Wolverhampton Safeguarding Together

Child Safeguarding Practice Review – Baby L

Learning and Recommendations

Wolverhampton Safeguarding Partnership commissioned an independent Child Safeguarding Practice Review for Baby L following Baby L sustaining a number of serious injuries. This paper sets out the key learning and recommendations identified for agencies in order to learn from and improve future practice.

1. Learning

1.1 Consideration was not given to an early help pre-birth assessment being undertaken by the agencies involved early in 2019. This was a missed opportunity for agencies to work collaboratively together to support Mother to resolve difficulties early.

1.2 Concerns subsequently increased leading to a referral being made to children's social care.

1.3 The absence of clarity about referral criteria to mental health services meant that referrers were unclear about which mental health services were the most appropriate to refer to. This led to an increase in the number of professionals involved and a lack of clarity about their roles and responsibilities.

1.4 The lack of clarity by and between agencies about which agencies are responsible for the provision of services following a referral also lead to an increase in the number of agencies referred to.

1.5 When a referral to the MASH is not discussed with the referrer, it could lead to a lack of shared understanding about the referrer's concerns.

1.6 There was a failure to anticipate risks to Baby L even when the family history might suggest that these are present. An understanding of cumulative risk would also enable professionals to better anticipate and create opportunities for protecting children:

1.6.1 Whilst professionals worked hard to engage with Mother, they had not always taken into account the impact of her adverse childhood experiences upon her.

1.6.2 The practice of checking with expectant Mothers, if they are taking medication and whether they have brought it, should be reinforced to midwives on the ward.

1.6.3 Where a woman does not have her medication, this should be prescribed promptly.

1.6.4 It is critical that the roles and responsibilities of agencies working with children and families are understood by all of the agencies in order that agencies can work effectively together in a coordinated way.

1.6.5 Professionals need to be able to explore and probe with families issues that may be difficult for them, in a way that is respectful but conclusive.

1.6.6 GP practices hold key information about the health services being provided and should be contacted in cases where there are complex health needs.

1.6.7 That the interpretation of neglect is variable and the absence of tools routinely used by agencies meant that professionals did not have a shared understanding of the neglect and were not able to express their concerns about the neglect they thought L was likely to experience and why it constituted significant harm.

1.6.8 The language we use can paint a vivid picture of the context and risks of child neglect and abuse. Conversely the use of generic terminology can minimise concerns.

1.7 When a strategy meeting is convened, it is critical that the statutory guidance is followed and that the relevant professionals must be identified and invited to attend. This must include a relevant health professional.

1.8 When working with accommodation providers, it is important to clarify the different roles and responsibilities of the different parts of the organisation and seek clarification as to which workers are involved in order that they can be included in core groups and conferences.

1.9 When an initial child protection conference or review conference is held, it is important that the relevant agencies are identified and invited to attend, and this includes any agencies who have commenced involvement with the family since the initial conference.

1.10 Despite it being a requirement, not all agencies provide a report to a conference, whether they are in attendance or not. This means that valuable information known by that agency is not shared with the other professionals.

1.11 When making the decision to end a child protection plan, consideration should be given to whether the improvements made in a parent or child's circumstances demonstrate sustained

change.

1.12 Agencies must understand the different duties and responsibilities placed upon agencies and families when services are delivered under a child in need plan and under a child protection plan in order that children receive the right level of services in accordance with their needs and the level of risk of harm to them.

1.13 The language used to describe different plans needs to be clear and consistent with the relevant legislation and statutory guidance.

1.14 Where a child in need plan is in place, multi-agency planning should take into account the discharge plan for a new Mother and work with the hospital to ensure that the discharge plan is supportive and mitigates against the risks to the Mother and child.

1.15 Fathers should be involved in the assessment and planning for children unless there is evidence that this would pose a risk to the child and family. Where this is not facilitated by the Mother, this should be pursued if s47 enquiries are initiated and information held by agencies should be used to explore the Father's information further.

1.16 Lack of understanding of how Mother's mental ill-health was impacting upon her parenting meant that professionals did not fully understand how L was being parented.

1.17 When child protection enquiries are being conducted, consideration must be given to the arrangements for safeguarding the child during the period of investigation.

1.18 The agreed arrangements must be recorded and reviewed in light of new information.

2. Recommendations

The main issues that have been identified as learning from this case have been highlighted within the analysis. The Lead Reviewer and the Review Team have considered the learning and have identified questions and recommendations for WST in the areas thought to be of most importance.

The Triennial Review[1] states that 'good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies'.

The questions and recommendations for the WST are directly linked to the learning areas of;

Effectiveness of referral processes.

Recommendation 1

WST to seek assurance that referrals received electronically by the MASH are followed up by a practitioner in the MASH, where clarification is needed, in order that the referral is discussed fully and informs the decision making for service provision and statutory assessment.

Recommendation 2

WST to seek assurance about the consideration of an early help pre-birth assessment by the partners within the early help network when emerging needs are identified.

Effectiveness of assessment processes.

Recommendation 3

WST should remind staff of the importance of parental and familial history and that the past may be a significant pointer of the future; and seek assurance that the history of the family is included in the information gathering in assessments and in the analysis and decision making.

Multi-agency response to parental mental-ill health

Recommendation 4

WST should seek clarity from BCHT about the different mental health services provided for pregnant women with mental ill-health and how those services work together.

Recommendation 5

That multi-agency safeguarding training includes learning from this case with regards to:

- how to appropriately engage and explore difficult issues with people who have mental ill-health.
- professional curiosity

Multi-agency response to concerns of neglect.

Recommendation 6

WST should satisfy itself that:

- The “We Can” tool for assessing neglect is used consistently in cases where neglect of a child is known or suspected.
- That multi-agency training includes the importance of using specific language when describing environments and circumstances for children and families.

Multi-agency child protection planning.

Recommendation 7

WST should seek assurance that when child protection conferences and reviews are held that there is evidence that:

- All professionals who are invited to attend submit a report
- That all relevant professionals are invited to child protection conferences and reviews and to be members of the core group.

Multi-agency child in need

Recommendation 8

WST to ensure that multi-agency child protection procedures make clear the different responsibilities upon agencies when providing services under s17 of the Children Act 1989 and under “Working Together to Safeguard Children” 2018.