Child Safeguarding Practice Review

Ben

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1. Executive Summary

1.1 The review has identified lessons about working with vulnerable young and first-time mothers (and separated fathers) and the challenges of engaging them in Universal and Early Help Services. It shows that the needs of infants and toddlers can be missed when there is no engagement. It raises practice questions about how to engage parents where there are concerns about alleged domestic abuse and the need for assertive enquiry and analysis about men who are known to have a violent history and who form new relationships.

1.2 Ms A, Ben's Mother, reported adverse childhood experiences, mixed feelings about her pregnancy and low-level depressive symptoms in pregnancy and later. She was offered a range of services because of her vulnerability but did not engage well.

1.3 On the occasions that she reported domestic abuse it was taken seriously but she did not then follow through with support, advice or possible actions.

1.4 Her vulnerability as a young and new mother was recognised after Ben's birth, it was assessed that they would benefit from the **Universal Plus Partnership Health Visiting Pathway**[1]**.** Initially there was good and persistent work to engage with her. This was then impacted by a move and the Universal Plus Pathway approach was disrupted and not re-assessed or re-established.

1.5 Following an allegation of domestic abuse several months later, a Child and Family Assessment was undertaken and it was decided that a child in need service was not required. It may have been useful to signpost the family back to Early Help Services. Ben and Ms A were again no longer being seen by services.

1.6 When Ben was one year and eight months, he had a significant injury to his head. The hospital's clinical assessments were rigorous and resulted in a judgement that the injury was most likely accidental; but concerns remained about the cause and further medical investigations were in place. The review has raised the question about the point at which a multi-agency child protection approach to such assessments should be considered when there is doubt about the cause of a significant injury. Although a referral was made to Children's Social Care this was not followed through as it was not seen in a child protection context, given the view that the injury was probably accidental. The decision not to proceed with a multi-agency Child and Family Assessment was influenced by the systems context of large numbers of ineffective referrals.

1.7 Opportunities were missed to identify a new male partner who was known to be a potential risk.

1.8 Ben died from significant injuries, aged two years and one month. His Mother and her new Partner have been charged with Ben's murder.

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[1] **Universal Partnership Plus - Health Visiting Service** Best Practice Pathways - NHS Healthy Child Programme

1.9 **Lessons learned include:**

- The need to consider a multi-disciplinary response when assessing head injuries, especially in young children
- The importance of informing referring agencies when a referral is not accepted, and why
- The need for a better local understanding of how the National Healthy Child Programme, Early Help Services and the multi-agency Threshold for Intervention are operating at Levels 1 and 2, to ensure that young children are not lost to the system
- The need for an understanding of how parenting education is provided for new and inexperienced parents
- Holding 'Was Not Brought' (to medical appointments or checks) in mind as a possible indicator of neglect of young children
- Keeping the child in mind and the child's experience central
- Assessments, Engagement and non-Engagement, where parental consent is required – the challenges of seeking to engage vulnerable parents who choose not to engage
- Assessing the risk of domestic abuse and supporting women who have experienced domestic abuse
- Including the importance of tracking known violent adults and identifying them when there are concerns about children with whom they are in contact.

1.10 A number of recommendations have been made in the light of these findings. They are summarised in section 7.

The Croydon Safeguarding Children Partnership endorsed this Review and agreed the recommendations in Section 7 in June 2021 and will put them in to place through a multi-agency Action Plan.

Croydon Safeguarding Children Partnership

June 2021

2. Reason for review and methodology

2.1 Ben died from significant non-accidental injuries, in October 2019, aged two years and one month. The Croydon Safeguarding Children Partnership commissioned a Rapid Response[2] and agreed that a Safeguarding Practice Review (SPR) should be undertaken. Ben's mother and her new partner were arrested, and a murder investigation was initiated.

2.2 The purpose of a SPR is to learn lessons through a systems analysis of the family dynamics and of the single and multi-agency work undertaken to assess and support the family. Such a review should make recommendations where any changes may be required to improve the way that local services for children and families are provided. The process seeks to involve family members and practitioners as much as possible, to learn from their perspective.

2.3 An Independent Panel drawn from key agencies was appointed with an Independent Chair and an Independent Reviewer. The Panel analysed a detailed chronology of all the agency contacts with Ben, his mother and other key adults from when his mother's pregnancy became known (2017) until his tragic death. Agencies were asked to provide an internal independent evaluation of the work undertaken in the context of local procedures and resources and any significant systems issues which may have influenced the work; and to identify any lessons.

2.4 Ben's parents and Ben's Mother's partner were advised of the review and invited to contribute their views. Ben's Mother and Partner did not respond to the initial invitation. Ben's Father and Paternal Grandmother met with the Lead Reviewer at the end of the review Process to share their views on services received.

2.5 The **Review Terms of Reference** set the following **Learning Outcomes**

- To gain an understanding of the systemic factors that led to this child's death
- To identify learning from all aspects of the history and engagement with the family
- To promote any learning from this SPR across the safeguarding partnership

Specific Questions (areas for exploration)

- Expectations from professional referrals which result in no further action e.g., Hospital to Children's Services, Hospital to Mental Health
- Procedures and expectations in relation to serious child injury
- Information sharing - VISOR offenders, moves across boroughs, Domestic Abuse, MARAC expectations
- Risk assessments – including the child's experience, parenting capacity, culture, and any possible substance use.

[2] A Rapid Response is required by statutory guidance **Working Together to Safeguard Children 2018**. One of the outcomes may be a Child Safeguarding Practice review as set out in Chapter 4.
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

2.6 **Panel Membership**

Independent Chair Lead Reviewer Bridget Griffin

Independent Author Lead Reviewer Malcolm Ward

They are both experienced in leading child safeguarding reviews using a systems approach.

Representatives from the following agencies:

Croydon Children's Social Care, Croydon Community Development Service, Croydon University Hospital NHS Trust, Lambeth Children's Social Care, London Ambulance Service, Metropolitan Police Service, National Probation Service, South London and Maudsley NHS Trust, and the Croydon Safeguarding Children Partnership and the Lambeth Safeguarding Children Partnership. The review was supported by the Croydon Safeguarding Children Partnership

The Panel Representatives were senior managers who had no direct involvement in the case.

2.7 During the main period of the review, the Covid-19 pandemic prevented face to face meetings. It was not possible to hold an online Practitioners' Focus Group until November 2020.

2.8 The criminal investigation into Ben's death was impacted by a long period awaiting the results of the post-mortem and biopsies; this is a known national shortage and systems issue for such investigations which impacts on learning reviews as well as on criminal justice processes. In December 2020, Ms A and Mr D were charged with murder and causing or allowing the death of a child. Their trial is awaited

3. Background information

3.1 Ben was born in autumn 2017. He was Black British. He was the first child to his mother, who was nearly 20, when he was born. Ms A initially described the pregnancy as "unplanned but welcome" but later she said that she was unhappy about the pregnancy.

3.2 Ben's Mother and Father ended their relationship before Ben was born but Ben's Father continued to have contact for a substantial part of the period under review.

3.3 Ben's maternal grandparents had settled in the UK. They were said to have had a difficult relationship during Ms A's childhood and divorced when Ms A was 17.

3.4 When Ms A was 18 Police were called to an incident between Ms A and her mother when Ms A alleged that she was assaulted. However, she continued to live in the household after this.

3.5 After Ben's death it was learned that Ms A had been in a relationship with Mr D, probably from November 2018. He was previously known to the police, youth offending services and to children's services in a neighbouring local authority where there was concern about his previous involvement in criminal activity and domestic abuse.

4 Summary account of events and agencies' involvement with Ben's family February 2017 to September 2019

The summary is drawn from agency records[3] of many contacts with Ms A and Ben and their family and parallel and then later contacts with Mr D. It covers the period from when Ms A was confirmed as pregnant with Ben.

February to October 2017 (Pregnancy with Ben)

4.1 Early in the pregnancy there was an allegation that Ms A had been assaulted by her mother. Ms A's mother counter-alleged that Ms A was drinking and using drugs. Police informed Children's Social Care (CSC) because of the vulnerability of Ms A's younger brother and the pregnancy.

4.2 Ms A was supported by the Croydon Family Justice Centre and Housing to move to temporary emergency accommodation. Her situation was discussed at the Multi-Agency Risk Assessment Conference - MARAC[4] on two occasions during the pregnancy but Ms A withdrew from support of the Independent Domestic Violence Advisor.

4.3 Midwifery saw Ms A for the first time in late March. She reported little family support and a history of depression and was referred to the Perinatal Mental Health Team but did not meet their criteria.

4.4 The Children with Disabilities Team assessed that there was no risk to Ms A's younger brother. The case was closed with no contact with Ms A or consideration of her as the potential victim of domestic abuse. This was a missed opportunity to consider unborn Ben's needs, including the allegation of Ms A's use of alcohol and drugs.

4.5 A Midwife saw Ms A at 16 weeks' pregnant. She was still only 19 and was in "homeless persons accommodation" and isolated. She did not attend any antenatal classes during her pregnancy. In mid-May she moved to temporary self-contained accommodation, within a hostel.

4.6 In June, the Health Visitor sought information from the GP, and the Best Start Social Worker to initiate a pre-birth health visiting assessment.

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[3] Services involved were GP, Midwifery, Police, Domestic Abuse Services, Early Help Services/Best Start, Health Visiting, Ambulance Service, Mental Health Services, Children's Social Care (in two Local Authorities) and Probation

[4] **MARAC** Multi-agency Risk Assessment Conference. These are local multi-agency meetings where service representatives share and review information about cases of domestic abuse to plan and co-ordinate responses.

4.7 At the end of July, Ms A told a Midwife that she was still feeling low, had financial worries, and had fallen out with her mother. The Midwife re-referred her to the Perinatal Mental Health Service, but again the referral did not meet the criteria. It was wrongly assumed that Ms A had been referred to the Family Nurse Partnership[5]. The Perinatal Service advised the GP that Talking Therapies could be considered.

4.8 The Health Visitor met Ms A for the first time in early August. Ms A had not kept a prior appointment. Ms A was unhappy about the pregnancy. She agreed to an **Early Help**[6] referral and for the GP to be informed.

4.9 Ms A saw a GP in mid-August. She was tearful and reported financial difficulties and no support. At the follow up review with the GP, Ms A said she was feeling better. She had seen her mother and was again in contact with Ben's Father who she now described as "supportive". When seen by the Health Visitor Ms A reported feeling better. The Early Help/Best Start Social Worker was due to visit.

4.10 In the third week of September, Ben was born prematurely. Ben's Father was present at the birth. Ben was in the Special Care Baby Unit for eleven days. There were mixed observations about Ms A's care of Ben and although this concern was to be passed on to community health staff there is no evidence that it was.

October 2017 to December 2017 (Ben birth to 3 months)

4.11 A different Health Visitor made the **New Birth Visit** and observed good mother-baby interaction. Ms A reported no low mood and expressed trust in her GP and knew how to seek help. When asked, through **Routine Enquiry**[7], about domestic abuse Ms A said there had been none. An enhanced **Universal Plus Health Visiting service**[8] was agreed due to "prematurity and Mother's history". Ben was seen at home a week later and was progressing well.

4.12 In mid-October, the Early Help Teenage Pregnancy Support Worker (from Best Start) met Ms A for the first time as Ms A had not accepted previous appointments, during the pregnancy. Ms A was assessed to be coping and to have made connections to services. They agreed a plan to work together but Ms A did not respond to further contacts.

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[5] **Family Nurse Partnership** The Family Nurse Partnership is a voluntary home visiting programme for first time parents aged 19 or under, it should be started before the 28th week of the pregnancy. A specially trained family nurse supports the mother from early in pregnancy until the child is two.

[6] **Early Help** is the additional voluntary available for children, and their families where they have additional needs that are not being met by universal services. At the time this was provided by the Best Start Service.

[7] **Routine Enquiry** Involves the safe screening of all service users within a service by asking sensitive questions about their experiences of specific issues – in this case of domestic abuse. It is expected practice for Midwifery and Health Visiting Services. Domestic abuse: a resource for health professionals - GOV.UK (www.gov.uk)

[8] **Universal Partnership Plus - Health Visiting Service** Best Practice Pathways - NHS Healthy Child Programme

4.13 The original Health Visitor took lead responsibility from this point. Ms A reported regular visits and support from her mother, Ben's Father and other friends and family. However, a member of the community reported to the GP and to the Health Visitor that Ms A had low mood, was tearful and was feeling unsupported. Ms A was seen separately by the GP and by the Health Visitor. She had low mood and was concerned about not bonding with Ben as he had been in SCBU. She felt unsupported. She declined medication and was advised to refer herself to the Improving Access to Psychological Therapies Programme (IAPT)[9]. The GP and Health Visitor planned to monitor her. The Health Visitor updated the Teenage Pregnancy Worker.

4.14 Ms A referred herself to IAPT, which accepted her referral, noting it as 'low risk'. They offered her a telephone assessment.

4.15 Ms A did not respond to the Health Visitor's further contacts until mid-November. She felt more positive, but she had argued with Ben's Father. She felt a strong bond with Ben. Ms A said that she had not received an appointment from the IAPT. *The IAPT had closed the referral as they had not heard back from her. She had not followed up with the Teenage Pregnancy Worker as part of the agreed support plan.*

4.16 Ms A saw the GP, Ben (now eight weeks old) was not present. Her mood was better she said that was awaiting a response from IAPT. The next week the Health Visitor saw Ms A and Ben. Ms A was feeling positive and continued to see her family and Ben's Father. The Health Visitor observed "Sensitive and responsive parenting". Ms A intended to transfer to a more local GP and to attend the baby clinic nearer to her temporary home.

4.17 The Health Visitor saw Ms A and Ben for the last time in mid-December, as Ms A was transferring to a different geographical team. Ben's Father and Ms A's mother were said to be visiting regularly. Ms A was still awaiting her appointment from the IAPT, which had been closed. In late December Ms A transferred to a more local GP and more local Health Visiting Team.

January to October 2018 (Ben aged 3 months to 13 months)

4.18 Ben was seen by an Out of Hours GP in mid-January for a minor issue. (This was the first time Ben was seen by a GP, aged 4 months.) He was seen in the surgery three days later and had his first and overdue immunisation.

4.19 In early February Ms A contacted NHS 111 for herself. She was advised to contact her own GP within two hours – but did not.

4.20 In late February, Police received information that a package sent to Ms A's address, containing cannabis, had been intercepted; it was not specifically addressed to Ms A. The investigation was inconclusive.

4.21 Ben was not brought for his next immunisation. The Surgery wrote to Ms A about this in April.

[9] **IAPT** Welcome | SLaM: Improving Access to Psychological Therapies (slam-iapt.nhs.uk)

4.22 Ms A called the Police in April because of a dispute with her mother and sister. They claimed that Ms A had mental health problems and that they were worried about Ben's welfare. Police noted Ben to be well; there were no concerns about the home. Ms A made a historic allegation about a significant traumatic event in her childhood; Police tried to follow up this historic allegation but Ms A did not take it further. Croydon Children's Social Care was informed of this call out.

4.23 In May, Ms A alleged to the Police that Ben's Father had seriously physically assaulted her in April. She had not reported it at the time as she had thought that it would make matters worse but had been advised to do so by the Family Justice Centre worker. The Police had no concerns about Ben. They advised Children's Services of the new allegation. Police later arrested Ben's Father for this alleged domestic violence but could not investigate further as Ms A declined to assist.

4.24 Ms A requested a consultation with her GP but did not then respond to calls from the surgery.

4.25 Ms A told the Family Justice Centre worker that Ben's Father had punched her in the face. (*This was different to the account given to the police*) The FJC arranged for Ms A's locks to be changed and made referrals to Housing, Children's Social Care and to the MARAC.

4.26 Children's Social Care agreed to undertake a **Child and Family Assessment**[10]. In late June, the case was discussed at MARAC. Ms A had alleged that Ben's Father was coercive and controlling and that he had physically assaulted her in front of Ben. She did not wish to press charges or seek a non-molestation order against him because she was too fearful of him. It was understood that Ms A's younger, disabled brother was resident with her and Ben. The Independent Domestic Violence Advisor (IDVA) agreed to liaise with Children's Services about both children. The new Health Visiting Team for Ben and the School Nurse for Ms A's disabled brother were advised of this MARAC discussion.

4.27 The IDVA later alerted CSC that Ms A was not responding to attempts to work with her. The Social Worker visited Ms A at the end of June. There were no immediate safeguarding concerns. Ben was seen to be physically healthy. Ms A reported that she had taken protective measures to cease contact with Ben's Father. This was assessed as her ability to prioritise Ben's safety. Ms A was advised to speak to the Family Justice Centre about safe contact arrangements between Ben and his father. It is not clear that the safety of Ms A's brother was considered, nor for Ben regarding the parallel allegations about the maternal family.

4.28 In late September, the GP surgery wrote again to Ms A about Ben's outstanding immunisations. She contacted the surgery seeking a consultation for herself but did not respond to several return calls to follow this up until October when she spoke with a GP by phone. She had been feeling tired for a few months. Ben was said to have been unwell with a fever and vomiting for two weeks. This was a possible opportunity to discuss Ben's outstanding immunisations. An appointment was given for Ben, but he was not brought to it.

[10] A multi-agency assessment under the Children Act 1989, led by a social worker, to ascertain if a child needs additional services.

4.29 At the start of October, the CSC Children with Disabilities Team responded to the Family Justice Worker, following the MARAC meeting in June, to say that Ms A was not known to them but that they were working with her younger brother. There appears to have been no assessment of the concerns raised about possible risk to the younger brother.

4.30 In late October, the GP Surgery wrote again to Ms A about Ben's outstanding immunisations.

4.31 At the end of October Children's Services completed the Child and Family Assessment. This was completed outside the recommended time scale. It noted that contact with Ben's Father was an important but unresolved issue and that both Ben's parents had been given advice about this. There were said to be no other concerns, despite the alleged domestic abuse and the GP being worried that immunisations were overdue. The case was closed to CSC with no further action. It is not clear that there was an attempt to speak with Health Visitor or refer for Early Help such as a Children's Centre.

November 2018 to April 2019 (Ben aged 14 months to 19 months)

Hindsight information suggests that Ms A met and started a relationship with Mr D in November 2018, but this was not known to agencies at the time.

4.32 At the end of November, the GP surgery sent another letter to Ms A about Ben's overdue immunisations.

4.33 There appears to have been no involvement with Ben or Ms A by any agency until April 2019.

4.34 In April 2019 Ms A consulted the GP Surgery about Ben by telephone. He was assessed to have a viral infection. The Surgery later followed up this phone consultation with a text alert asking Ms A to bring Ben for his overdue immunisations.

May 2019 Critical incident - Ben's Head Injury, Inpatient Stay and Referral to Children's Social Care (Ben aged 1 year 8 months)

4.35 In early May, Ben was brought by ambulance to hospital with a head injury and extensive bruising to the side of his head and face. Ms A stated that Ben had jumped one metre from the sofa on to the metal edge of a highchair. There were two different accounts given – one referring to the base of the highchair and one to the leg, but they were similar. Ben was admitted to the children's ward.

4.36 Further tests were done and second and third opinions were obtained. It was suggested that there may have been multiple impacts. Safeguarding was to be considered. Background checks were made to Children's Social Care which shared the limited previous involvement and that Ms A had been responsible for the domestic abuse of Ben's Father, which was not the case.

4.37 The view was being formed that the injury was, on balance, more likely accidental and consistent with Ms A's account that Ben had jumped from a sofa and hit his head on the base of the highchair. She said that she had witnessed this and that her partner was in the kitchen. **This is the first information received by any agency that Ms A may have been in a new relationship. It is possible that this was Mr D, but his identity was not checked at the time.**

4.38 Ben was observed regularly; there were no concerns about the mother and child relationship. Family members reported that Ben was boisterous and often flung himself from furniture. Hospital staff also noted such risky behaviour.

4.39 Lead Safeguarding Advisors within the hospital recommended that a body map of injuries should be completed and that a referral should be made to Children's Social Care, given the uncertainty. The written referral to CSC did not reflect the uncertainty or the seriousness of the current concerns held by medical staff about Ben's injuries.

4.40 In the absence of clear contrary evidence, a medical view was formed that the injuries were likely to be consistent with Ms A's account. The Named Nurse observed that the injuries were extensive for a fall, that Mother was in a new relationship with an unknown male and that even if accidental, the injury should raise concerns regarding lack of supervision as Ben was described as highly active.

4.41 The Named Nurse, the Consultant and a Doctor met to review the case. The CT scan was inconclusive. The next day a skeletal survey was done as the injuries were out of proportion to the stated mechanism. No fractures or other bony injuries were seen in that survey.

4.42 The Named Nurse made a special effort to speak face to face with the Manager of the Single Point of Contact / MASH, because of her concerns. Children's Social Care noted that the injury to Ben's face was considerable. The hospital Multi-Disciplinary Team were not calling the case Non-Accidental Injury but felt that the injury was big given the explanation. Further results were awaited. The CSC Manager agreed for CSC to undertake a home visit and to share the family background information with the hospital. The Named Nurse understood that a Child and Family Assessment would be undertaken and that an Early Help referral would be made if social work was not required.

4.43 Ben was discharged home. An ophthalmology review later showed no damage but was to be repeated in four weeks. The GP was informed.

4.44 A Senior Manager in Children's Social Care reviewed and overturned the decision to undertake a home visit on the basis that the threshold for a referral and had not been met. Social Care understood from the written referral that Ben had not suffered Non-Accidental Injury. The Child and Family Assessment was cancelled as an opinion was formed that it was not proportionate to complete an assessment of need based on mother's personal history and on the hospital staff's "professional anxiety". There was no dialogue with the hospital Safeguarding Team about overturning this decision; nor was the decision to close the referral conveyed back to them.

4.45 Ben had a follow up chest X-ray two weeks later which showed that there was no evidence of any fractures.

Mid-May 2019 to October 2019 & Ben's death (Ben aged 1 year 8 months to 2 years)

4.46 A new Health Visitor (alerted by the hospital) tried unsuccessfully to contact Ms A both by phone and by unannounced visit. No Health Visitor had seen him since December 2017.

4.47 In late May, Ms A contacted the GP surgery by phone worried about a swelling in Ben's scrotum. She was offered an appointment for that afternoon - but did not bring him.

4.48 In late June, the new Health Visitor saw Ben and completed his **two-year developmental check**. He was one year and nine months. Ms A reported that Ben jumped from the sofa and hit his head on the wall; a different account to the one given to the hospital. The home was clean and tidy with plenty of age-appropriate toys. Ben's assessment suggested that he had significant speech delay for his age. Ms A was advised to take him to a service which could then link him on to the speech and language service. The Health Visitor planned to liaise with Children's Social Care but noted, a week later, that CSC had closed the case.

4.49 In late July, Police were called to the family home because of a domestic dispute between Ms A and Mr D. Ms A had been heard to shout "Stop hitting my face". She told the Police that she and Mr D had been together for nine months (from November 2018). They had been arguing but Ms A denied that there had been a physical assault. She declined to answer the SafeLives domestic abuse assessment / DASH questionnaire.[11] Police checks showed that there had been no previous incidents between this couple. Ben and Mr D's own child were present at the time. Both children appeared happy and well fed. **This appears to be the last time Ben was seen by any professional.**

4.50 The Police did not complete a routine notification to Children's Services which would have been expected operational procedure after such a domestic incident. This was the first time that there was clear evidence that Ms A had a new partner. Mr D's violent background and convictions would have been known in Police records. This was a missed opportunity.

Historic information about Mr D which was available in July 2019
Mr D was well known to the Police from 2006 for offences of robbery, assault, burglary, affray, possessing weapons, possessing cannabis, breaching bail conditions and domestic abuse. He had been assessed by the Probation Service as a high risk of harm to the public, to rival gang members and to previous or future partners. From November 2018, Mr D missed occasional meetings with his Probation Officer and admitted to daily use of cannabis. He also reported regular contact with his own child. Lambeth Children's Services were not advised about this, at the time. In February 2019 he told his Probation Officer that he was not in a personal relationship. In April, the Probation Officer was concerned that Mr D was not staying at his approved address.

[11] **DASH** Domestic Abuse, Stalking and Honour Based Violence https://safelives.org.uk/node/516 https://safelives.org.uk/

In July Mr D informed his Probation Officer that the Hostel was helping him look for work, giving the impression that he was still resident in, and co-operating with, the Hostel.

4.51 The day after this domestic abuse incident Ben was not brought to a follow up appointment at the hospital in relation to his head injury.

4.52 In the last week of July, Ms A saw her GP. She described depression and low mood for a year with poor sleep and being tearful and that she had been emotional since Ben's birth. She was advised to self-refer to the IAPT Service, which she did the same day.

4.53 Mr D was warned by his Probation Officer about non-co-operation. In subsequent meetings he said that he smoked cannabis twice per day and that he did not see cannabis misuse as either a problem or illegal.

4.54 The GP Surgery sent a message to Ms A about Ben not having been taken to his follow up hospital appointment. She was seen in the surgery a few days later for herself by a different practitioner. No link was made to the request for her to contact the surgery to discuss Ben not being taken for the hospital follow up.

4.55 In late July, Police received intelligence about Mr D's probable association with gang activity.

4.56 In early August, the Probation Service wrote to both the Croydon CSC and the Lambeth CSC giving information about a possible move by Mr D to an address in Croydon, not Ms A's address. Croydon CSC replied that they were not aware of any children at the address given and had no awareness of Mr D's child in Lambeth. Lambeth Children's Services have not been able to confirm that they received this request for assistance from Probation.

4.57 In the second week of August the IAPT assessed Ms A. She had severe symptoms of depression and anxiety arising from social anxiety and low mood with a history of suicidal thoughts resulting from trauma. She denied current thoughts to harm herself or others and reported no substance misuse. Ben was seen as a protective factor, which was noted to be unrealistic, given his young age. It was agreed that she should be allocated a higher level of intervention and an appointment was given.

4.58 The same day Ms A contacted the Health Visitor by phone to seek advice about funding for a nursery for Ben. Ms A told the Health Visitor that she was accessing support through IAPT for depression and was feeling better.

4.59 In mid-August Ms A attended an appointment in her own right at the Surgery. Ben was not discussed. Two days later the Surgery Administration texted her asking her to contact them about Ben's missed immunisations.

4.60 The Health Visitor contacted Ms A to be told that Ms A was out of London.

4.61 In the third week of August Ms A called IAPT to cancel her appointment saying that Ben had chickenpox. That same day Ms A did not keep a GP appointment for herself.

4.62 Mr D met with his Probation Officer and for the first time shared that he was in a new relationship. This should have been explored more fully so that relevant checks could be undertaken, given his history, and known risk to prospective partners. This was a missed opportunity to assess risk to Ms A from Mr D.

4.63 In early September Ms A did not attend the replacement appointment with the IAPT therapist. She was asked to make a further appointment, or the request would be closed. Three weeks later the service closed the contact as there had been no response.

4.64 In the last week of September, Ms A was seen at the GP Surgery for herself. Later in the week she sought further medical advice by phone and after not responding to return calls from the GP she was finally spoken with and given advice over the phone.

4.65 In contacts with his Probation Officer in late September and early October Mr D was noted to be looking for employment and continuing to smoke cannabis. He reported that he was still seeing his child but there was no mention of his probable regular contact with Ms A and Ben. There was no follow up to the information request to Lambeth Children's Services about his own child.

4.66 Ms A contacted the GP Surgery concerned (again) that Ben's scrotum was swollen from time to time. She was advised to ring back when the swelling was evident so that he could be examined.

4.67 Four days later Ms A attended the surgery for herself.

4.68 In mid-October Mr D completed his one-year Probation follow up to his discharge from prison. Regarding accommodation, he said that if he could not afford the rent he would live with his partner. There was no exploration as to who his partner was.

4.69 Two days later an ambulance was called to the house as Ben had 'collapsed'. He was taken to hospital where he died, despite attempts to save him. Initial examination of the home noted a distinct smell of cannabis and a cannabis grinder was found.

4.70 A murder investigation was started.

4.71 The post-mortems showed many non-accidental fractures and re-fractures which were assessed to have occurred over the preceding four weeks. Ben's death was caused by blunt force trauma. He had injuries to his liver and other bruising, including to his penis.

5. Family involvement in the review and their views

5.1 At the start of the review Ms A and Ben's Father, Mr B, were contacted and invited to contribute their views about the services that they had received to inform the learning for this review. Mr D was also informed of the review. None of them responded.

5.2 At the end of the review process, they were contacted again. Ms A and Mr D did not respond (they had been charged by this time). Mr B and his Mother agreed to meet with the Lead Reviewer. This took place in May 2021.

5.3 Mr B and his Mother were very upset by Ben's death. A different picture emerged from their account as they had been much more involved in Ben's life than agencies working with Ms A had known at the time.

5.4 Mr B and Ms A were not a couple and had no intention of being together. However, Mr B and his Mother reported frequent regular contact with Ben and that Ben came often, when Ms A permitted this, to his grandmother's home.

5.5 Mr B was present at Ben's birth. He had Parental Responsibility. Despite this he believed that the system was weighted towards mothers when parents were not together. He was not invited to any antenatal appointments or classes and wondered whether services should write to fathers who are interested in being part of their children's lives. He was not clear about which services were available for fathers to get information. He believed that the power was with the mothers.

5.6 He tried to see Ben as often as he could but was dependent on Ms A agreeing to this, and at times, she would refuse it. His contact with Ben was not as regular as he would have liked as a result, especially when Ms A was working and Ben was, at times cared for by a relative of Ms A's, sometimes for a week at a time.

5.7 Mr B was shocked about being arrested and detained by the Police in May 2018 when Ms A alleged Actual Bodily Harm. He said that he had not hit her.

5.8 His contact with the Social Worker undertaking the Child and Family Assessment was by telephone and he was able to express his wish to have ongoing contact with Ben. He was able to have occasional contact with Ben after that.

5.9 Mr B believed that from April 2019 things changed. He was most concerned about the head injury to Ben in early May 2019. Ben had been with him that weekend at his Mother's house. The next day Ms A informed him that Ben was in hospital. Mr B was angry and very worried about when he saw the injury to Ben's head and face. He felt that despite being the father he was not being given information. This outburst led to Ms A seeking to have Mr B removed from the hospital. A doctor then spoke with him and was reported to have said "these things can happen". Mr B felt that the injury was not being taken seriously. He believed that Social Care should have been involved and was not aware that the hospital had, in fact, referred their concern about the injury to Social Care. No professional contacted him after that.

5.10 He was able to see Ben for a few weekends after that but then things broke down between Mr B and Ms A in July and there was no more contact. Mr B did not feel that he could take the matter to court to have greater or more consistent access or even care of Ben as he believed that the courts place greater weight on children being with their mothers.

5.11 *This conversation with Mr B and his Mother shows a different picture to that given by Ms A. It was clear from evidence provided to the reviewer that Mr B and his Mother were frequently in contact with or had care of Ben. It raises questions about how services work with separated parents and with absent fathers; and how services form a view of fathers when the only informant is the mother.*

5.12 *Ben's Father and Grandmother agreed to use of the pseudonym "Ben".*

6. Analysis and lessons

6.1 A Reflective Workshop for as many practitioners and managers as possible who had been involved in the case was held online because of the Covid 19 Pandemic. The purpose was to capture the experience and reflections at the time of the work from a systemic perspective and to seek to avoid hindsight bias. The practitioners were asked to comment on the emerging lessons from the review identified by the Panel. Their responses are incorporated into the analysis and lessons below.

6.2 It is not the purpose of a Child Safeguarding Practice Review to assess whether the death of a child or significant harm was preventable. The Review's purpose is to use the case as an example of how well the local child welfare systems were or are working singly and together and whether there are any actions which should be taken to improve services and their delivery.

6.3 From mid-July to his death three months later it seems that no practitioner saw Ben. Questions are: whether he was being kept from view and/or whether Ms A may have been subject to coercive control? At this point we do not have evidence to answer these questions. They underline the potential vulnerability of young children who may be being harmed but who are not involved in pre-school activities and thus hidden from view unless drawn to attention by family or the community.

6.4 The review highlights lessons for local agencies, some of which are familiar and some not. It is easier to see these with hindsight and it would be unfair to judge practitioners and services by what was not apparent at the time, or which could not have reasonably been obtained. There were, however, missed opportunities to identify risks to Ben.

This section highlights the most important lessons from the review.

6.5 **Assessing head injuries in young children – the need for a multi-disciplinary response**

6.5.1 Ben's time in hospital in May 2019 is significant. Head injuries in children are potentially profoundly serious. The fact that there was no fracture or damage to his brain and that he made a quick and apparently good recovery may have lessened the concern about him. Thorough assessments were done as part of the medical diagnosis and appropriate advice was sought from specialists and from the hospital's lead professional advisors on child protection. After several assessments and observation over a few days a view was formed by the treating clinicians that the injury may have been accidental. However, there was still doubt about the cause of the injuries and the explanation given by his mother, which was plausible, but which had changed slightly over time. *(A third, different account was later given after Ben had been discharged from hospital.)* Given that it could not be established that the harm to Ben had been caused by an adult, on balance it was seen that the account that Ben had caused the injury himself by jumping could be possible, but there was still doubt. There also remained, however, the question of the possible lack of parental supervision and Ben's overactive behaviour, which was observed by hospital staff and also reported by family members.

Therefore, even if the injury had not been deliberate, the possibility of elements of neglect or behavioural and developmental issues being involved was still present.

6.5.2 A lesson which must be repeated is that diagnosis of non-accidental injury is complicated and needs to consider not only the medical aspects but also the wider circumstances; including the possibility of checking the environment of the alleged accident to confirm its mechanism.[12] It has been noted in previous enquiries that child protection investigating agencies often want the confirmation of a clear diagnosis of deliberate harm but that this is not always possible, and that the system must, therefore, work with uncertainty.

6.5.3 The lack of an immediate 'child protection' label about the cause of the injury meant that a **Strategy Meeting** was not considered as the threshold was not seen to be definitively met. Nor was a **Discharge Planning Meeting** convened. However, hospital staff still had serious concerns and further tests were to be undertaken by further monitoring and follow up x-rays and a skeletal survey, which is used rarely and usually only in serious cases. A Strategy Meeting or Discharge Planning Meeting would have enabled a greater sharing about what was known and the degree of uncertainty and concern that remained. A Strategy Meeting would also have led to Police involvement and screening and to more curiosity about the male who had been present in the home – probably Mr D.

6.5.4 It was noted as a systems dynamic that paediatricians are more likely to focus on the clinical issues of the injury and are less familiar with child protection procedures, such as Strategy Discussions, and that Strategy Discussions may not be happening locally as often as they should.

6.5.5 All extensive injuries to young children are worrying, and some will, of course, be accidents. However, head injuries may be particularly significant in younger children especially where there is doubt about their cause. It was appropriate for the hospital to refer Ben to Children's Social Care for a fuller assessment. However, the referral only raised questions about parenting and history rather than about unanswered questions about the injury, possible inconsistences in the account and possible other injuries to Ben. Further medical investigations were still to be undertaken to seek to explain the injury. This raises questions about how such referrals are quality assured and updated when further diagnostic work (for example additional tests) is planned after the referral to social care has already been sent in. Also, what is reasonable to expect in a busy Emergency Department or Children's Ward?

6.5.6 The Named Nurse continued to be seriously concerned about Ben and took the extra steps as outlined in 4.44.

[12] See **Abusive head trauma in infants,** BMJ, April 2018 & December 2020 Abusive head trauma in infants - Symptoms, diagnosis and treatment | BMJ Best Practice;
and **Child Abuse Review: Special Issue: Abusive Head Trauma: Recognition, Response and Prevention,** May – June 2020 https://onlinelibrary.wiley.com/doi/epdf/10.1002/car.2578; and
A National Child Safeguarding Practice Review Panel **Thematic review into non-accidental injury in children under one** is expected to be published in 2021.

6.5.7 Children's Social Care later overturned the decision to undertake a Child and Family Assessment seeing the hospital's concern as 'professional anxiety', rather than seeing it as a legitimate statement of professional concern about a child without being able to ascertain as fully as possible the cause of that concern, without the fuller assessment of the child's circumstances. The decision to close the referral did not take into account wider issues of the context of the injuries, even if they were being seen as consistent with an accident. The wider context included the nature of Ben's possible overactive behaviour, a new and unknown male partner in the household, and that Ben was not being seen by universal and pre-school services. Ben's behaviour seems to have been accepted rather than reflected upon. It raised questions about both his development and about parenting.

6.5.8 This review made an interim recommendation about the multi-agency assessment of head injuries to the Croydon Safeguarding Children Partnership and Croydon Children's Social Care:

Recommendation 1a: <u>Serious Injuries to Children</u> There should be serious consideration of routine progression to a Child and Family Assessment for any child with an injury where this is requested by Health professionals.

Recommendation 1b: When, after a serious unexplained injury, a child requires in-patient observation and/or a skeletal survey there should always be inter-agency dialogue about next steps. This would best be achieved through a multi-disciplinary Strategy Discussion.

It is important that there is dialogue between the key services (Health, Social Care and the Police) about whether a wider assessment is required and how that can best be undertaken. This is best done through a Strategy Discussion or other conversation rather than by solely written referrals. Then the medical assessments, further planned assessments and background enquiries can be fully considered and non-medical professionals can ask relevant questions of the medical assessors to support the multi-agency decision about the need for a child and family assessment.

6.6 A single agency overturning agreed multi-agency decisions; communicating decisions to referring agencies and ensuring representation and escalation where there is (possibility of) disagreement about whether to undertake a multi-agency assessment

6.6.1 Despite the initial agreement by the MASH to undertake an assessment this was later overturned, and the case was closed. This Review has been informed that the decision not to proceed was taken in a wider context of a bigger system view which had been formed within Social Care that too many referrals were being made by partner agencies which did not meet the threshold for assessments. Such referrals were often found to be unsuccessful as they did not have the consent or cooperation of the parents, who often declined assessment. This must also be seen in the context of Croydon Social Care improving following an Inspection in 2017 which had judged the authority as inadequate. In February 2019, just before this incident, improvements were being noted for most cases but there was still variability [13].

[13] https://files.ofsted.gov.uk/v1/file/50062794 Children's services OFSTED Monitoring Letter

6.6.2 The decision to close the referral in May 2019 was taken unilaterally without reference back to the referrer or to the Named Nurse who had advocated specially for the case. She is clear that had she known that the agreement had been overturned she would have made further representation and escalated her concerns about Ben. No other agency, such as Health Visiting or the GP was consulted about whether an assessment was required. Consulting the GP would have shown a pattern of non-engagement in universal health services.

6.6.3 To not inform the referrer of the change of decision and the case closure was not agreed practice. It was noted that this was a practice issue which had been highlighted previously in other local reviews. The Review Panel was advised that a recent changes introduced in Children's Social Care include work to ensure feedback to referrers.

6.6.4 **Recommendation 2: The Croydon Safeguarding Children Partnership should seek assurance from Services and through regular case audits that decisions not to proceed to a referral (for any issue) are communicated back to the referrer / referral agency in a timely way, with an explanation and an opportunity to question the decision not to accept the referral.**

6.7 The local operation of the National Healthy Child Programme, Universal Services monitoring of young children like Ben, ensuring that they do not get lost, the Threshold between universal services and the need for additional support and or Early Help; Use of the Croydon Thresholds Guidance

6.7.1 This review of Ben's life and wellbeing should be seen in the context of both his family-based care and the wider safety net of the universal services around him. Ben was a child for whom the **National Healthy Child Programme**[14] should have been both a support and a safety net. During the time of this review period, the Director of Public Health in Croydon published **The first 1000 days from conception to the age of 2** [15], this sets out the context and expectations for support of families with young babies and infants in Croydon. Ben also met the local threshold[16] for Early Help Services. All of these are services offered to families on a voluntary basis subject to family agreement and take up.

6.7.2 Ms A was a young and new single mother, separated from the child's father. She reported that she had allegedly experienced traumatic abuse as a young person, including historic domestic abuse in the family home; she also alleged serious sexual assault as a child. She was in temporary accommodation and was potentially isolated. She described low moods and a history of depression. Ms A became pregnant with Ben, unplanned – although he was said initially to be wanted, Ms A later said that she was unhappy about the pregnancy. As a result of the pregnancy, she felt that she had to step down from further education. No one appears to have talked with her about her feelings about giving up her course and what the potential loss of her ambitions meant.

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[14] **NHS, Healthy Child Programme,** http://www.healthychildprogramme.com/ date? 2014/15?

[15] **We are Croydon, Early Experiences Last a Life time, The first 1000 days from conception to the age of 2** http://croydonlcsb.org.uk/wp-content/uploads/2018/12/Director-of-Public-Health-report-2018-first-1000-days.pdf

[16] Croydon Safeguarding Children Board Thresholds Guidance. 2013 & 2017 http://croydonlcsb.org.uk/wp-content/uploads/2013/08/CSCB-Thresholds-Guidance-.pdf

6.7.3 The local delivery of the **National Healthy Child Programme** and the Croydon Early Help services were there to support her in becoming a (first-time) parent, as a vulnerable person. The systems were also there to monitor Ben's growth and development through routine screening services. This review suggests that these did not work as well as they might have done. It should be noted, however, that such services are voluntary and rely on parental cooperation and engagement. Questions arise, however, about how well the systems work when a family has been identified as vulnerable and in need of additional support but when parents do not engage – what should agency responses be?

6.7.4 It has been agreed that Ms A would have benefitted from a referral to the **Family Nurse Partnership**[17] which offers targeted support to young and vulnerable parents. This does not appear to have been considered by Midwifery and when the Health Visitor first became involved it was too late to refer Ms A.

6.7.5 **Midwifery, Health Visiting and other services supporting vulnerable pregnant women (especially those under) 19 may wish to consider reviewing how well practitioners are informed about The Family Nurse Partnership Service and how well it is used.**

6.8 Parenting education for new and inexperienced parents

6.8.1 A systems question arises: **How are new and possibly young parents supported by parenting education as they become first-time parents**? It seems that Ms A did not attend any antenatal classes – although it was usual practice to inform and invite prospective parents, including fathers. Records do not indicate if Ms A was invited to such parenting classes. Mr B said that he was not invited. Parenting education would, therefore, have been advice from Midwifery during limited antenatal contacts – where sessions often concentrate on the mother and developing baby's well-being and preparation for the birth rather than future parenting. Beyond this a soon-to-be parent is offered leaflets which are not a reliable education medium. Or the parent is left to their own devices, and the experiences, advice and teaching from family and friends or social media. Where does such a parent learn to parent, apart from her own experiences and in Ms A's case occasional care of her disabled younger brother?

6.8.2 **Recommendation 2: Public Health, with Midwifery, Health Visiting and other relevant services are recommended to undertake a review of the current strategy and practice response to parenting education for first time and young parents. This should include the use and efficacy of alternative approaches and best practice such as leaflets and online media, especially when a parent does not accept the offer of parenting classes. The review should include how fathers are included in parenting education.**

[17] **Family Nurse Partnership** Search | Croydon Health Services NHS Trust

6.8.3 **Early Help** Throughout the pregnancy and early in the postnatal period there were several occasions when practitioners noted concern for Ms A, and thus for unborn Ben and Ben after birth. The Midwifery Services, the Domestic Abuse Services of the Family Justice Centre and the Health Visiting Service all noted her vulnerability and that she may need additional support. At times she seemed to be coping or accepting of advice but she also expressed concern about her own low mood and depression (and history of depression and alleged adverse experiences when younger.) As such Ben and his mother met the criteria for Level 2 Early Help support under the agreed multi-agency Croydon Thresholds Guidance.[18]

6.8.4 Different practitioners offered help and advice directly or made referrals to other services (such as Housing, Perinatal Mental Health Services or Best Start Services[19]) but such multi-agency work appears to have been linear rather than a joined-up team approach making use of a **Team around the Child** and a **Lead Professional** [20]. This raises questions about how well the Team Around the Child approach worked in Croydon's Early Help system.

6.8.5 **Recommendation 3 The Croydon Safeguarding Children Partnership should review the wider operation of the arrangements for Early Help provision at Tier 2 of the agreed Threshold Guidance and test how well a Team Around the Child System is understood and is working in practice for vulnerable families. It may be useful to commission some case audits as part of this as well as undertaking a review of agencies' understanding and evaluation of the TAC system.**

6.8.6 The Midwifery Services were concerned about Ms A's emotional state on two separate occasions during pregnancy and referred her to the Perinatal Mental Health Services. This review has learned, however, that the Midwifery Service agrees that on neither occasion did Ms A actually meet the criteria for referral. However, a discussion about her in the in-house Midwifery Service **Vulnerable Women's Meeting**[21] may have been beneficial; for professionals to consider possible additional types of support. This was not considered at the time and would have required Ms A's consent.

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[18] Croydon Safeguarding Children Board Thresholds Guidance. 2013 & 2017 http://croydonlcsb.org.uk/wp-content/uploads/2013/08/CSCB-Thresholds-Guidance-.pdf

[19] The Best Start Social Work Team was an integrated team within the Best Start Partnership which provided social work interventions and support to children, young people and their families. The key objective of the service was to offer practical advice, support and direct case work to prevent issues escalating and requiring statutory intervention.

[20] ***Tier 2: Early help*** These are children with additional needs, who may be vulnerable and showing early signs of abuse and/or neglect; their needs are not clear, not known or not being met. *These children may be subject to adult focused care giving*. This is the threshold for a multi-agency early help assessment to begin. These are children who require a lead professional for a co-ordinated approach to the provision of additional services such as family support services, parenting programmes and children's centres. These will be provided within universal or targeted services provision and do not include services from children's social care.

[21] **The Vulnerable Women's Meeting** is a monthly multi-agency professionals' meeting for case discussion about pregnant women where there is a likelihood of a safeguarding concern or need for early supportive intervention (Early Help). It is not a direct service for women but an advisory service for professionals.

6.8.7 After Ben's birth, a Health Visitor assessed the need for additional help and agreed a higher level of support through the **Universal Partnership Plus** approach**.** There was good and persistent work by the Health Visitor to establish rapport and engage Ms A, but there was no agreed Lead Professional and no team around the child (TAC) approach. There was some communication between the Independent Domestic Abuse Advisor, the Best Start Teenage Pregnancy Worker and the Health Visitor but this was not a team approach and it is significant that the GP and Clinics were not included. When Ms A's first self-referral to the IAPT stalled there was no attempt by professionals to help her follow it up. Some of this appears to be because of Ms A's non-engagement and giving varying accounts about how she was feeling to different people. *This will be discussed below.* Some may also have been caused by organisational systemic factors, such as staffing and workloads.

6.8.8 The first Health Visitor worked hard to keep in contact with Ms A and establish a supportive relationship. However, circumstances intervened when Ms A and Ben were appropriately offered new temporary accommodation in a different area and had to transfer to a new GP Practice and to a new Health Visiting Team. This break in continuity is a well-known systemic problem and it can lead to disruption of good support and relationships with vulnerable parents and understanding of their history. Delay of transfer of GP records may have been an issue in this case, and this review has been told that this is a common systems issue.

6.8.9 The new Health Visiting Team did not work with Ms A in a similar enhanced way, although there is no evidence that the status of Universal Partnership Plus had been re-assessed or stepped down. There was no Health Visitor contact from December 2017 until after Ben's head injury in May 2019. This raises the question of how the Health Visiting Service monitors the delivery of the Universal Partnership Plus Programme locally and how families move into and formally out of it.

6.8.10 As the timeline has shown, Ben missed key immunisations and developmental checks to monitor his development. These were not monitored or followed up at the time. By the time that he came to attention with a head injury in May 2019, aged 20 months, there were questions about his behaviour and possible speech delay. Ms A appears to have withdrawn from active contact with services except when she perceived a need and so encouragement to support Ben through linking with a children's centre or other pre-school activity as part of supporting her as a parent and assisting Ben's development had not happened.

6.8.11 **Recommendation 4 : Croydon Public Health Services, with the Health Visiting Providers and Clinical Commissioning Group, acting for the Croydon Safeguarding Children Partnership, should consider the local specification and operation of the Universal Plus Health Visiting Offer under the commissioning contract to ensure that there is clarity about how vulnerable parents and children are monitored to prevent them dropping out of the Universal Plus System and ensuring that they are reviewed to assess if they should be considered for other services, including Early Help, or stepped up to children in need or child protection services if there is evidence of neglect.**

6.9 **Holding 'Was Not Brought' in mind as a possible indicator of neglect of children**

6.9.1 Over time a pattern of Ben not being seen or brought for appointments, checks or immunisations came to be noted. It is interesting to note that in Croydon these were often referred to as 'Did not Attend' rather than the newer agreed term of 'Was not Brought' to ensure that there is a focus on the adult responsibility to bring the vulnerable child and consider if there is a safeguarding need. The Croydon Health Services Trust advised this review that they now have in place a "Was Not Brought Policy" for children. This does not include GPs, however.

6.9.2 In mid-2019, after the head injury, the GP Surgery became increasingly concerned about Ben's missed immunisations and through an administrative process sought to follow these up by text, but to no effect. Ms A had contact by phone or in person in her own right several times in this period but there was no joined up **Think Family**[22] approach on those occasions to speak with her about Ben and his missed checks and immunisations. On one occasion she sought an appointment for him as his scrotum was swollen. She did not follow through with this but there was no follow up with her as to why.

6.9.3 Practitioners told this review that young parents often act in the "here and now" if they feel low. If they feel they have a problem they want help immediately and so may not respond to delayed appointments, and if they then feel better or do not still perceive the problem in the same way and they do not follow up.

6.9.4 Texts are convenient for services to send and they can perhaps be set up automatically, but they can easily be ignored by recipients. Has this become a system of convenience for agencies? What research has there been about their efficacy in health care provision to support patient engagement, especially when there is evidence of non-engagement?

6.9.5 **Declining immunisations.** A social care practitioner told this review that Ms A was reluctant to have Ben vaccinated because of what she had read on websites. She was advised to discuss this with her health visitor, but at that time she was no longer seeing a health visitor. She had, however, previously agreed to Ben being immunised and he had some of his early vaccinations. It does not appear to have been raised as a worry by Ms A with the first Health Visitor, with whom Ms A had a good relationship.

6.9.6 What is not clear in this case is why the issue of Ben not being brought for immunisations was not raised by the GP with the Health Visiting Service when Ms A continued to not respond to texts, and she did not take Ben back to the hospital after his head injury for a planned check.

6.9.7 This issue raises questions for strategy and practice. What advice is given to parents about this, and how is parental refusal recorded? Is there a point at which declining immunisations for children should be seen as possible neglect especially if accompanied by other examples of not bringing children for developmental or other forms of health care? How is refusal to vaccinate assessed by non-medical practitioners?

[22] **Think Family** – https://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp

6.9.8 The Croydon Public Health Service reported in 2019 to the Health and Social Care Subcommittee on the low take up of MMR immunisations in Croydon (contemporaneous to this case review) and the strategy being adopted to tackle this and to seek to achieve 95% take up[23].

6.9.9 **Recommendation 5a: The Croydon Safeguarding Children Partnership, with Public Health, should consider adopting the approach being taken in many other areas following the leadership of Nottingham Safeguarding Children Board's "Was Not Brought" Campaign and Video, which heightens the vulnerability of children and that not being brought to appointments is potentially a sign of neglect.[24]**

Recommendation 5b: The Clinical Commissioning Group should undertake a Review of current Did Not Attend / Was Not Brought policies for children to ensure that they recognise the vulnerability of young children and when to recognise and escalate concerns as possible symptoms of neglect.

Recommendation 5c: The Clinical Commissioning Group should review the guidance to GP Practices on linking Parent and Child records and childcare alerts – such as Was not Brought, child protection enquiries or concerns about possible domestic abuse to ensure that they are cross referenced in the records and the child's vulnerability is noted on the parent's record too.

6.10 **Keeping the child central The child's experience**

6.10.1 It has been hard to get a pen picture of Ben and his daily lived experience. This can be the case when young children are only minimally engaged in universal services. When he was seen as an infant by the first Health Visitor there was no concern about him physically or about his care or the relationship with his mother. From December 2017 to June 2018, he seems to have disappeared from view, no services saw him. The social work assessment from May to October 2018 following the concerns about domestic abuse noted Ben to be healthy but he seems to have been seen only once in that period and there is no picture of what his daily life was like. The main concern was possible exposure to domestic abuse and he was assessed as being protected from that by his mother's actions.

6.10.2 This review has noted from the feedback from practitioners that it is not expected practice to include pen pictures of children in agency records or build a picture of their daily life.

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[23] Immunisation Priorities in Croydon.pdf November 2019

[24] Nottingham Safeguarding Children Partnership **Was not Brought**
https://www.nottinghamshire.gov.uk/nscp/resources/for-professionals-and-volunteers
https://youtu.be/DPgw28DSgNA

6.10.3 When seen in May 2019, in response to the head injury, Ben was described as a very active child and there were concerns about his boisterousness, from wider family; also noted by hospital staff. His early two-year developmental check at one year and nine months suggested significant speech delay for his age. Although Ms A was given advice about this and how to link him to support there was no further assessment. The Health Visitor believed at the time that Social Care was undertaking an assessment (where any underlying concerns about causes for his behaviour and speech delay could have been explored further) but that assessment had been stopped. Ms A did not respond to the Health Visitor's further contacts.

6.10.4 This highlights the challenges in universal welfare and safeguarding systems that young children can go unnoticed unless there are specific worrying concerns which bring them to attention. They are sometimes seen briefly for occasional one-off contacts but, if parents do not engage in services or early years' provision, children with developmental needs may not come to attention until they start to attend nursery or school. On the few occasions when Ben was seen at home there were no grounds to think that he was being harmed or neglected. He was well provided for, appeared healthy and had toys, and Ms A appeared able to meet his needs.

6.10.5 In the few professional contacts that there were with Ben his ethnic identity was noted. Ms A was clear that she wished to have no contact with Ben's Father, but thought was being given to Ben's future need to possibly have contact with his father.

6.11 **Assessments, Engagement and non-Engagement, where parental consent is required**

6.11.1 Ms A was seen as an intelligent and able person. She was screened routinely antenatally and postnatally and was rightly identified as vulnerable. She was offered services to support her at the Early Help level with regard to domestic abuse and parenting support. However, she did not engage with the Best Start Early Help Services although she had agreed to do so. She also dropped out of domestic abuse support.

6.11.2 The first Health Visitor responded to Ms A's vulnerability with persistence and assertiveness to maintain contact and perhaps had the longest-term professional relationship with her. The contact was then broken by the move of locality (a systems issue). This demonstrates the value of relationship-based work but is not always possible for practitioners with large caseloads.

6.11.3 Ms A reported a traumatic history. In pregnancy and later she also reported low mood and that she was not coping, at times. At other times she reported that she was coping with support from family, friends and Ben's Father (although he was also alleged to have been abusive to her). Given the adverse childhood experiences that Ms A reported, research[25] suggests that there would possibly have been longer term impacts on her ability to cope as a parent. She was referred for talking therapy support twice in pregnancy but did not meet the threshold and no alternative provision was offered for her. Later she was again referred for talking therapy and was offered an assessment but did not follow this through.

6.11.4 At times Ms A appeared to be able to parent Ben well and initially he was developing well. Her vulnerability was noted, and she was offered services, but she did not engage. There were no grounds to require her to use services. At times she expressed a need for advice or a service and then did not follow up when appointments were offered. Her ability to cope was fragile. Adults who have been traumatised may require longer term services and relationship-based support to develop trust and to engage. The persistent approach of the first Health Visitor did appear to engage her. Practitioners may have to work hard to maintain links and engage with some parents but busy services with high caseloads are not set up for this and "Did not attend" or "Did not respond" policies and services which rely on self-referrals and commitment as evidence of motivation may lose touch with service users who are not emotionally well-integrated because of previous trauma and who may require more proactive encouragement and trust building.

6.11.5 A question in non-engagement which perhaps needs greater consideration is the possible impact of coercive control. Women who are subject to coercive control may want assistance but may be fearful of reactions from an abusive partner if they take up a service or may be fearful of threats that a child will be removed or may be prevented from accessing services. Ms A was advised as part of the Child and family Assessment in 2018 that if there were further examples of domestic abuse child safeguarding measures would be considered. The fear of such safeguarding procedures may be a disincentive to parents to come forward when they need help or protection as they believe children will be removed. Telling the police in July 2019 that Mr D had in fact assaulted her, as had been alleged, may have been more worrying for her than his abuse.

6.11.6 A health practitioner noted that it is not uncommon for mothers to withhold the identity of fathers or partners from professional agencies. Unless there are grounds for child protection or criminal investigation this has to be accepted or negotiated with.

6.12 Assessing the risk of domestic abuse and supporting women who have experienced domestic abuse

[25] **Adverse Childhood Experiences** For a helpful introduction and signpost to current research about the possible impact of adverse childhood experiences and the pros and cons of ACEs as a tool in assessments and intervention in work to support those affected see Children and Young People Now Special Report September 2020 Adverse Childhood Experiences: Special Report | CYP Now

6.12.1 Ms A made several allegations of abusive experiences from her family and from Ben's Father. These were taken seriously, and she was offered support by the Croydon Family Justice Service and referred to MARAC on two occasions. She later withdrew from domestic abuse support services. She denied to the Police that Mr D had been physically abusive.

6.12.2 It would have been expected that she would have been asked about possible domestic abuse at her Midwifery Booking appointment – this is known as **Routine Enquiry**. There is no record of this having been asked. Practitioners told this review that there was no system for recording why a woman has not been asked and that a note may have been made in the hand-held records. This would be surprising as making such a note in hand-held records may place a woman at greater risk if an abusive partner were to access the patient-held notes. Policy expects that if a woman is not asked at the first appointment, then this should be followed up in a later appointment, but no evidence has been found that this was done. The Health Visitor did ask at the New Birth Visit and was told by Ms A that there had been no domestic abuse; this was not the case. A recent (2020) review of this Routine Enquiry policy in the Trust suggests that compliance may be as low as 5%.

6.12.3 **Recommendation 6: The Croydon Health Services NHS Trust and its commissioners and the Clinical Commissioning Group should review the Routine Enquiry Policy, and how the Trust supports and monitors the competence and confidence of Midwives and Health Visitors in managing this; and provide evidence to the Croydon Safeguarding Children Partnership that the system is working effectively.**

6.12.4 Following a witnessed assault by Ben's Father in April 2018 Ms A alleged that she was subject to verbal abuse and to his coercive and controlling behaviour. Ms A did not wish to press charges or seek a non-molestation order because she was, she said, too fearful of him. Police reported that Ms A, did not wish to complete a risk assessment[26] and withdrew her statement. Later she did not continue with support offered by the Family Justice Service. The case was discussed, appropriately, at MARAC and relevant professionals were advised of the incident. Children's Social Care undertook a Child and Family Assessment following this incident and found a more confusing picture of the incident. Ben was found not to have been harmed and to be developing well. Both parents were advised of the risk to children from domestic abuse and that if this were to be repeated safeguarding procedures may be used. Ms A reported being torn between allowing Ben to have contact with his father and risking domestic abuse. No further incidents between them were reported.

6.12.5 A question for practice raised by this case is how to work with women who are subject to abuse and particularly if the abuse includes coercive control. They may be fearful for themselves and therefore reluctant to engage with services for fear of further abuse from their partner or ex-partner. Related to this question is how to work with the male partners. Contact was made with Ben's Father and he was given advice. As this was an assessment and no service was working with Ms A in the longer term at that time there was not an opportunity to work with Ms A in more depth about dynamics of domestic abuse and implications for future relationships. She disengaged from the Family Justice Service.

[26] SafeLives DASH Risk Assessment [Dash without guidance.pdf (safelives.org.uk)]

6.12.6 Mr D was under the supervision of the Probation Service which enquired of Croydon Children's Social Care and Lambeth Children's Social Care about any possible connection he may have to children in their areas. This information sharing and assessment system worked effectively in Croydon, in that Croydon Social Care checked their records for the address given (not Ms A's) and found no record of any children who could be at risk at that address. The parallel request to Lambeth received no response. Lambeth Social Care has advised this review that they can find no trace of the request. (This does not mean that it was not sent but may raise system issues about risk of requests for information not getting to the right service or not being picked up by partner agencies). It is unfortunate that the Probation Service did not follow up the lack of response to their information request to Lambeth Social Care, as he was still seeing his own child who was resident there.

6.12.7 In May 2019, when Ben sustained his head injury it was noted, by the Ambulance Service, that a male was in the household. We cannot be sure that this was Mr D as his identity was not established at the time. Ms A's statement that this man was "in the kitchen" at the time when Ben was said to have jumped from the sofa was accepted. As there was no immediate and conclusive evidence that Ben's head injury was non-accidental at the time there was no follow up to ascertain who this man was. If it was Mr D his presence was worrying. As noted above, had there been a Strategy Discussion his identity would probably have been ascertained and given his history was likely to have led to a new Child and Family Assessment. Given his assessed level of potential violence a question which should have been asked, easier now with hindsight than for practitioners at the time, was: "Is Mr D exerting control over Ms A?". This raises a question about how practitioners keep this in mind as a possibility even if there is no immediate report of domestic abuse. A woman who does not feel safe is unlikely to report this for fear of the consequences.

6.12.8 In July 2019, Police were called to the home by a community member alleging domestic abuse by Mr D against Ms A. This is the first time that Mr D was confirmed to be in a relationship with Ms A. His child from another relationship and Ben were both present. The Police Officers attending had no concerns about the children. Ms A denied that there had been any domestic abuse. Although a check was undertaken by the Police it was noted that there had been no previous record of concern about Mr D and Ms A as a couple. A routine notification was not therefore sent to the relevant Children's Services for either child, as it should have been. This was a procedural error and a missed opportunity and has been assessed to have been related to a single officer's understanding rather than a whole systems issue, as appropriate systems were in place but not followed.

6.12.9 In late August 2019, Mr D told his Probation Officer that he was in a new relationship, given his history there should have been a more rigorous safeguarding enquiry about this to establish who the partner was and if there were children present.

6.13 Conclusions

6.13.1 Ms A's vulnerability from both her personal history and to alleged domestic abuse was recognised and she was offered services to support her in the early period. However, for reasons which are not fully clear she did not engage with services or dropped out, which was her right. There were no grounds for mandatory intervention.

6.13.2 When alleged domestic abuse came to light this led to appropriate responses from the Family Justice Centre, Ms A was given good advice and offered support, but she did not continue with this.

6.13.3 The recognition by the first Health Visitor that Ms A was vulnerable and required a Universal Plus pathway was good and there was good and persistent work to engage with Ms A as a young mother. A systems dynamic of a move of temporary housing, which was an improvement for Ms A and Ben, meant that the continuity of health visiting was broken. Although assessed as needing an enhanced service this was not followed up by the second health visiting team, which it is understood had staffing difficulties and pressures at the time.

6.13.4 The Child and Family Assessment in 2018, following alleged domestic abuse concluded that a child in need service was not required. It is not clear if consideration was given to steering Ms A to Early Help services again and, given Ben's age at the time, signposting him to Early Years provision which would have supported his development. When an assessment decides that a child in need service is not required it is important that consideration is given to considering if an Early Help Service may be useful.

6.13.5 The clinical assessments into Ben's head injury in May 2019 were rigorous and considered the possibility of non-accidental injury but on balance made a judgement that the injuries were probably accidental; but concerns remained. This raises a question about the point at which a child protection strategy discussion with other key agencies should be considered and whether this should be during the clinical assessment or at the end of the clinical assessment. The referral from the hospital requesting a social care assessment was lacking in depth about the uncertainty that still remained about the cause of Ben's injuries. The identity of the male in the household was not established and without being in a formal multi-agency safeguarding framework there was no possibility to complete checks on him that would have revealed a worrying background. These are difficult practice judgement calls which clinicians make all the time and it is clear from this review that the clinicians explored the injuries carefully and also sought specialist advice. It is not practical to say that every consideration of a head injury in a child must result in a Strategy Discussion as many will be accidents but where there are doubts about cause the value of a multi-disciplinary discussion should be considered.

6.13.6 The decision by Children's Social Care to overturn the previous decision to undertake an Assessment was made in a bigger systems context of the high incidence of referrals being made to social care which were unsuccessful because parents were not fully engaged, had not given consent and there was not a clear threshold for child protection. The safeguarding system was slowly emerging from being "inadequate" and was more crisis-led and thus seeking to accept only the highest priority referrals. To close the case without informing the hospital was a mistake as this would have led to further dialogue about the hospital's concerns.

6.13.7 The police call out in July 2019 when Mr D was identified was not shared with Children's Services, as it should have been, and given information about Mr D would probably have led to a Child and Family Assessment. This would have identified potential risk to Ben.

7. Recommendations

Recommendation 1a: Serious Injuries to Children There should be serious consideration of routine progression to a Child and Family Assessment for any child with an injury where this is requested by Health professionals.

Recommendation 1b: When, after a serious unexplained injury, a child requires in-patient observation and/or a skeletal survey there should always be inter-agency dialogue about next steps. This would best be achieved through a multi-disciplinary Strategy Discussion.

Recommendation 2 The Croydon Safeguarding Children Partnership should seek assurance from Services and through regular case audits that decisions not to proceed to a referral (for any issue) are communicated back to the referrer / referral agency in a timely way, with an explanation and an opportunity to question the decision not to accept the referral**.**

Recommendation 3 The Croydon Safeguarding Children Partnership should review the wider operation of the arrangements for Early Help provision at Tier 2 of the agreed Threshold Guidance and test how well a Team Around the Child System is understood and is working in practice for vulnerable families. It may be useful to commission some case audits as part of this as well as undertaking a review of agencies understanding and evaluation of the TAC system.

Recommendation 4 Croydon Public Health Services, with the Health Visiting Providers and Clinical Commissioning Group, acting for the Croydon Safeguarding Children Partnership, should consider the local specification and operation of the Universal Plus Health Visiting Offer under the commissioning contract to ensure that there is clarity about how vulnerable parents and children are monitored to prevent them dropping out of the Universal Plus System and ensuring that they are reviewed to assess if they should be considered for other services, including Early Help, or stepped up to children in need or child protection services if there is evidence of neglect.

Recommendation 5a The Croydon Safeguarding Children Partnership, with Public Health, should consider adopting the approach being taken in many other areas following the leadership of Nottingham Safeguarding Children Board's "Was Not Brought" Campaign and Video, which heightens the vulnerability of children and that not being brought to appointments is potentially a sign of neglect.[27]

Recommendation 5b The Clinical Commissioning Group should undertake a Review of current Did Not Attend / Was Not Brought policies for children to ensure that they recognise the vulnerability of young children and when to recognise and escalate concerns as possible symptoms of neglect.

Recommendation 5c The Clinical Commissioning Group should review the guidance to GP Practices on linking Parent and Child records and childcare alerts – such as Was not Brought, child protection enquiries or concerns about possible domestic abuse to ensure that they are cross referenced in the records and the child's vulnerability is noted on the parent's record too.

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[27] Nottingham Safeguarding Children Partnership **Was not Brought**
https://www.nottinghamshire.gov.uk/nscp/resources/for-professionals-and-volunteers
https://youtu.be/DPgw28DSgNA

Recommendation 6 The Croydon Health Services NHS Trust and its commissioners and Clinical Commissioning Group should review the Routine Enquiry Policy, and how the Trust supports and monitors the competence and confidence of Midwives and Health Visitors in managing this; and provide evidence to the Croydon Safeguarding Children Partnership that the system is working effectively.

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