of focus identified in the themed review.

Safer Sleep for Infants

As has been described the living arrangements for Mother and Liam were complicated and appeared to worsen during the pregnancy and after Thomas was born. Mother would have been under considerable

[13] Demographics of Abusive Head Trauma in the Commonwealth of Pennsylvania, Kesler et al, 2008
[14] Maternity review of 4 cases of non-accidental injuries to babies in 2018, February 2019

pressure which is demonstrated by her speaking to professionals about her worries regarding housing and related debt. This was Mother's own priority need and often over shadowed other support which professionals tried to provide, including safer sleep advice for infants.

Moving between temporary addresses presents difficulties for children, in particular with regard to safe sleep settings for babies and younger children. Mother described that she and Liam, a toddler at the time, were sometimes sleeping on sofas at the different locations where they stayed. Once Thomas was born there was still a lack of clarity as to what was a permanent address for the family. It was unclear whether Mother was in possession of required equipment to facilitate a safe sleep setting for a newborn each time she stayed at a different address, albeit a moses basket was later noted as being in use.

Records show health visiting advice regarding swaddling and overheating. Specific safe sleep guidance was provided intermittently but Mother was observed as 'agitated' and therefore possibly not receptive to the information provided. Due to the frequency of appointments not attended by Mother during the antenatal period other opportunities to share routine advice had not always occurred. The position with Father and his contact/involvement with professionals was explored above. Father received no guidance relating to safer sleep for infants.

It was positive that multi-disciplinary discussions took place regarding the concerns for the family's living arrangements especially after Thomas was born. Conversations are recorded including queries related to equipment and furniture. Professionals recognised the stress that the housing position for the family created.

The Author was told there has been much attention and progress across the local partnership area regarding support for parents and carers relating to safer sleep for infants. Evidence of the work includes a drive on public facing campaigns; introduction of safer sleep assessment tool; a multi-agency initiative by the police who on visiting a family home. If any safer sleep concerns are identified they will refer via MASH to the health visiting service.

Whilst the significant incident for Thomas did not relate to safer sleep provision there were identified risks for him due to the context in which he and his family were having to live and sleep. Clear guidance repeated consistently in a method which takes account of any additional needs and circumstances of the parents should be a priority for all professionals to share with families who they are trying to support. The local safer sleep assessment tool was described as now being accessible, for parents with additional needs and where English is not the first language.

Identifying and Supporting Learning Difficulties of Parents and Carers

Information submitted through the timeline of the review suggested Mother had a learning difficulty[15]. Several times in recording it was noted that learning difficulties were present or suspected for Mother but evidence of specific action taken, or evidence of adjustments being made or additional support being offered was limited.

Around the pregnancy for Liam Mother was recorded as saying she could not read or spell and this was repeated in early help support provided in the first year after Liam was born. Mother continued to be open about her learning needs when pregnant with Thomas and particularly when asking for help regarding her housing situation. Dyslexia was disclosed by Mother twice prior to Thomas being born and records also show Mother saying she had had a statement of special educational needs.

There is no record in the timeframe of Mother having a diagnosed learning disability.

The Working Together with Parents Network has updated the 'Good Practice Guidance of working with parents with a learning disability[16]'. The updated guidance supports professionals working with parents with learning difficulties and learning disabilities, and their children. It is "not just for professionals involved in child protection proceedings but contains useful information for anyone working with a family affected by parental learning disability".

The Guidance suggests good practice in working with parents which includes accessible information and communication, support designed to meet the needs of parents and children based on assessment of their needs and strengths, and access to independent advocacy. It is not sufficient to simply record an observation that a parent or carer has a learning difficulty or disability. Adults, particularly those with caring responsibilities for others and who have additional needs identified should receive appropriate support which takes account of their wishes and feelings, and of other known circumstances.

Learning point 3

The Safeguarding Children Partnership should consider how professionals across the partnership are supporting parents and carers with learning disabilities and learning difficulties, what resources are available and whether further awareness raising and promotion regarding responding well to people with learning disabilities and difficulties is required.

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[15] A learning disability is different from a learning difficulty as a learning difficulty does not affect general intellect. There are many types of learning difficulty, some more well-known are dyslexia, ADHD, dyspraxia. A person can have one or a combination. Learning difficulties can exist on a scale, as with learning disabilities, from mild to severe. A person can have both a learning disability and learning difficulty. www.mencap.org.uk

[16] The Good Practice Guidance was updated in July 2021, the original guidance being published in 2007 by the Department of Health and the Department for Education and Skills.

6. Good Practice

It is clear many professionals and services worked hard to support Mother, Liam and Thomas. 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.

The Panel and Author when examining all agency involvement felt that the following good practice should be noted: In 2017 when a health visitor discussed Clare's Law[17] with Mother regarding her new relationship. In 2018 there was good liaison between community midwifery and health visiting after Thomas was born regarding concerns for Mother's living arrangements. In 2016 the GP requested Mother attend an appointment to talk over two attendances in quick succession for Liam at Accident and Emergency. The GP notes showed an appropriate focus on safeguarding for the child and after exploration no safeguarding issues identified.

7. Conclusion/What Needs to Happen

Thomas suffered a significant head injury within the first month of his life. He was living with his Mother, Father and brother Liam at the time. The actual cause of the injury was never discovered despite extensive enquiries, but abusive head trauma was strongly suspected. It is known children under 1 are the most likely age group to die through abuse or neglect [18]. In this case Thomas was very seriously harmed but survived the abuse.

Mother and Father's relationship was quite new, and a domestic abuse incident had occurred in Liam's presence just prior to the pregnancy (for Thomas) being known. As well as the concerns regarding domestic abuse Mother had experienced other trauma in her life including suspected child sexual abuse and bereavement. Housing difficulties and debt were continuing problems for her and the children throughout the time frame of the review.

The review has focused on key themes but recognises other concerning aspects in the lives of the family to be significant including housing and housing related issues. The Author was told housing was a feature in another local review "Millie, April 2022" and as a consequence has been a focus for the Partnership. The strategic partners were keen to ensure this learning was not lost and therefore asked that an additional learning point for the Safeguarding Children Partnership be added (see below). The longer term impact on children of housing challenges for families and related debt should not be under-estimated with

[17] The Domestic Violence Disclosure Scheme (also known as Clare's Law) enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex- partner's previous abusive or violent offending, Domestic Violence Disclosure Scheme Factsheet updated 31 January 2022, www.gov.uk

[18] Child deaths by abuse and neglect, NSPCC Statistics briefing, September 2020

homelessness and housing difficulties often associated with neglect, as the basic requirements for a child/children to live and thrive are not being consistently met.

The delay in the review has been explained and is unfortunate. This meant the involvement of family members was not possible, but it is positive to know that Thomas appears to now be happy and thriving.

The original terms of reference were re-examined to ensure key lines of enquiry identified at the start of the process had been explored. Reviewing practice, whenever this occurs, will always provide an opportunity to reflect on ways in which services can be developed and further enhanced, or to examine improvements already in place. As a result of the significant incident which occurred in the life of Thomas, learning points have been agreed by the Panel based on analysis and findings from the case and taking account of the current position for the local area. These are repeated below for consideration and action by the local Safeguarding Children Partnership.

8. Learning Points

- The Safeguarding Children Partnership should require all partners to evidence their organisational focus and response in relation to the Domestic Abuse Act 2021's requirement to recognise children who see, hear or experience the effects of domestic abuse as victims in their own right.
- The Safeguarding Children Partnership should re-promote the local area's pre-birth protocol across all partners including the examples of pre-birth strengths and concerns to ensure all practitioners have a sound awareness of when and how to consider its use.
- The Safeguarding Children Partnership should consider how professionals across the partnership are supporting parents and carers with learning disabilities and learning difficulties, what resources are available and whether further awareness raising and promotion regarding responding well to people with learning disabilities and difficulties is required.
- The Safeguarding Children Partnership should request assurance from members/ subgroups that housing related challenges for families remain a focus across the Partnership, including all professionals becoming more aware of the cumulative risks to children which housing issues can bring.

9. References

- Working together to safeguard children, Gov.UK July 2018
- The Little Book of ACEs, local resource
- Local Area Continuum of Need and Thresholds Guidance, June 2016

- Sowing the Seeds- Dr Elaine Wedlock, Dr Julian Molina for the Victims' Commissioner (England and Wales), April 2020
- The Domestic Abuse Act 2021
- Local area multi-agency pre-birth protocol 2021
- Child Safeguarding Practice Review Panel annual report, 2018-19
- CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014
- ICON, iconcope.org
- Demographics of Abusive Head Trauma in the Commonwealth of Pennsylvania, Kesler et al, 2008
- Maternity review of 4 cases of non-accidental injuries to babies in 2018, Local NHS trust, February 2019
- www.mencap.org.uk
- Good Practice Guidance of working with parents with a learning disability, The Working Together with Parents Network, July 2021
- Domestic Violence Disclosure Scheme Factsheet, www.gov.uk updated 31 January 2022
- Child deaths by abuse and neglect, NSPCC Statistics briefing, September 2020
- Millie, April 2022 Serious Case Review.

Appendix A

Legal Framework

Purpose of Child Safeguarding Practice Reviews, Working Together 2018

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy makers.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose.

Serious child safeguarding cases are those in which:

• abuse or neglect of a child is known or suspected and

• the child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in

cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states: Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if – (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Safeguarding partners must make arrangements to identify serious child safeguarding cases which raise issues of importance in relation to the area and commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review.

The criteria which the local safeguarding partners must take into account include whether the case:

• highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified

• highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

• highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children

• is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

• where the safeguarding partners have cause for concern about the actions of a single agency

• where there has been no agency involvement, and this gives the safeguarding partners cause for concern

• where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around

• where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Terms of Reference- Child LS

Introduction

This Review is being commissioned by the Chair of Lancashire Local Safeguarding Children Board (LSCB) in accordance with Working Together to Safeguard Children (2018) Transitional Guidance.

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 (Author) and representatives from key agencies with involvement.

Timeframe for the Review

The review will cover the timeframe of 01/12/2016 to 09/11/2018. Any significant incident relevant to the case but prior to the start date of the timeframe should be included in the timeline completed by each agency.

Subject(s) of the Review

T XXX – DOB: 2018

xx (Sibling) – DOB: 2015

Significant Others

(Mother) – DOB: 1989

(Father of T) – DOB: 1987

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 service provision, information sharing and working relationships between agencies and within agencies, including case handovers/ transfers and joint working opportunities;
- Explore the consideration and use of early help processes, and whether this was effective;
- Determine the extent to which decisions and actions were focussed on the subject child/ children;
- Analyse whether risks to the unborn child were assessed sufficiently including consideration of use of the pre- birth protocol;
- Examine the quality of assessments relating to the child/children and to the parenting capacity/ ability to protect of all possible carers within the family;

- Determine the extent to which professionals identified domestic abuse and what actions were taken to share information about domestic abuse, to support the family and identify risks to the children;
- Explore whether additional risk factors within the family including parental mental ill health, new relationships, substance misuse and housing issues were consistently and appropriately considered;
- Explore how professionals responded to non-attendance at appointments and non-engagement generally and how this was professionally challenged;
- Examine to what extent safe handling advice and support was provided and reinforced to all carers;
- Explore whether opportunities to scrutinise and support the development and lived experience of older infants were taken, including safer sleep, safety in the home and responses to/ management of minor injuries;
- Were responses to adults with learning disabilities appropriate and was consideration given to the literacy skills of all carers when providing information or making requests;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify any actions required by the LSCB to promote learning to support and improve systems and practice.

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 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 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 recommendations 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 identify considerations for learning/ recommendations and make arrangements with the Lead reviewer for presentation to the LSCB for consideration and agreement;
12. The Panel will plan for feedback to be provided 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.