CHILD SAFEGUARDING PRACTICE REVIEW

Child G

Date agreed by the partnership: June 2022

Lead Reviewer: Karen Perry

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INTRODUCTION

1.1. This Child Safeguarding Practice Review is in respect of Child G. At the age of 6 months Child G had non accidental injuries; brain injuries which are thought to have been caused by shaking, and fractured ribs caused on a separate occasion. At the time this review was undertaken both parents were subjects of a criminal investigation; subsequently a Finding of Fact Exercise, undertaken by the court, made adverse findings in respect of Child G's Father.

1.2. Learning for this review was analysed under 3 themes; transfer in arrangements, meeting the health and education needs of the children; the arrangements to safeguard Child G and his siblings and promote their welfare; consideration of cultural background. All learning points are listed in section 4, at the end of each theme. What follows is a summary of the most significant learning from this review.

1.3. Children benefit from effective systems to share information between agencies and services about families who move between areas. Where arrangements include written transfer summaries these need to be written in a style which minimises scope for misinterpretation by a new practitioner.

1.4. "Respectful scepticism" is important when parents deny reported incidents of domestic abuse, especially if the mother has previously been subject to domestic abuse, and/or she is pregnant. It is helpful to remember that risks for children can include retriggering trauma if they have witnessed domestic abuse of their mother by a previous partner. It is important to record the cultural heritage of both parents of all children in the family and enquire what this/these means to them and consider the impact on parenting. It is important to specifically engage BOTH parents directly in providing information and support about crying babies. This may require creative approaches as current maternity and early years health services are not currently designed with fathers' needs in mind.

1.5. Prompt referrals of Acute Life-Threatening Events (ALTE) to police and Children's Services are important as some of these later turn out to be due to abuse. Agencies reporting or receiving reports of ALTE need to identify any siblings and consider any risks to them. Further concerns about parental behaviour and care of children may emerge in hospital, these also need to be promptly reported.

1.6. The period under review is from February 2020 (the approximate date of Child 's conception) until early June 2021 (2 weeks after Child G presented for treatment for the injuries which precipitated this review). Halton Children and Young People Safeguarding Partnership (HCYPSP) will ensure that learning is widely disseminated locally. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning.

1.7. Halton Children and Young People Safeguarding Partnership (HCYPSP) agreed to undertake this review using a learning model focussing on why those involved acted as they did at the time to identify learning to improve services for other similar local families. The process engages frontline staff and their managers in reviewing cases during the production of single agency reports as well as at a practitioner event led by the author (who is independent of this case and all agencies involved with the family). Family members were also offered the opportunity to speak to the lead reviewer. No-one wished to.

1.8. Family members will be referred to by their family relationship to Child G e.g. Mother, Father, Sibling etc. At the time of the incident that prompted this review Child G was living with Mother, Father, and 3 older siblings: one preschool and two at primary school. The two older siblings have a different father. The family moved to Halton in December 2020. This was the third move between different local authorities in northwest England since August 2018. These had been necessitated by domestic abuse from Mother's ex-partner (the father of the two older siblings) and threatening and

abusive behaviour from his family. Mother and her ex-partner are from a minority ethnic background. Father is white British. The family had a low income and neither parent was in employment.

1.9. Practitioners who know Child G describe him as developing within normal ranges currently, although any long-term impact of his injuries is not yet certain. Child G has been observed to enjoy playing and particularly loves to watch and engage with his siblings.

2. THE STORY OF THE CHILD AND FAMILY

2.1. Some history prior to the scoping period is relevant. Mother moved in with Father in August 2018. This was in a different council area (Local Authority 1), away from the one where she had experienced several serious incidents of domestic abuse from Ex-Partner, the father of her two older children. Despite moving area again in December 2018 to Local Authority 2, the family continued to receive threats from Ex-Partner and his family and moved to Halton in December 2020.

2.2. Whilst living in Local Authority 1 the children had been subject to Child in Need plans[1] to provide support due to the domestic abuse from Ex-Partner. There were no concerns about the actual care of any of the children.

2.3. There were two historical incidents of alleged domestic abuse by Father against Mother reported by members of the public to the police, in August 2019 and October 2020. When Mother was pregnant with Sibling 3 and Child G respectively police shared information with other agencies about the incidents. They took no further action largely because Mother would not accept it. Since the injuries that prompted this review further allegations about domestic abuse and controlling behaviour by Father toward Mother have been made by 3rd parties. Parents deny this and no practitioners were aware of these incidents at the time.

2.4. Child G had been born in November 2020 having accessed appropriate ante-natal care. Although the family moved to Halton in December 2020, the health visiting service was not aware of this until they received a notification of change of address triggered from the GP towards the end of January 2021. Despite trying twice, the health visitor in the previous authority had been unable to complete the 6–8-week visit because the family had not informed her that they had moved. The 6-8 week visit was conducted by a health visitor alongside the "movement in" appointment in early February 2021.

2.5. In early January 2021 Mother applied to the local authority for school places for the two older children. In early February she was informed which local school had places for them. She wanted places nearer home. This preference, the appeals process and the impact of Covid restrictions combined meant the two older children did not start their new school, the original school suggested, until the end of April 2021. Once in school staff described the siblings as happy, well presented and eager to learn and quick to settle and make friends. During the period covered by the review, prior to Child G's injuries, the only concerns about any of the children were minor ones about the two older siblings which were identified and appropriately addressed in school.

2.6. Towards the end of May 2021, Child G was in the care of his father when he was reported to have stopped breathing. The ambulance personnel restored circulation and took him to the regional specialist children's hospital. He was an inpatient there for just over 3 weeks. before being discharged into the care of an extended family member, after a Prior to his discharge the hospital convened a planning meeting which involved all relevant agencies and the extended family member who was going to be caring for him.

[1] A Child in Need (CIN) plan co-ordinates services provided under Section 17 Children Act 1989; services to support children to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development

2.7. Satisfactory arrangements have been made to safeguard all the children.

3. THEMATIC ANALYSIS

3.1. The learning from this review was identified from information and opinions provided in the agency reports and at the practitioner event. The themes are:

- **Transfer in arrangements, meeting the health and education needs of the children**
- **The arrangements to safeguard Child G and his siblings and promote their welfare**
- **Consideration of cultural background**

Theme: Transfer in arrangements, meeting the health and education needs of the children

3.2. There are significant challenges for agencies providing services to families who move frequently between areas. Relevant information about children's health, education and care and any vulnerabilities of the parents may not be easily available or joined up. The first issue is whether key agencies know that families have moved; some families deliberately try to avoid agencies discovering this, although this is not a feature of this case. If they have not previously been informed, agencies often discover children's arrival in a new area by application for a new school, or registration at a GP.[2] In this case the family stayed at the same GP but notified the practice of a change in address. Nationally, delays in transferring records between GPs and between health visiting services agencies are common; practitioners told this review that sometime all a new health visitor might know is the name and address of the child. In this case the community health trust is commissioned to provide services across different areas in the region, so this was not an issue.

3.3. Even the best records are not the same as having experienced the engagement, and poor entries in records may not reflect all the necessary detail. In addition, some information can be difficult to find on health visitor records, and the complexity (e.g. number of potential letters and reports as attachments) increases with the age of the child. Multiple changes in practitioners therefore dilutes oversight causing a risk of gaps in knowledge or misunderstandings. To minimise the risk of this, the transferring out health visitor is expected to complete a transfer summary and initiate a conversation with the new health visitor if there are safeguarding concerns or complex health issues. In this case the latter did not apply and the safeguarding risks were considered to be historical as they related almost entirely to the violence and intimidation from Ex-Partner and his family, which the move was intended to reduce.

3.4. Health visitor managers told this review that they were reviewing movement arrangements between areas, transfer on and receiving in. This is due to having discovered that there is more than one version of the summary template being used as well as other learning from this review about smoother arrangements to ensure relevant services know about the arrival and needs of all children in the family.

3.5. The transfer summary written by health visitor A did include all key information, including about Ex-Partner/his family's behaviour. However, the summary was very brief and used abbreviations (the pressures on the service due to the Covid Pandemic may have been relevant) and the statement about past concerns of domestic abuse "between mum and dad" was open to interpretation if the

[2] The name of the child's GP is recorded on the Electronic Patient Record. Any change by a parent results in a notification to the health visitor or school nurse next time they access the record.

reader did not know the family. The new health visitor B told this review that she had not been aware of the domestic abuse between Child G's parents because she had misread this to mean the abuse from Ex-Partner (the father of the two oldest siblings). Had she understood correctly she would likely have found out more, by contacting the previous health visitor or searching through the records. She could also have explicitly asked Mother about the incidents. This could have been difficult during the "movement in" visit, as although Father was not present, the children were.

3.6. The "movement in" visit by health visitor B was done within 2 weeks of the family arriving in Halton as it should have been and made face to face after a risk assessment (this was during lockdown due to the Covid pandemic). The purpose of "movement in visits" is to review the health needs of the family including the health and development of any pre-school children. In addition, practitioners raised the importance of the following issues: understanding why people have moved and, in cases like these, were they safe; whether they had adequate support, especially at the time this family moved as it was during lockdown; completing any outstanding contacts, in this case the 6-8 week visit was outstanding; and ensuring they had accessed, or knew how to access appropriate local services.

3.7. At the point of transferring out health visitor A felt the level of service should be increased from the "Universal" category she had allocated at the new birth visit to "Universal plus"[3] because of the outstanding 6-8 week check. This was a use of initiative to emphasise the unmet need, it was not standard practice. After the "movement in" visit health visitor B decided the appropriate level of service was "Universal". Managers told this review that they believed an appropriate level of service throughout was "Universal plus" rather than "Universal", because of the history of domestic abuse, by Ex-Partner plus the alleged incidents between Child G's parents, and the addition of increased emotional vulnerability during lockdown having recently moved area. During this review health visiting managers have concluded there are inconsistencies of decision-making about the appropriate level of service amongst health visitors across the health trust not helped by serving several areas commissioned by different local authorities. They plan to address this.[4] A "Universal plus" category on arrival in Halton would have meant a further visit by the health visitor and a further opportunity to develop a confiding relationship. Whilst health visitors are very practiced at developing rapport, first meetings are not easy places to tackle lots of key issues.

3.8. Health visitors told this review that although it was not an explicit part of standard expected practice locally, they would ask about education arrangements for the school-aged children during any movement in visit. Mother told health visitor B they had been allocated a school place and were "accessing education" although she was trying to get a place at a school that was closer to home. Prior to this review there are no formal arrangements for notifications between health visitors and school nurses who work for the same health trust. The school nursing service was notified after an exchange of information between the relevant local authorities of the names of children leaving or being added to a school roll. This is an administrative process; school nurses would not be routinely aware of, or involved with, individual children unless there was a specific health or current safeguarding issue. If there had been either it would be good practice for the school nurse from the previous school to contact the school nurse for the new school, if one was in place, and vice versa if the new school nurse felt insufficiently informed about historical concerns. School nurses contact

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[3] The national Healthy Child Programme identifies different levels of service delivery by health visitors. This includes "Universal" which is activities/contacts that are delivered to all young children and their families and "universal plus" which involves additional advice and support/contact when specific additional needs of the child or parent have been identified

[4] As a result of internal review and discussions the health trust has concluded that more detailed guidance is needed to support practitioner's decisions about when a "Universal Plus" service is indicated and what that would include.

the Education Welfare Service if they identify any children for whom no school place application has been made. An internal health trust process for notifications between health visitors and school nurses would be an additional safety net for any children who had specific health needs (which did not apply to the siblings) but also in circumstances where there were safeguarding concerns, or the children were not enrolled at a new school.

3.9. Mother told the school in Local authority 2 that she was moving. This triggers a notification to the receiving authority. During the Spring term the Education Welfare Officer (EWO) offered support and advice to Mother (and the school) by telephone and email. No home visits were undertaken, as they normally would have been, due to the Covid pandemic. Mother was promptly offered information about which schools with places might be suitable and supported to apply; schools are required to respond to applications within 10 working days, which was achieved in this case. The school the siblings eventually attended offered places at the beginning of February 2021. This school was a mile and a half away from the family home, the family do not have a car and Mother would have preferred a school closer to home, unfortunately, there were no places in those schools. Until school places are offered children have the right to attend their previous school. This would not have been practical, even in circumstances not affected by Covid restrictions.

3.10. As the school which offered places was partially closed during the spring term of 2021 because of Covid restrictions, fortnightly work packs were made available to families and daily online activities were provided via the school website. School staff told this review that only one work pack was collected from the school by Child G's father and there was no evidence of any engagement in remote learning. This was not untypical of pupils at the school, although an additional challenge for staff with this family was the absence of a previous ongoing relationship. School staff did make home visits to deliver two further work packs, and the family explained they were going through the appeal process (which takes up to 30 days) to try and obtain places at a school nearer home.

3.11. During the spring term 2021 children considered "vulnerable" were allowed to attend school. Prior to admission, the head teacher at the new school had made enquiries about the children with their previous school and shared information with key staff. The head teacher's understanding was that the concerns were in the past and that home was a safe and nurturing place for the children, so they were not categorised as vulnerable. The previous school did not share information about the domestic abuse between Child G's parents, for reasons that are not known (police records indicate they they should have been notified due to Operation Encompass.[5]) However, looking back, the head teacher told this review that he could have justified attendance and might do so in future if similar circumstances arose. However, even had it been suggested that the children attend school it is quite possible the parents would not have taken up the places given they were appealing. Whilst there might have been educational benefits there is no evidence the children suffered any more than any other pupils not in school due to the pandemic. Had the country not been in lockdown, if parents had chosen not to send the children to school, the lack of attendance would have been very obvious in the attendance data and the school would have contacted parents to try to improve this. Had such attempts not been effective the EWO service would have provided support and, if necessary, enforcement action. Neither was possible during the time period covered by the review due to a combination of national and local Covid restrictions

3.12. At the beginning of March 2021 Mother informed the school that the children would not be joining the school as it was too far away from the family home. During March and April the EWO encouraged

[5] Operation Encompass is a scheme that local areas sign up to where the police share all incidents involving children with the school they attend on the next school day so that staff are aware and can provide any necessary support and monitoring

Mother to contact the 3 nearby schools directly, and informed Mother how to appeal when places were not available. During this time Mother decided to "home educate"[6] the children. The EWO asked Mother to put this decision in writing and refused a request from the school to take the children off the roll pending receipt of the letter, so that the school was responsible for continuing to offer educational opportunities. No letter was received, and by the end of April 2021, Mother decided to send the children to the school which had originally offered them places.

Summary of learning: Transfer in arrangements, meeting the health and education needs of the children

- The importance of effective systems to share information between agencies and services about families who move between areas

- The importance of written transfer summaries being written in a style which minimises scope for misinterpretation by a new practitioner

- The need for health visitors to take account of key vulnerabilities e.g historical domestic abuse and being new in an area plus the impact of unusual circumstances (in this case the Covid restrictions) when categorising the service level to be offered.

See recommendation A

Theme: The arrangements to safeguard Child G and his siblings and promote their welfare.

3.13. Child G was a newborn baby who was entirely dependent on the care provided by the adults responsible for him. Children under 12 months consistently form the significant minority (approximately 40%) of children subject to Serious Case Reviews/Child Safeguarding Practice Reviews.[7]

3.14. Despite the Covid pandemic, records show that core health visitor contacts continued to be offered to this family face-to-face, subject to advance contact by telephone and a Covid risk assessment to ensure a home visit could take place safely. Difficulties arose when Father to Child G reported Covid symptoms when health visitor A arrived for the ante-natal visit for unborn Child G prior to the family moving to Halton. This visit could not take place and subsequently took place as a telephone appointment. Telephone contacts pose challenges for discussions about health and wellbeing for more sensitive topics such as maternal mental health and the "routine enquiry" about domestic abuse. For example, it is not possible to be certain who can overhear nor pick up on any nonverbal cues or see the physical environment where the babies will live.

3.15. There are several key research findings about the incidence of domestic abuse relevant to this review. Firstly, that that women who have been subjected to domestic abuse are vulnerable to two kinds of repeat victimisation, by the same person or by future partners[8]; secondly that that whilst pregnancy can offer a protection for some women the risk of domestic abuse is known to increase

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[6] A parent can decide to "home educate" their child. The parent must make sure their child receives a full-time education from the age of 5, but they do not have to follow the national curriculum. The council can make an 'informal enquiry' to check the child is getting a suitable education at home and can serve a school attendance order if they think the child needs to be taught at school.

[7] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education and all previous analyses of SCR/CSPRs published by the government of the day

[8] https://www.ucl.ac.uk/jill-dando-institute/study/jdibrief/analysis-briefs

in pregnancy or shortly after birth;[9] thirdly that domestic abuse can have a serious impact on all children,[10] including unborn children, at worst increasing the risk of miscarriage or prematurity and causes stress and anxiety for the mother which can affect the development of the baby[11] and fourthly that incidents of domestic abuse are known to be under-reported.[12] Records show that Mother had been subject to significant and sustained domestic abuse and harassment from Ex-Partner and his family respectively over several years. The impact of any incidents between Child G's parents on all the children therefore would be important to consider not just because of the impact of the incident itself but also for its capacity to retrigger previous trauma. Information not known to the practitioners until after the injuries to Child G suggests there was a level of domestic abuse by Father of Mother while they lived in Halton.

3.16. Whilst living in Local Authority 2, Mother obtained a non-molestation order in January 2020 and the family were considered by the Multi-Agency Risk Assessment Conference process (MARAC)[13] due to concerns about Ex Partner and his family. Records show a MARAC notification was sent to midwives and the health visitor in March 2020. Domestic Abuse was flagged on the midwifery records with a note to say Mother had been a victim of historical domestic abuse from Ex-Partner and that a non-molestation order was in place. At each contact with Mother the midwife undertook a routine enquiry in respect of the DA and when she stated she had started a new relationship they screened her again. This was good practice

3.17. Health visitor A, who knew the parents in local authority 2 between 2019 and 2020 told this review that she knew about the domestic abuse reported in 2019 during Mother's pregnancy with sibling, where there was evidence of a potential assault (denied by both parents). She knew that social workers from Local Authority 2 had visited the family to offer a Child and Family Assessment[14] but had the parents had not consented. She planned to discuss the incident at the subsequent standard antenatal visit but no-one had been in and Mother did not make contact to re-arrange it. During her involvement she had not been able to see Mother alone to enquire about domestic abuse in the current relationship. During her visits to the family home, she told this review that she had observed a relaxed and joking relationship between the parents. When she broached the subject of the domestic abuse notification from the police regarding the incident in October 2020 which involved Father grabbing Mother to prevent her leaving the house when Mother was pregnant with Child G, both parents said this had been a malicious referral. This is not inconsistent with Mother's denial to the police of even an argument having taken place, despite Father having admitted this. Denial or minimisation (which was also a feature of the 2019 incident) is not unusual in relationships involving domestic abuse. This makes it more difficult for anyone to provide advice or support or protective action to prevent further incidents unless there is corroborative evidence. Research shows that women subject to domestic abuse may act in ways that appear inconsistent and harmful to their best interests.[15] There are many potential motivations for minimisation and denial by victims of domestic abuse. They may feel disclosing it might increase the risk to themselves or their children, they may also fear that disclosure would prompt unwelcome social work involvement with their children. In

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[9] NICE (2014) Public Health Guidline; Domestic violence and abuse; multi-agency working NICE
[10] James E (2020) Not just collateral damage; the hidden impact of domestic abuse on children Barnardos
[11] https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/
[12] The most recent report indicating this is Women's Aid (2018) Survival and Beyond; the Domestic Abuse Report 2017 Bristol: Women's Aid
[13] A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed and safety plans agreed

[14] A Child and Family Assessment is an assessment to establish whether a child is in need of local authority services (under section 17 of the Children Act 1989) to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development
[15] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education para 4.2.5 passim

this case the siblings had already been subject to child protection plans due to domestic abuse by Ex-Partner.

3.18. Health visitor managers told this review that because of learning from an internal audit within Halton Midwifery and 0-19 team, an alert is now added to the electronic record when the “routine enquiry” about domestic abuse has been unable to be completed due to the presence of partner/family members at home visits /appointments or when appointments are undertaken virtually. This was not in place within the timeline of the review. This will ensure the next practitioner will know the “routine enquiry” remains outstanding and opportunities to discuss this are maximised. Currently all Halton 0-19 templates are being revised to include a mandatory field for DVA enquiry. Consideration might useful be given to how to ensure that Vulnerable Persons Notifications from the police are specifically discussed with alleged victims, as for some women these may represent more “reachable moments” when women may be receptive to advice and support. A safeguarding specialist nurse screens VPNs and provides advice to health visitors. Since this review a Standard Operating Procedure had been finalised for responding to VPNs which will further strengthen practice.

3.19. Health visitor A told this review that because no Child and Family Assessment was to be undertaken, (because the parents would not consent) the family would remain universal for the health visiting service. Decision-making across the trust about service levels is variable as previously described and this is not part of the standard criteria for decision-making about level of service. Considering the history and research about domestic abuse, as described above, a service level of “Universal plus” would have been more appropriate; this would have enabled further visits and whatever support was appropriate.

3.20. It is standard practice for midwives and health visitors to deliver messages about coping with crying babies and the dangers of shaking babies. Health visitors A told this review that such a conversation was had with Mother at the new birth visit in November 2020 but not with Father, as he was not present. Health visitors told this review that if the mother was not present at such a visit then further contact would be made until it had been possible to discuss these issues with her. If fathers were not present however, the assumption would be that mothers would share the information, either verbally or via a leaflet, and no specific follow up with fathers is undertaken. Therefore, a key finding from a recent national report[16] about non-accidental Injury in babies under 12 months is relevant to this case. This was that parenting is still viewed as the mother’s role and responsibility by society and the services which support families through pregnancy and the first year of life. It was clear that overall antenatal and postnatal services are not commissioned for men or delivered to fathers/male carers, with the result that fathers/male carers are not able to access the information/advice /guidance provided to mothers around the fragility of babies, the impact of young babies within the family and the needs of infants.

3.21. Health visitors told this review that Halton had also begun to roll out the ICON programnme “Babies cry you can cope”[17]. This programme was developed in America due to research which identified how people can lose control in response to babies crying, and shake them, with devastating consequences. They concluded that the most effect intervention to prevent this was to support parents to adopt simple techniques to cope with crying. The programme has a particular emphasis on making parents aware that crying is something that men find particularly difficult to cope with. However, this can be a difficult conversation for a less confident or experienced practitioner to have with a father, or, if he is not present at the visit, for any mother who might be vulnerable to domestic

[16] Walters A et al (2021) Fieldwork report: National Review of Non-Accidental Injury in under 1s Child Safeguarding Practice Review Panel

[17] https://iconcope.org/

abuse. Therefore, effective rollout will require support for practitioner to have such a conversation with parents and arrangements which ensure that if the father is not present during the relevant visit that steps are taken to follow up further until these messages have been provided to him too. The father of Child F previously mentioned was convicted of murdering him; his injuries were caused by shaking. Whilst we do not know the immediate precursor to the non-accidental brain injuries for either child, this may indicate a need for greater public awareness of how to cope with crying and the dangers of shaking babies.

3.22. Child G's collapse at home due to the injuries which prompted this review amounted to a Acute Life-Threatening Events (ALTE). In another recent local Child Safeguarding Practice Review (Child F), police and hospital staff told this review of their perception that partner agencies are sometimes confused about the expected response to ALTE when there are no immediate safeguarding concerns. The actions taken/not taken because of Child G's collapse at home further support that view.

3.23. Because some ALTEs later turn out to be due to abuse, instances should be promptly reported to the police and Children's Services so that police investigations and action to protect the child and any siblings can be considered immediately. No notification to the police was made by the ambulance service for reasons which are not known. Once in the specialist children's hospital the Emergency Department (ED) staff correctly recognised the circumstances as being an ALTE. However, this was de-escalated by a neurosurgical registrar before a referral was made to the police and Children's Services. This was due to the discovery of a possible medical cause for Child G's collapse; a congenital cyst on Child G's brain which had burst. The de-escalation was done without the discussion with the Safeguarding on call consultant which is required by the hospital policy. The neurosurgical registrar told this review that he had not fully understand the multi-agency working and safeguarding implications of making a quick decision to stand down the ALTE based on results of the CT scan.[18] The ALTE process was re-initiated at the hospital the following day, pending further tests. The referral was made to ICART[19] at 2pm and passed to the Child in Need team awaiting allocation for assessment. The referral did not mention any siblings and no-one in ICART enquired whether there were any. At 4.45pm the hospital informed ICART that there were siblings at home in the care of the parents and this information was then shared with the Children in Need Team and a strategy discussion held between children's social care and the police which considered the safety of all the children. It would have been preferable if ICART had been more proactive, for example by seeking more information by telephone from the hospital and liaising with the police, which might had discovered the existence of the siblings earlier. This gap in proactive action regarding siblings on receipt of ALTE referrals within ICART was also seen in the Child F review.

3.24. Since the time of both reviews the ambulance service has raised awareness within the Emergency Operation Centre (EOC) about the Sudden Unexpected Death of an Infant or Child SUDIC procedures and the ALTE process which is contained within them. The service has also discussed the importance of police notifications in the EOC Learning Forum. They have also recruited a new Safeguarding Practitioner whose remit includes EOC; induction includes a catch up discussion with Police Child Death Overview Panel (CDOP) representative. As a result of learning from this and the other case review referred to previously, steps are being taken within ICART to improve the identification and consideration of the needs of siblings. Hospital managers told this review that training had been delivered to Paediatric Intensive Care Unit (PICU) staff regarding ALTE process and contributing to assessments, including the use of genograms.

[18] are a specialist type of xrays which produce cross sectional images of the body
[19] Integrated Contact And Referral Team. The "front door" to Early Help or Social Work support including safeguarding

3.25. Since the incidents that prompted both reviews the local multi-agency Sudden Unexpected Death of an Infant (SUDIC) procedures have been reviewed and the new ones[20] make more explicit mention of ALTE, both in the title and the content. However, the document is almost entirely focused on SUDIC, it is very lengthy and not easy to navigate. It is difficult to locate references to ALTE, which do not recognise that despite some ALTEs being the result of NAI, but that this is often not apparent immediately, as in this case.[21] The required initial response from ICART, where there are no immediately obvious safeguarding concerns (to check records for current and previous involvement and provide information to hospital staff and the police about the family background), remains the same. Practitioners suggested that there would be benefits in considering separating out the ALTE element from the SUDIC guidance to make them more visible; perhaps developing a standalone flowchart and separate forms rather than practitioners having to adapt the ones referring to a child's death as practitioners currently must.

3.26. A few days after Child G's admission to hospital a nurse observed Child G having seizures. Mother then told her that she had witnessed two possible seizures earlier in the day, however the nurse did not discuss this with the hospital safeguarding team as she should have done, for reasons that are not known. Subsequently Mother was overheard by another nurse to be trying to warn Father about staff being present in the room, so that they would not hear what he was saying to her. The nurse overhearing her told this review that although parents often stop conversations on their entry to cubicles either anticipating they are there to do something or to be polite this stuck her as sufficiently odd to record it and mention it to the night staff. However she did not report it to safeguarding staff; the context to this was the timing being around the time of shift change. Hospital safeguarding staff told this review that they would be addressing reporting concerns during Level 3 safeguarding training for staff and "spotlight sessions" for nurses, as well as ways of raising parents' awareness of the importance of informing staff of any changes they observe in their child's condition.

<u>Summary of learning:</u> The arrangements to safeguard and promote the wellbeing of Child G and his siblings.

- To maximise opportunities for reachable moments for providing advice and support to victims of domestic abuse, the importance of liaison with each other if either midwives or health visitors have not been able to fully explore notifications about domestic abuse incidents

- The importance of "respectful scepticism" when parents deny reported incidents of domestic abuse, especially if the mother has previously been subject to domestic abuse, and/or she is pregnant

- The importance of recognising the impact of domestic abuse on children including unborn babies and that this can include the risk of retriggering trauma if they have witnessed domestic abuse of their mother by a previous partner

- The importance of specifically engaging BOTH parents directly in providing information and support about crying babies. This may require creative approaches as current maternity and early years health services are not currently designed with fathers' needs in mind

- The importance of prompt referral of all Acute Life Threatening Events (ALTE) to police and Children's Services as some of these later turn out to be due to abuse

[20] (Pan Cheshire) April 2021 Sudden Unexpected Death of an Infant (SUDIC)or Child and Acute Life-Threatening Event (ALTE) that are unexplained and/or suspicious requiring resuscitation and intensive care interventions in children
[21] Ibid page 59 reference to the guidance being used for "cases of ALTE (Acute Life-Threatening event) where the child may have survived but is highly likely to suffer / has suffered significant harm.

- The importance of agencies reporting or receiving reports of Acute Life-Threatening Events (ALTE) promptly identifying any siblings and considering any risks to them and their needs
- The importance of hospital staff reporting all concerning parental behaviour to their safeguarding teams

See recommendations B,C,D,F

Theme: consideration of cultural background

3.27. Practice in this case echoes findings from a recent national report[22] into non accidental deaths of babies under 12 months old which found limited evidence that the impact of ethnicity and culture on parenting was being considered. Knowledge of the family's cultural background was patchy amongst the practitioners and the recording and sharing of information about this was inconsistent. The health visitor in local authority 1 was aware that Mother came from a minority ethnic and cultural background because this was recorded on a police Vulnerable People Assessment (VPA). When she asked Mother about this, Mother told her that one of her parents was from a minority ethnic and cultural background and her other parent was not. The health visitor in local authority 2 cannot recall which parent was which and this is not detailed on the records.

3.28. Child G's mother provided some information which indicated norms in common with the local majority White British community. These were key differences from others with her heritage and Mother indicated that she did not identify with her minority cultural background. However, there may still have been an impact from her cultural heritage not least because Ex-Partner (the siblings' father) and his family was from that background too. However, there is no evidence of a detailed conversation with Mother about the potential impact on her or her parenting or the siblings due to this. The health visitor in Halton had misunderstood the information in the transfer summary thinking it referred to Ex-Partner (the sibling's father). The school knew Ex-Partner was from (the same) minority ethnic and cultural background from information shared by the siblings' previous school. However, there is no evidence of specific consideration of any potential impact of this on his children or Mother. This may have partly been because having moved to Halton the family were considered to be safe and he was no longer part of the children's lives.

3.29. Both health visitors told this review that their knowledge of the relevant cultural background was limited. Practitioners told this review that the only training they were aware of that touched on the relevant ethnic and cultural background was as part of training about domestic abuse. The findings described above are very similar to those of another local CSPR (Child F) whose scope covered a similar time period. The national report mentioned above concluded that practitioners need more confidence to acknowledge and explore the impact of ethnicity and culture on parenting. Practitioners involved with the review for Child F told that review that they would welcome some training about the cultural backgrounds of the small populations of BAME people that had recently begun to arrive in Halton. This would usefully include how to find out about less common cultural backgrounds with which they were (still) unfamiliar. As well as using interpreters to find out more about a family's background (which was relevant to Child F but not Child G), practitioners suggested seeking advice from adjoining areas with higher numbers of the relevant populations; sometimes this had resulted in key agencies having specialist staff who could be a resource, or there might be a relevant community or faith organisation. Alternatively, a wider consideration of the relevant

[22] Walters A et al (2021) Fieldwork report: National Review of Non-Accidental Injury in under 1s Child Safeguarding Practice Review Panel

community in other parts of the UK could also be helpful. Practitioners involved with Child G agreed with their colleagues.

Summary of learning: consideration of cultural background

- Importance of accurate recording about the ethnic and cultural background of all members of the family
- The importance of enquiring what a parent's cultural heritage means to them, and considering the impact on parenting

See recommendation E

4. POSITIVE PRACTICE

When undertaking a review, it is important to also consider the kind of positive practice that might have broader applicability to protecting or supporting other children and families. Examples not previously referred to are listed below

Protective and supportive actions by practitioners
Movement in health visitor appointment conducted promptly
The health visitor recorded Child G's voice as if he were expressing his views
The Education Welfare Officer did not accept the schools request to de-roll the children pending receipt of a written request from the parents to home educate the two older siblings
School liaised with previous schools prior to admission and obtained key educational and family background information
The school's Designated Safeguarding Lead shared information with key members of staff
The school provided additional support as the children were not working to age related expectations
Ambulance service decided to take Child G to the specialist hospital rather than to the local hospital due the complexity of Child G's presentation
Reciprocal effective liaison between Specialist safeguarding paediatric nurse and the community health trust safeguarding team after Child G's admission to hospital including updates regarding change in diagnosis
ICART and subsequently the allocated social worker each contacted school promptly for background information
School staff attended the care planning meeting to consider the needs of the siblings

5. CONCLUSION

5.1. National analyses of Serious Case Reviews[23] consistently show that children who are the subject of these often look very similar to those other children who practitioners encounter in their day-to-day work. This highlights a key challenge in identifying those individual children that are at risk of very serious injury or death.

5.2. The family's move to Halton was the latest in a series of attempts to escape the domestic violence and harassment from Mother's Ex Partner and his family. Accordingly, practitioners tended to view the new home as a safe place for the children. The only contrary indicator to this was some evidence of domestic abuse by Father against Mother, which not all the practitioners knew about. Even if those that had, had been more sceptical about the parents' denials this was not at the level where anyone would suspect a child was at risk of serious physical harm. Nonetheless there is some learning from this case that would benefit other similar families for the future; in particular the importance of clear communication between practitioners the needs and risks for families moving to a new area and gaps in usual practice in ensuring that BOTH parents, fathers as well as mothers, consistently receive messages about the fragility of babies and coping with crying.

6. RECOMMENDATIONS

The individual agency reports have made single agency recommendations. Halton Children and Young People Safeguarding Partnership Safeguarding Children Partnership (HCYPSP) has accepted these and will ensure their implementation is monitored. To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations for HCYPSP.

A) That HCYPSP seeks assurance from the health providers delivering midwifery, health visiting and school nursing services, the local authority regarding education, and the CCG regarding GPs that effective arrangements are in place to share information about children moving in and out of Halton.

B) That HCYPSP seeks assurance from all relevant agencies (Police, Children's Social Care, Hospitals providing services to Halton children, and the Ambulance service) that when information is shared or received about an Acute Life-Threatening Events (ALTE) steps are taken to identify and safeguard any siblings

C) That HCYPSP seeks assurance from the health trusts responsible for the delivery of midwifery and health visiting services that;

   a. Health visitors and midwives exercise "respectful scepticism" and curiosity when parents deny reported incidents of domestic abuse, especially if the mother has previously been subject to domestic abuse, and/or she is pregnant, and consider the potential impact on the unborn child and any siblings.

   b. arrangements have been put in place to ensure appropriate reciprocal liaison between health visitors and midwives regarding any difficulties in making "routine enquiries" about domestic abuse and/or addressing notifications about incidents of domestic abuse, especially where a practitioner has not had the opportunity to discuss these with the victim in private.

[23] Chapter 6 Brandon M et al (2010) Building on learning from Serious Case Reviews; two year analysis from child protection notifications database 2007-9 DfE Sidebottam P et al (2016) Pathways to harm pathways to protection; a triennial analysis of Serious Case Reviews 2011-14 Department for Education

D) The HCYPSP supports partner agencies to raise awareness about the dangers of shaking babies and how to reduce the risk by

   a. Considering a publicity campaign for local or regional delivery which addresses the learning from this review

   b. Seeking assurance from the health visiting service that specific arrangements are in place to ensure that fathers are aware of the dangers of shaking babies and that this is also addressed in the roll out of the ICON programmed "Babies cry you can cope".

E) That HCYPSP seeks assurance from partner agencies that they have or will develop training and briefing materials for practitioners about working with BAME people. This should include input on the cultural background of BAME groups now living in Halton. Training should include how to find out about unfamiliar families' cultural backgrounds. [24]

F) That HCYPSP share the learning form this review with the Child Death Overview Panel (CDOP) and request they ensure this is considered in the current work being undertaken on revision and implementation of the SUDIC procedures. This should include the development and dissemination of a specific Acute Life Threatening Events (ALTE) pathway flowchart. The ALTE element might be usefully informed by data collection regarding the percentage of ALTE that are subsequently identified as NAI. The effectiveness of the new guidance might be measured by a baseline audit now regarding awareness of ALTE repeated 12 months after the new procedure has been implemented.[25]

G) That HCYPSP seeks assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them.

[24] The CSPR into Child F covered a similar timescale to the scope for Child G and had some similar learning. This recommendation is a repeat of one for Child F without the reference to interpreting.

[25] The CSPR into Child F covered a similar timescale to the scope for Child G and had some similar learning. This recommendation is a repeat of one for Child F.