Serious Case Review

Overview Report

Child LH

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1 Legal Context

1.1 This serious case review was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) in March 2016 following a recommendation by the LSCB Serious Case Review Sub Group. The circumstances regarding the death of a child met the criteria for a serious case review in accordance with Working Together to Safeguard Children (2015)[1].

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

1.3 5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

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

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

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

2 Family Composition

2.1 Mother and Father were in a relationship for six years before the birth of Sibling 1 who was 2 years 3 months old when LH died.

2.2 The subject child is referred to as LH. Within this report the sibling of LH is referred to as Sibling 1 and their parents as Mother and Father. Other family members are referred to by their relationship to LH e.g. Maternal Grandmother.

2.3 LH, Mother, Father and Sib 1 are White British. There were no issues relating to ethnicity or religion in this case.

3 Incident which resulted in the Serious Case Review

3.1 In March 2016, LH, an 8 week old baby was taken from home to hospital by emergency services as she had become unresponsive. A CT scan revealed that LH had a serious head injury which led to her death. The Father received a sentence of life imprisonment for the murder of LH. The family had received support from Early Help Services and no safeguarding concerns had been identified.

4 Methodology

4.1 A concise multi-agency Child Practice Review (CPR)[2] was identified as the most appropriate and proportionate model to conduct the review. The CPR

[1] Working Together to Safeguard Children (HM Government, 2015)

[2] The CPR is also referred to as the 'Welsh Model' for more information see; Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews (Welsh Government, 2012).

process supports practitioners to reflect on cases in an informed way and the review report focuses on learning and practice improvement. The CPR methodology provides a learning tool for Local Safeguarding Children's Boards to use when it is important to consider how agencies worked together. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These will be included in the final report of the review or in an action plan as appropriate.

4.2 This Review has been conducted in accordance with the principles for Serious Case Reviews set out in Working Together (2015), which;

- Recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- Is transparent about the way data is collected and analysed
- Makes use of relevant research and case evidence to inform the findings

4.3 Working Together (2015) states that serious case reviews should;

- Identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice
- Clearly identify what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result

5 **The Process**

5.1 A Review Panel comprising of managers from relevant agencies was established in accordance with the guidance. The panel was chaired by Hazel Gregory, Head of Safeguarding, Blackpool Teaching Hospitals NHS Foundation Trust. Dr Cath Connor, an Independent Reviewer was commissioned to work with the panel and to undertake the review.

5.2 The review focussed on events from November 2013 (immediately before the birth of Sibling 1) until the death of LH in March 2016. It was agreed at a meeting of the Review Panel to extend the timeframe beyond twelve months to explore the involvement of Early Help Services and maximise opportunities for multi-agency learning.

5.3 A timeline of significant events with a brief analysis of agency involvement was provided by each organisation. The timelines were reviewed by the panel to clarify understanding of the circumstances of the case and the support and intervention provided by separate services.

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http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/Child_Practice_Review_Guidance_-_Welsh_Government.pdf

5.4 Agency timelines were merged to produce an interagency timeline of key events which was reviewed and analysed by panel members in line with the agreed Terms of Reference for this review (Appendix 1). The Review sought to understand how multi agency systems impacted on this case and identify factors which influenced the actions of practitioners and agencies. Good practice was recognised by the panel (detailed later in this report) and opportunities for inter and intra agency learning and practice improvement were highlighted.

5.5 Key Practitioners who had direct involvement with the case were invited to attend a Learning Event. Following a meeting between representatives of the Review Panel and the Police it was decided to delay the learning event by six weeks to ensure conclusion of the criminal trial and enable the meaningful involvement of Mother, Father and practitioners. The Learning Event took place in October 2016 and was attended by eleven practitioners in addition to the Chair and Independent Reviewer. Following the Learning Event a draft report was provided in advance of the panel meeting in November 2016.

5.6 Mother and Father of LH both agreed to participate in the review and a summary of their contribution is provided below. The final report has been shared with them prior to publication

6 Relevant background information prior to November 2013 (start of timeline)

6.1 In 2006 Mother made a disclosure to GP 1 about historical child sexual abuse by her Stepfather. Mother was referred by GP 1 to the Primary Care Mental Health Team[3] (PCMHT) and following two missed appointments the referral was closed.

6.2 Maternal Grand Mother reported the historical sexual abuse of Mother to the police in 2011 following discovery of a letter written by Mother which stated that she was sexually abused by her Stepfather from 12 yrs of age.

6.3 In 2012 Mother informed GP 1 that she was anxious and on edge due to her experience of historical child abuse and the pending prosecution of Stepfather. Mother said that her mood was low and this affected her relationship with Father. GP 1 referred Mother to the PCMHT, Mother attended an initial assessment and following two missed appointments the referral was closed by the PCMHT.

6.4 Mother's Stepfather was convicted for historical sexual abuse of Mother and imprisoned for four years in 2013.

6.5 Father of LH presented at Accident and Emergency departments on two occasions - in 2000 and 2013 - with an injury to his hand after punching a wall.

7 Perspectives of parents

7.1 Given the tragedy of LH's death, the willingness of Mother and Father to participate in this review process was much appreciated by the Independent Reviewer and Chair. Mother and Father were interviewed separately by

[3] The Primary Care Mental Health Team was commissioned by GP 2 and accepts referrals from GP 1 and GP 2

members of the Review Panel and it was explained that the primary purpose of discussions would be to identify learning for agencies that may improve future practice. Discussion focussed on;

- understanding the perspective of Mother and Father about their daily lives and how this impacted on LH
- understanding how Mother and Father experienced services and whether they thought that interventions offered were helpful and/or if there were missed opportunities to provide support

7.2 It is important to acknowledge that whilst the following information from Mother and Father can support learning from this review it is not possible to be fully confident of factual accuracy due to hindsight bias and the current differing circumstances of mother and father[4].

7.3 Mother and Father said that they used cannabis on a daily basis and would at times spend up to £200 a week on cannabis. They incurred debts as a result and acknowledged that this was a significant source of friction in their relationship. Father acknowledged that his relationship with Mother was difficult at times and said that he had moved out of the family home on many occasions to stay with his mother or sister (Paternal Grandmother and Paternal Aunt).

7.4 Mother and Father stressed that the practical needs of LH and Sibling 1 were always prioritised before money was spent on cannabis.

7.5 Whilst the amount of cannabis smoked by each may have differed[5], the impact of significant amounts of the family budget being spent on cannabis affected them both. Father said that he worked for very long hours and both he and Mother had lost significant amounts of weight as they often went without food.

7.6 Father said that he began smoking cannabis at 11 yrs of age in response to a difficult childhood Father shared that he had struggled since childhood to control his emotions. Both Mother and Father described themselves as private people and said that professionals were not aware of, or did not notice their cannabis use. Father said that he did not consider seeking help with his cannabis use and probably would not have admitted how much he smoked as he did not realise at the time that he had become dependent on cannabis. Father described a feeling in his stomach as 'winding up like a tight knot' when he had no cannabis.

7.7 Father said that he worked long hours and received little support from the extended family. Both Mother and Father spoke about Father's bad temper which resulted in him banging doors or punching walls when very stressed. Father said that he had never hit anyone and Mother said that she had no concerns at any time that Father would physically harm the children or herself.

7.8 Father said that it was very unlikely that he would have acknowledged any difficulties if he had been asked by a professional. Father said that it may have

[4] Mother is seeking to resume care of Sibling 1 and Father is in custody following conviction of the murder of LH. They are no longer in a relationship.

[5] It is important to consider that this information was obtained retrospectively and it is not possible to be confident about the level of cannabis use for each parent. Toxicology reports indicated that Father had higher usage and Mother stated that Father smoked cannabis constantly. Mother had 3 negative cannabis tests between January 2016 and April 2016.

been helpful for Mother to have attended some groups at the Children's Centre but they were too expensive for them to afford. Mother said that she put on an act that everything was fine, even to her own family, although she was very unhappy and unable to see how things could improve.

7.9 Mother was surprised that the Midwives and Health Visitors were not aware of her experience of child sexual abuse and the court case which resulted in the prosecution of her Stepfather. She had not spoken to them about it but assumed they would know and felt it may have been helpful had they known. Mother said that she found it very difficult to trust people and when Sibling 1 was born memories of her past abuse returned and it was difficult for her to allow anyone else to look after Sibling 1.

7.10 Mother said that she struggled to talk about her experience of abuse in childhood and found it very difficult to attend appointments with the Primary Care Mental Health Service. Mother said that she was not able to tell practitioners that she did not find cognitive behavioural therapy helpful.

7.11 Mother said that the family were living in poor housing conditions and that she had shown a Health Visitor the damp in every room including the kitchen and that the midwives were aware that all the family slept in one bedroom due to the damp. Father said that housing and cannabis use were the two biggest problems for himself and Mother. Both Mother and Father said that when LH woke in the night for a feed she would wake Sibling 1, Father would give LH a bottle as Sibling 1 would only settle back to sleep for Mother.

8 **Brief summary of circumstances leading to this Serious Case Review**

8.1 Following complaints about the smell of cannabis by a neighbour Police visited the home of Mother and Father on two occasions in November 2013. The house was searched on both occasions, no cannabis was found and no further action was taken. Mother was heavily pregnant with Sibling 1 at this time and attended the Police Station shortly after these home visits to state that she had been very stressed by the Police searching her house and advised that there would be no further concerns as it was Father who smoked cannabis and he no longer lived at the property as their relationship had ended.

8.2 In May 2014, six months after the birth of Sibling 1 Mother advised GP 1 that she was experiencing low mood, lacked motivation and had recently separated from Father. GP 1 made a referral to the Primary Care Mental Health Team however Mother did not attend two appointments and the referral was closed.

8.3 Father attended an appointment with GP 1 in September 2014 and reported symptoms of anxiety and depression. It was recorded[6] that Mother and Father had recently separated and Mother was struggling with post-natal depression which had put a strain on their relationship.

8.4 Mother registered with GP 2 in September 2014 following a house move. Records indicate that during an initial appointment with GP 2 Mother was thought to have post-natal depression and GP 2 made a referral to the Primary Care Mental Health Team. Following a triage appointment with the Primary

[6] In the medical notes of Father

Care Mental Health Team Mother was referred to the Mental Health Practitioner for cognitive behavioural therapy however she did not attend the initial appointment.

8.5 Mother requested a support visit from the Health Visitor in October 2014 and reported that counselling and visits to the GP hadn't worked. During a subsequent home visit Mother agreed to a referral to the GP and additional support was offered via the Universal Plus Health Visiting Programme[7] which included a referral to the Children's Centre[8].

8.6 In November 2014 Mother attended a further appointment with GP 2. It was recorded that Mother presented with stress and low mood and said that she had the support of Father. GP 2 advised Mother to keep an appointment with the Primary Care mental Health Team later the same week[9] however Mother did not attend and the referral was subsequently closed.

8.7 Mother and Father were both present during a home visit by the Children's Centre Outreach Worker in December 2014 in response to the referral by the Health Visitor. It was recorded that a CAF[10] was not initiated as Mother did not choose further support and needs could be met by universal services. In January 2015 the Health Visitor was informed by the Children's Centre Outreach Worker that support had been declined and the referral was closed to the Children's Centre.

8.8 In March 2015 Mother's Stepfather was released from custody. A Victim Liaison Officer[11] (VLO) attempted to meet with Mother however Mother cancelled a home visit as it clashed with an appointment with the midwife and Mother did not respond to other attempts made by the VLO to arrange a meeting.

8.9 In June 2015 GP 2 gave mother a choice of a further referral to the PCMHS or a review with a female GP. Mother chose a review with a female GP however this did not take place as Mother cancelled the appointment and saw a male GP on an earlier date.

8.10 At the initial booking for ante-natal care in July 2015 Mother was noted to have a body mass index of 18[12] and a referral was made to a dietician. Mother did not engage with the dietician and was not weighed again. No concerns were recorded as scans identified that baby was growing as expected. LH was born by natural delivery in January 2016. Following an overnight stay in hospital Mother and LH were discharged.

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[7] Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children. *Health Visiting Programme and 0-5 Commissioning of Public Health Services* NHS England, DH, PHE, November 2014.

[8] A request for support form was submitted to the Children's Centre by the Health Visitor in November 2014

[9] Mother had a pre-arranged appointment with the primary Care Mental Health Team three days after she visited the GP.

[10] Lancashire Common Assessment Framework, an assessment and planning tool; http://panlancashirescb.proceduresonline.com/pdfs/con_need_thresh_guid.pdf

[11] The role of a VLO is to empower victims of crime and contribute to community safety by providing relevant information about Probation Supervised sentences to victims of crime.

[12] This could be an indicator of low weight www.nice.org.uk/guidance/ph27

8.11 Mother received routine post-natal care and was visited at home by a Midwife on two occasions which included a weekend visit. No concerns were identified and records indicated that all was satisfactory. LH was discharged from Midwifery into the care of the Health Visitor in January 2016.

8.12 Mother, Father, Sibling 1 and LH were present at a home visit by a Health Visitor in February 2016. Mother said that she was feeling depressed and had an appointment with GP 2 later that week. The Health Visitor was informed that the family were sleeping in one room as the second bedroom was damp. Records indicate that LH was stepped up to the Universal Plus Health Visiting Programme to provide support with maternal mood and housing.

LH sustained non accidental, life threatening injuries and died in March 2016.

9 **Analysis: Practice and Organisational Learning**

9.1 The circumstances which resulted in the death of LH were very distressing for the practitioners involved, all of whom expressed great sorrow at this tragic loss. Whilst learning has been identified from this review it is important to acknowledge that professionals responded to the needs of the family as they understood them at the time. Child LH was known to a number of services which included the GP, Midwifery, Health Visiting and Children's Centre. The Police and Victim Liaison Services had some contact with mother whilst she was pregnant with LH.

9.2 Scrutiny of the multi agency timeline, sharing of information and reflection on practice at panel meetings and the learning event provided an opportunity for wider learning to emerge about the ways in which services work together as well as identifying good practice. The following is an analysis of the key issues identified.

9.3 Cannabis Use

Professionals were unaware of the extent of substance misuse within the family. Mother and Father acknowledged that this was hidden from their families and resulted in significant debts and difficulties in their relationship. Other than the two police visits following the complaint by neighbours about the smell of cannabis there was no mention of substance misuse within the multi-agency chronology. Professionals were clear that they observed no evidence of excessive use or an overpowering smell of cannabis. It was acknowledged by practitioners at the Learning Event that use of cannabis was not unusual for many of the families with whom they had contact. It is a challenge however to understand how such high levels of cannabis use could have been undetected by professionals.

9.4 Practitioners stated that without cause for concern about the wellbeing of LH or Sibling 1 it was difficult to question the presentation of parents. There was no evidence that Mother and Father were routinely asked about domestic abuse, substance misuse and depression/mental health in line with the Healthy Child Programme (2009) and routine reporting enquiries. As cannabis use was not identified by parents or professionals as a concern there was no consideration of the impact of parental cannabis use on LH. Mother said in interview that she could not recall being asked by professionals about domestic abuse or substance misuse. It is expected practice that these enquiries would be made

at each midwifery appointment however there is no record of this in Mother's records and it is not possible to be confident that the required checks were made in line with practice guidance and expectations.

9.5 In January 2016 days after the birth of LH a routine home visit was made by a Midwife at the weekend. Records from this visit are limited and it was noted that all was satisfactory. There was no record that routine enquiries about domestic abuse, substance use and emotional wellbeing were made at this visit. At the Learning Event practitioners spoke about the considerable pressures on Midwives (particularly those working at the weekend) to complete routine tasks with very limited opportunity to assess and identify additional vulnerabilities.

9.6 Various professionals which included the GP, Health Visitors, Midwives, Mental Health Practitioners and Children's Centre Outreach Workers had contact with Mother and /or Father. Support and intervention was not coordinated and there was a lack of holistic assessment[13] by professionals to identify risk and resilience factors which would have enabled exploration of substance misuse, parental mental health and additional stresses such as housing. It is important to acknowledge, however, that Mother and Father both stated that it was unlikely they would have been open about their cannabis use if asked.

9.7 In the interview for this review Mother and Father provided consistent information about the extent of their cannabis use and the impact this had on their mental health, finances and relationship. Father stated that he felt under significant pressure to work long hours in order to provide for the children and purchase cannabis which was smoked by both parents.

9.8 Whilst it is recognised that use of cannabis is not without risk[14] this review has identified the possibility that frequent exposure of practitioners to parents who use cannabis could result in the risks being overlooked. This may be combined with limited appreciation of the associated risks and failure to assess and appreciate the potential impact of parental cannabis use on children.

9.9 The impact of cannabis use on parenting was identified by a previous LSCB serious case review[15] which recommended the promotion of increased and more consistent use of relevant risk assessment tools and frameworks that include cannabis. In response to this recommendation the LSCB had identified that there appeared to be inconsistent understanding amongst practitioners about the seriousness of cannabis use and the impact on children and also confusion regarding the classification of cannabis. The Board utilised research regarding cannabis to inform multi-agency training. The quality assurance sub group had also made substance misuse a priority area which informed further work with practitioners.

Recommendation 1 and 2 will address the learning identified by this review and compliment and strengthen current work of the LSCB to increase awareness about cannabis use and the potential impact on children.

[13] Universal health visitor reviews: advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015

[14] 'Hidden harm' report on children of drug users .Advisory Council on the Misuse of Drugs, 2011

[15] Child K, Overview SCR Report for Lancashire Safeguarding Children Board, 2013

9.10 Primary Care Mental Health Services

This Review has highlighted learning with regard to the referral process to the PCMHT, monitoring of clients following referral and information sharing among professionals and agencies regarding the mental health of patients.

9.11 Mother was referred by GP 1 and GP 2 to the Primary Care Mental Health Team during the time period considered for this review. On one occasion Mother was signposted by GP 2 to self-refer to Mental Health services[16]. If patients who have been identified as in need of a service and signposted by the GP do not self-refer there is a risk that their emotional wellbeing could deteriorate. There was no record that Mother completed the self-referral form and it is questionable whether self-referral is an appropriate process for vulnerable patients.

9.12 Whilst the Primary Care Mental Health Team complied with policy and procedure Mother did not receive any support to enable her to engage effectively with Mental Health Services. There was no discussion with mother about her lack of engagement with the Primary Care Mental Health Team and little evidence of services working holistically to explore with Mother why she did not attend appointments and what may have helped her to engage with the service. In September 2014 Mother was signposted to access online help from a website. Given the lack of engagement with Mental Health services it is unclear whether Mother would have had the capacity or motivation to access an online resource.

9.13 There was no formal process to monitor referrals (referrals were made by GP 1 and GP 2) to the Primary Care Mental Health Team making it difficult to identify patients who do not engage with services. Whilst it was good practice by GP 2 to arrange a review of Mother's mental health by a female GP there was no follow up and it was not identified that the review did not take place. It was likely that Mother was expected to rearrange the review herself which, given Mother's lack of engagement with services was unlikely and an unrealistic expectation.

9.14 The Health Visitor was not informed at any time that Mother had missed the appointments with the PCMHT or that this had resulted in closure of referrals made by the GP. At a routine follow up visit in February 2016 the Health Visitor recorded that Mother was feeling depressed, there were problems with damp in the house and all the family were sleeping in one room. Increased support was offered through Universal Plus Health Visiting Programme

9.15 In October 2014 Mother informed the Health Visitor that counselling was not working, this information was not shared with the Primary Care Mental Health Team. It is important that all professionals respond to patient/family feedback in an efficient and effective way. If the Health Visitor had supported Mother to talk directly to the Mental Health Practitioners about why she felt the service was not helping her it is possible that a more responsive approach to enable her to engage could have been provided.

[16] Mother was given a form to complete and return to GP reception self-referral with the in-house Mental Health Team.

9.16 There was limited appreciation about the challenge some patients may experience when accessing Primary Care Mental Health Services as outlined in NICE Clinical Guideline 192[17]

1.5.1 Recognise that women who have a mental health problem (or are worried that they might have) may be:

- *unwilling to disclose or discuss their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care*
- *Reluctant to engage, or have difficulty in engaging, in treatment because of avoidance associated with their mental health problem or dependence on alcohol or drugs.*

9.17 Very limited information was provided by GP 2 to Maternity Services. It was an omission that when GP 2 became aware of Mother's pregnancy with LH, the concerns regarding Mother's previous post-natal depression when Sibling 1 was eight months old were not shared with maternity services. NICE Guideline 192[18] highlights the importance of health professionals sharing information about a mother's mental health with Maternity Services.

9.18 As Mother did not access services there was limited opportunity for professionals to consider with her the impact of low mood/post-natal depression on the children and her relationship with Father. There was no opportunity to assess the impact of Father's emotional wellbeing on his parenting ability and wider relationships as he declined a referral to mental health services.

9.19 There was limited information sharing between agencies about Mother's mental health. Practitioners from Midwifery and Health Visiting Services who had direct contact with LH and the family said at the Learning Event that they were not aware of the intervention provided by the GP and PCMHT. Intervention provided to address the mental health of Mother was not coordinated and had limited impact. Lack of monitoring of referrals made by the GP to PCMHT could result in vulnerable patients who do not attend appointments being overlooked and risk further deterioration in their mental health. Learning from this review about the intervention and support provided to address the emotional wellbeing of patients is considered within Recommendation 3.

9.20 <u>Involvement of Fathers</u>

It was evident within the multi-agency chronology that there was very limited information about Father in agency records. It was acknowledged by practitioners at the Learning Event that recording of information about fathers and partners requires improvement across agencies.

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[17] NICE Clinical Guideline (2007) *'Antenatal and postnatal mental health: clinical management and service guidance'* http://www.nice.org.uk/guidance/cg192

[18] NICE Clinical Guideline (2007) *'Antenatal and postnatal mental health: clinical management and service guidance'* http://www.nice.org.uk/guidance/cg192

9.21 Absence of engagement with fathers is a well-rehearsed theme within Serious Case Reviews nationally. Despite recognition of the benefits of father inclusive health and family services, services are still heavily weighted in favour of mothers, and appear slow to change[19]. Whilst the circumstances differed, the importance of working proactively with fathers was emphasised in a recent review undertaken by LSCB[20]. The importance of engaging fathers is emphasised in The Healthy Child Programme (DH, 2009) and the following points are of direct relevance to this review;

- *From the beginning, promote the father's role as being important to his child's outcomes.*
- *Include an assessment of the father's needs as well as the mother's, as these will have a direct impact on both the mother and the child.*
- *Include an assessment of the father's health behaviours (e.g. in relation to diet, smoking, and alcohol or drug use), asking him directly wherever possible. These behaviours have a direct impact on both the mother and the child, and specifically on the mother's own health behaviours.*
- *Signpost fathers to all of the relevant services.*
- *Make sure that fathers (as well as mothers) are in possession of information about, for example, the benefits of stopping smoking and strategies for doing so. Where possible, provide fathers with this information directly (rather than second-hand, via the mother) and ensure that it also incorporates information on their role in relation to their child.*

9.22 A summary of learning from serious case reviews by the NSPCC[21] highlighted the important role that men play in the lives of children. The necessity of working proactively to involve male carers from the outset was recognised as an area in need of improved practice.

9.23 Mother and Father both stated that Father had a significant role in the care of both children particularly LH as Father gave the night feeds whilst Mother settled Sibling 1. Practitioners did not understand or appreciate the extent of Father's involvement in the care of LH as this was not discussed or explored with either Mother or Father. The records of Midwives, Children's Centre Workers and Health Visitors focused on interactions with Mother. There was very limited Information about Father and his involvement with the care and parenting of Sibling 1 and LH.

9.24 Father was at work during many of the visits made by professionals and when he was present it was understood that he was supportive of Mother. Mother and Father declined the support of services which included support groups at the Children's Centre and appointments with the Primary Care Mental Health

[19] http://www.fatherhoodinstitute.org/wp-content/uploads/2014/10/Burdett-Report-Final-Version-June-18-2014.pdf

[20] http://www.lancashiresafeguarding.org.uk/media/14220/SCR-learning-briefing-Child-O-March-2016.pdf

[21] Hidden men: learning from case reviews , NSPCC 2015

team. There was consensus amongst all professionals who had involvement with the family that, given the information that was known at the time, there were no concerns about the wellbeing or safety of LH or Sibling 1.

9.25 Lack of information sharing about the emotional wellbeing of parents, and limited involvement of Father in meetings with Midwives and Health Visitors contributed to professionals working predominately with Mother. Father stated that he thought the role of the Health Visitor was to support Mother. There was little evidence within agency record keeping and the combined Timeline of professionals using think family principles whilst working with the family.

9.26 It was acknowledged during this review that failure to involve Fathers and appreciate the positive contribution they can make to the lives of children (as well as potential risks) is a national issue. It is not possible from the review of this single case to generalise or have a deeper understanding about the extent practitioners in Lancashire routinely assess the involvement of fathers/ male carers on children in their care. The importance of having an organisational culture and skilled workforce to enable and promote a constructive, proactive approach to engage fathers is widely recognised. Learning regarding the involvement of fathers that has emerged from this review will be addressed in Recommendation 4.

9.27 <u>Information sharing and Adverse Childhood Experiences (ACEs)</u>

Examples of limited information sharing within and between agencies has been highlighted within this analysis. Additional learning which emerged from this review relates to information sharing following a change in GP and when adults have experienced adverse experiences in childhood.

9.28 Mother registered with GP 2 in September 2014. Practitioners at the Learning Event stated that information sharing is limited when a patient moves GP within the area in contrast to the robust procedure that is followed when a patient transfers in from a GP surgery out of the area. There is an expectation that practitioners share information between GP surgeries in the same area[22] however this is inconsistent and may result in omission of some information when transfers are made between GP surgeries in the same geographical area.

9.29 At this time Mother and Father were registered at separate GP Surgeries.[23] Mother visited GP 2 and was thought to have post-natal depression. Ten days later Father saw GP 1 and it was recorded in the medical notes that Father had symptoms of anxiety and depression. Mother and Father were supported individually by the respective GP's and there is little evidence to suggest that consideration was given to the impact of their emotional wellbeing on their parenting capacity. At the Learning Event practitioners said that when it became known that family members were registered with different GP's efforts would be made to encourage families to register with the same GP however this could not be enforced and patients have the final choice. Improved information sharing following transfer of GP surgery is addressed as a single agency issue later in this report.

[22] Historically professionals met and shared information however Health Visitors now serve a larger geographical area and opportunities for informal information sharing are limited.

[23] Father remained registered at GP 1 whilst Mother had registered with GP 2

9.30 GP 1 and the Primary Care Mental Health Practitioner had information about historical childhood sexual abuse experienced by Mother. There was an assumption by Mother that this information and knowledge about the trial and subsequent prosecution of Stepfather would have been shared among professionals. In this case it would have been helpful for historical information to be shared[24] given the overlap with the criminal trial of Stepfather during Mother's pregnancy. History of abuse in childhood is well recognised as a risk factor for some women to experience perinatal mental health problems[25].

9.31 Mother was clear in interview that her experience of abuse in childhood and the criminal trial of her stepfather had a significant impact on her emotional wellbeing. There was no evidence of coordinated intervention to assess the impact of childhood abuse on the mental health of mother and subsequent impact on her parenting of LH and Sibling 1. The Midwife, Health Visitors and Children's Centre workers were clear at the Learning Event that had they known about Mother's history of childhood abuse and lack of engagement with mental health services this would have influenced their intervention and they would have been more probing in their enquiries about Mother's emotional wellbeing, attachment with Sibling 1 and family relationships.

9.32 Both Mother and Father were subject to adverse experiences in childhood. Some professionals were aware of Mother's childhood experiences which resulted in the imprisonment of her Stepfather and impacted on her mental health and parenting capacity[26]. Mother spoke with the GP and PCMHS practitioner about feeling stressed and anxious as a result of her experiences in childhood. Whilst Father spoke in interview for this review about his difficult childhood experiences, there had been no agency engagement with him and this information was not, therefore, known to professionals.

9.33 There is increasing research evidence to illustrate the substantial negative impact that adverse experiences during childhood can have on an individual's physical and mental health[27]. Unhealthy coping behaviour and mental health consequences associated with adverse childhood experiences can compromise parenting skills and create adversity for children. Learning from this review has highlighted some of the challenges faced by practitioners and agencies when supporting parents with adverse childhood experiences. In some areas of the UK routine enquiry about adverse childhood experience is embedded in practice, informs intervention and reduces negative consequences[28]. This was a fundamental issue which underpinned life within this family unit and as such a recommendation has been made to raise professional awareness and address this complex area of work.

9.34 Mother cancelled an appointment with the Victim Liaison Officer (VLO) to consider any support needs following the sentencing of Stepfather stating that

[24] With the permission of Mother

[25] Early years High Impact Area 2: Maternal mental health: Public Health England 2016

[26] Mother spoke in interview about being overly protective of Sibling 1 and said she found it very difficult to leave her in the care of anyone else

[27] Adverse Childhood Experiences and their association with Mental Well-being in the Welsh adult population. Public Health Wales NHS Trust 2016

[28] file:///C:/Users/Home/Downloads/updated_final_-_aces_-_slides%20(1).pdf Public Health England 2016

she had an appointment with her Midwife. The VLO attempted[29] to arrange a further appointment but Mother did not respond. Given the information that Mother was pregnant it would have been good practice for the VLO to have explored with Mother whether any other professional were aware of the stresses arising from the court case, and/ or whether she required support in sharing this information. Further attempts were made to meet with Mother at the point of Step-father's release from prison. Again she did not respond.

9.35 Had there been more effective information sharing within and between agencies including follow up of referrals to Primary Care Mental Health Services it is possible that professionals would have obtained a clearer understanding of family circumstances and the impact of parental stresses on LH and Sibling 1. It is important to note that Mother and Father were both very clear in interview that they did not disclose the pressure and stress that they were experiencing even to their own families. Given the guarded presentation of parents and the limited extent of professional curiosity about the arrangements for the care of LH and Sibling 1 it is not possible to state with confidence that had information sharing been more effective the outcome would have been different.

9.36 At the Learning Event professionals spoke about the challenge of keeping an open mind and questioning parents when there are no identified concerns and parents decline support. Practitioners stated that practice varied depending on the confidence and experience of the individual worker. Whilst the circumstances vary there is some overlap with the learning within this review and that from a previous LSCB SCR (Child G, 2015). The importance of showing professional curiosity is of particular relevance.

9.37 <u>Referral to Early Help Services</u>

In November 2014 Mother informed the Health Visitor that she was feeling low and in an effort to obtain additional support for Mother the Health Visitor requested support services via a referral to the Children's Centre as part of the Universal Plus Home Visitor programme.

9.38 In response to this referral an Outreach Worker from the Children's Centre visited the family and following discussion Mother and Father declined additional support. The Outreach Worker made contact with Mother on various occasions to encourage attendance at groups however at the time Mother said she was unable to attend due to ill health. Mother did not access additional support from the Children's Centre.

9.39 Home visits were undertaken separately by the Health Visitor and Children's Centre Outreach Worker and it appears that Mother presented differently to each professional. It is not possible to be confident whether the different presentation was influenced by the presence of Father as both the Health Visitor and Children's Centre Outreach worker had contact with Mother alone and with Father. Although this case was not formally open to the Children's Centre it may have been appropriate to undertake a joint home visit to ensure that the needs identified by the Health Visitor were addressed by the Outreach Worker. The support provided lacked focus and clarity due in part to the limited

[29] Via text message and letter

information on the referral from the Health Visitor about concerns identified and support required. Practise has since changed and completion of the Common Assessment Framework (CAF)[30] is now requested when making referrals to the Children's Centre.

9.40 At this time Mother had also informed the GP that she was feeling low and stressed and did not attend an appointment with the PCMHT. Whilst Mother was telling some services how she was feeling it was very difficult for her to access support at this time and as Mother herself acknowledged she put on a front to pretend that she was coping and struggled to talk about past experiences.

9.41 In December 2014 the referral from the Health Visitor to the Children's Centre was closed in line with guidelines available at the time following non-engagement of the family. As there were no safeguarding concerns identified by the Health Visitor or the Outreach Worker this decision appears to have been proportionate.

9.42 Efforts were made to support Mother with registration for Early Years Free Education[31] (EYFE) for Sibling 1. Accessing EYFE is a personal choice and not all families take up the offer. It may have been helpful had someone explored with Mother whether she had any questions, anxieties, concerns about the EYFE provision. Mother stated in interview that she was very protective of Sibling 1due to her childhood experience of abuse and found it very difficult to leave Sibling 1 in the care of another adult.

9.43 Practitioners at the Learning Event stated that the parents had declined a CAF however there was no evidence that the purpose and benefits of completing a CAF had been clearly explained. Early identification of needs and use of the CAF was identified as a requirement in the Thematic Inspection of Early Help undertaken by LSCB in 2014 and it was noted that;

The instigation of CAF at the earliest identification of need to be reinforced within workforce development training for CAF (6)

9.44 The decision to provide Universal Plus Health Visiting services was appropriate however completion of a CAF would have enabled a comprehensive and holistic assessment of needs and a coordinated approach to meet these. It was recorded by the Children's Centre Outreach Worker that the CAF was not initiated as mother did not choose further support.

Learning identified about the provision of Early Help Services is addressed by Recommendation 5

9.45 <u>Housing</u>

[30] The Common Assessment Framework [CAF] is a key tool in the early identification of children and young people and families who may experience problems or who are vulnerable to poor outcomes and underpins the work of Early Support.

[31] Early education and childcare, Statutory guidance for local authorities. DH (2014)

The family lived in private sector rented accommodation. Both Mother and Father identified housing as a significant concern and source of stress when interviewed for this Review. Mother said that she had shown a professional the damp in every room except the bedroom in which the family slept. Professionals at the Learning Event stated that whilst it was known the family were all sleeping in one room housing problems were not raised as a concern until Parents informed the Health Visitor following the birth of LH.

9.46 In interview Mother spoke at length about the difficulties she experienced whilst trying to move house.[32] Had the emotional wellbeing of parents been explored during routine enquiries and as part of a holistic assessment it is possible that the strain of living in damp housing conditions would have been discussed earlier. This may have enabled professionals to obtain a more realistic understanding of the stress and pressure experienced by Mother and Father on a daily basis and the impact of this on their ability to parent LH and Sibling 1.

9.47 Had a CAF been completed there would have been an opportunity for housing to be included as part of an initial identification of support needs. This is addressed in Recommendation 5.

9.48 Non Accidental Head Injuries

Across the country new parents and carers are provided with information regarding different aspects of care for babies, for example safe sleep guidance, and information regarding sudden infant death syndrome (SIDs) and associated risks. There is evidence that both parents of LH were present when such advice and support was shared by health professionals.

9.49 The provision of guidance regarding safe handling, and in particular prevention of non-accidental head injuries in babies, is less consistent. Within a different Lancashire SCR (Child LG) national awareness programmes and research regarding non-accidental head injuries are critically analysed. The Independent Reviewer notes the differences between other more common forms of child abuse and non-accidental head injuries. Clarke (2017)[33] reports "the differences include that one single event may cause a catastrophic outcome; there is frequently no intent to harm the child; and the immediate and follow on outcome is worse than with other causes of head injury in childhood (Bruce & Zimmerman 1989). In the majority of cases the primary trigger is linked to inconsolable crying (Dias et al 2005)."

9.50 Clarke (2017) explains that although non-accidental head injuries are recognised as criminal acts, they are also public health issues; therefore, it was recommended that Lancashire Safeguarding Children Board, in conjunction with health partner agencies and it's Child Death Overview Panel (CDOP), should raise awareness with parents and families of the dangers of shaking a baby, and how to cope with an inconsolable crying baby.

9.51 This review fully endorses the recommendation above and notes it will be taken forward as a result of the Child LG review.

[32] Mother spoke about financial difficulties and the challenge to complete necessary paperwork

[33] Child LG, SCR Report, Lancashire Safeguarding Children Board (2017) – awaiting publication.

10 **Good Practice**

10.1 During this review there was clear evidence of good practice which is important to highlight;

- Appropriate increase of support to Universal Plus by the Health Visitor on two occasions
- Mother was offered the choice by GP 2 of a further referral to PCMHS or a review with a female GP.

11 **Improving Systems and Practice**

11.1 Practice Issues

A number of single agency practice issues were identified during this review and actions are already in place to address these. They are not subject to separate recommendations. The governance arrangements of the responsible organisations will monitor that issues have been or continue to be resolved. Of particular importance are:

- Ensuring there are effective information sharing procedures regarding pregnant women and unborn babies when there are additional vulnerabilities (Police/VLO).
- Ensuring transfer of information between GP surgeries within the NHS Trust is strengthened and of at least as good a standard as occurs in transfers from out of area;
- Practitioners with access to GP records were using the system in different ways in terms of the way notes were made and utilising the function which allows significant events such as childhood sexual abuse and safeguarding concerns to be 'flagged'. A consistent approach needs to be utilised;

11.2 Conclusion

The assault on child LH was unpredictable and the guarded responses from the parents and their reluctance to engage with professionals also resulted in the stresses within the family being unknown to some extent.

Scrutiny of practice and an effective learning event with practitioners has provided an opportunity to reflect on ways in which services can be improved. As a result of the learning identified in this review there is an opportunity to develop an awareness raising programme amongst practitioners about the potential negative impact of significant cannabis use, together with the likely impact of adverse childhood experiences in order to enhance support and advice to families which will aim to prevent similar injuries occurring. This will hopefully assist in the prevention of similar incidences in the future.

11.3 Recommendations

The following recommendations have been made from the learning identified during this review.

1. Lancashire Safeguarding Children Board and partner agencies to consider the development of resources to increase awareness of the public and professionals about the risks associated with cannabis use and the potential impact on parenting capacity.

   Intended Outcome: Increased awareness among professionals and parents/carers about the risks associated with cannabis use and exploration of cannabis use in all assessments which involve children.

2. Lancashire Safeguarding Children Board to take steps to assess practitioner understanding of the possible impact of significant cannabis use on parenting and review the impact of the recommendation from SCR child K 2013; *to promote increased and more consistent use of relevant risk assessment tools and frameworks that include cannabis*

   Intended Outcome: To ensure that learning from this review strengthens ongoing work and furthers the development and effectiveness of tools to enable practitioners assess the extent of cannabis use.

3. Lancashire Safeguarding Children Board to highlight the learning from this review to the relevant Clinical Commissioning Group (CCG). In particular the board should emphasise to the CCG the need to review referral processes, monitor repeat referrals and explore non engagement with patients.

   Intended Outcome: Improved effectiveness of Primary Care Mental Health Services and increased understanding about barriers to engagement.

4. Lancashire Safeguarding Children Board to request partner agencies to review their strategic approach to working proactively with fathers and male carers and assess the impact of this work on the outcomes for children[34].

   Intended Outcome: Improved involvement of fathers/male carers in all assessments regarding children to inform support and/or intervention that will contribute to improved outcomes for children.

5. Lancashire Safeguarding Children Board to satisfy itself that partner agencies have effective monitoring processes to ensure that a CAF is instigated at the earliest identification of need.

   Intended Outcome: Improved focus and coordination of Early Help Services to prevent escalation of concerns.

6. Lancashire Safeguarding Children Board to seek assurance from Partner Agencies that impact of adverse childhood experiences on parenting capacity is understood by professionals and considered as part of assessment processes.

[34] Previous recommendation made in SCR Child O 2014

Intended Outcome: Professionals have a full understanding of the impacts and risks associated with adverse childhood experiences on parenting capacity. Professionals use this to inform their assessments and offer support to families deemed to be at risk.