South Gloucestershire Children Partnership & Bath & Northeast Somerset Safety and Safeguarding Partnership

Local Child Safeguarding Practice Review

Baby M:

Unexplained Non-Accidental Injury in children under 1 year

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South Gloucestershire CHILDREN'S PARTNERSHIP

Contents

Executive Summary

This LCSPR considers Baby M, who suffered serious and significant injuries at age 3 months thought to be non-accidental. There are three key areas of focus:
1. Identifying & responding to the vulnerability of babies
2. Keeping a focus on the child when there are moves between areas
3. Critical thinking in practice

Analysis of these areas is given through sections 4-6 of this report and leads to the following recommendations with actions starting at page 22 of the report as follows:

1. Health Recording Systems include a holistic assessment of a child's needs which includes contextual maternal and paternal family factors
2. The ICON Programme & increasing awareness of Non-Accidental Injury in Babies
3. Effective Transfer of Information between areas and services
4. Safeguarding Supervision arrangements for community health professionals which ensures there is a safe space for critical thinking in practice, promotes professional curiosity, and is trauma informed approach to the family's needs when working with pre and post birth situations.

Introduction

1.Reason for this Local Child Safeguarding Practice Review

The reason for this Local Child Safeguarding Practice Review (LCSPR) is to consider Baby M, a three-month-old baby who experienced serious and significant injuries, thought likely to be to be non-accidental[1]. According to National data[2], babies under the age of one have consistently been the largest category of serious incidents notified to the National Panel[3]. In 2021, 32% of incidents of non-fatal physical abuse involved children younger than a year old. Following a Rapid Review in July 2022 and in consultation with the National Panel, South Gloucestershire Children's Partnership (SGCP) and Bath and North East Somerset Children's Partnership (B&NES) jointly agreed the criteria for a local review was met[4]. The purpose of the joint arrangement was to understand the moves between geographical locations pre and post birth and the implications for both Partnerships in terms of practice and system learning.

1.2 What We Did

This Review examines likely non-accidental injuries to a child under 1 years of age. Non-accidental injuries are a serious form of physical abuse and can be life changing with significant long-term disabilities or death. This type of abuse may arise from shaking babies (which is often referred to as abusive head trauma, AHT) or from impact injuries. Such non accidental injuries can often happen when a parent becomes angry or frustrated because of a child's crying[5].

The Review Group analysed a ten-month timeframe from July 2021 (Baby M's 7-week booking in appointment with midwifery services) until May 2022 (presentation at hospital). This covers a 7-month period pre-birth and 3 months following birth. There has been a critical eye on what historical contextual factors were known by agencies about Baby M's parents prior to this time period and what attention they were given. The aim being to better understand how decisions were reached and why certain actions were or were not taken.

The Review considered all the identified key lines of enquiry from the Rapid Review which can be summarised as:

- Understanding how professionals assessed risk pre and post birth, paying attention to what was known about parental contextual factors and when suspected parental or wider family behaviours of concern were raised
- Analysing professional understanding of what life was like for Baby M when his mother, Ms M, moved between geographical areas
- Consideration of how the learning from two previous South Gloucestershire Serious Case Reviews 'Toby' and 'Babies E&F' have been embedded in practice and systems

1.3 Aim & Methodology

The purpose of this Review is to understand the events leading up to Baby M's injuries by analysing decision and actions within the organisational systems in which professionals work, day to day. Through a systems methodology the review consisted of three phases:

- Data gathering and the development of a reconstruction (without the benefit of hindsight) of what was knowable at the time through written records, data, policies, and procedures.

[1] Non-accidental injury (NAI) is defined as "*any abuse inflicted on a person or knowingly not prevented by a care giver where the injury is not consistent with the account of its occurrence"* Rizwan, M et al 2017in International Journal of Integrated Care
[2] Child Safeguarding Practice Review Panel Annual Report 2021 November 2022 HMO: Gov
[3] The Child Safeguarding Practice Review Panel is an independent panel commissioning reviews of serious child safeguarding cases. They want national and local reviews to focus on improving learning, professional practice, and outcomes for children
[4] Child safeguarding Practice Review Panel guidance for safeguarding partners September 2022 HMO: Gov
[5] NSPCC Core Information: Head and spinal injuries in children May 2014

- Appraisal of practice and explanation for why decisions were or were not taken via a practitioner workshop and meetings with the review panel to agree and appraise key practice episodes. Quotes from practitioners who worked with Baby M and parents are used so as to highlight typical experiences in day-to-day practice
- Involvement with family members, being mindful of the police investigation, with regular meetings with the Senior Investigating Officer

This Review does not address the question of how Baby M sustained the serious injuries as there are separate parallel processes in place to determine this and make decisions about the child's future care arrangements. The Review focuses upon how agencies understood the risks and how they worked together and with the family. This Review provides reflections against previous local reviews in South Gloucestershire[6] and national learning[7]. The LCSPR attempts to understand the rationale for strengths and shortcomings seen in practice and considers in the recommendations what additional support is required in individual systems and across South Gloucestershire and B&NES Partnerships to reduce the chance of a similar situation happening. The findings and recommendations for practice and system change were agreed with both Partnerships.

The Review finds the majority of direct work with the family was undertaken by a housing provider to the mother, Ms M and Health Services (Midwife Services, Hospital, GP, and B&NES Health Visiting Services postnatally). There was a limited role and input by Children's Social Care and Police until the injuries were known. The review process involved working with this range of multi-agency professionals. It included those practitioners who knew the family well, managers who provided supervision and senior managers responsible for the services provided so as to best understand Baby M's day to day experiences and responses to identified needs.

This Review appreciates the considerable time and efforts by all agencies involved in preparing written evidence and chronologies and thanks all who contributed. The openness and honesty shared by all professionals working with the family has been invaluable - their ability to look back and reflect on what could have been done differently and what went well lies at the heart of this Report. This has not been easy, because finding out that a baby you have worked with has been significantly harmed is difficult work with a range of emotions felt; the professionals involved in this review have demonstrated a collective commitment and bravery to consider how to strengthen systems and practice in their local areas when working with parents pre-and post-birth when parental vulnerabilities are known.

2.Baby M & Family

In order to maintain a level of protection and privacy for Baby M and their birth family, a limited story is provided. This section provides a factual account of what happened pre and post birth during the 10-month timeframe.

2.1The voice of Baby M's family: The contributions of the family have been sought for this LCSPR to aid system thinking. The maternal family have decided not to participate, likely due to other parallel processes being underway at the same time as this LCSPR.

Mr M has shared his views with the Independent Reviewer as part of this process. This has been helpful to better understand what may have helped or hindered multi-agency practice and the Reviewer is grateful for Mr M's time and reflections. Mr M spoke of his hopes as a 1st time father to Baby M as "*wanting to do the best I could as a dad because I did not have the best start or upbringing in childhood. I wanted it to be different*".
Mr M has shared great honesty in explaining how he thinks he could have reached out to professionals and asked for more help as a new father, but he worried about doing so given

[6] Serious Case Review: Baby E and F 2019
[7] The Myth of Invisible Men: safeguarding children under 1 from non-accidental injury caused by male carers, The Child Safeguarding Practice Review Panel September 2021 HMO: Gov

his own childhood experiences. Mr M's biggest fear was that Baby M would end being taken from him and placed in the care system as he was. Mr M said the main issues centred upon conflict and arguments between Mr & Ms M and not having the right support to manage the stresses of becoming new parents, managing disagreements, and working through the range of emotions felt. Despite having some extended family support Mr M said he would have welcomed help regarding ensuring healthy adult relationships and navigating safe ways through when things became difficult. Mr M does not remember any professional who saw the extent of the relationship difficulties or discussed this aspect with him.

Mr M reflected upon what could have helped him which included:

- Checking out why young people might withdraw from support and services as a care experienced young adult – in this situation Mr M explained how he had not had the best experiences when in care, and the main barrier being a frequent change in workers which made it difficult to feel it was worth investing in relationships. He did not believe it would be any different as a young adult.
- Ensuring clear communication regarding the change in personal advisors as Mr M was confused as to who his personal advisor was and how to contact them.
- Practical help and support for new parents as Mr M found it hard to budget in times of financial hardships, especially when buying nappies and milk and specific items for Baby M.

2.2 Summary of what happened

Baby M and Ms M did not have a settled place to call home during the ante-natal and post-natal period. Baby M's maternal family originate and live in the South Gloucestershire area and the paternal family reside in B&NES. As a growing unborn baby, Baby M lived in South Gloucestershire initially temporarily in a hostel and briefly in supported housing, before going to live with Mr M and family in B&NES just before birth. This was a critical time to move areas as it resulted in a change in health visiting services from South Gloucestershire to B&NES, with all postnatal care to Baby M and family being provided by B&NES (HRCG). Following a hospital birth, Baby M was discharged back to live with both parents in B&NES to the extended paternal family home. Due to "*difficulties"* Mr M & Ms M's relationship ended in April 2022 and Ms M, was provided with a different supported home by the same housing provider back in South Gloucestershire. Baby M had been living in the paternal family home in B&NES in May 2022 at the time of the "*floppy*" episode which required hospitalisation, where likely non-accidental injuries were found.

Very little is known regarding mother, Ms M's childhood and early adult experiences living in South Gloucestershire; there are general comments seen for this LCSPR such as "*she lived in a close and supportive family*". Housing information shows that at the 8-week booking in appointment in July 2021 Ms M was living in a hostel in South Gloucestershire. Ms M self-referred via the Housing Access Team for accommodation and said this was needed as a result of family breakdowns, aged 22 years. Ms M moved to a different supported housing provision in South Gloucestershire from December 2021. There is limited professional exploration of what happened to Ms M and why supported housing was needed in all documentation analysed for this Review. The need for a more enquiring stance is a theme which is considered throughout this LCSPR (see Key Learning 3).

Baby M's father Mr M is a care experienced young adult, who upon reaching adulthood returned to live with members of his extended family. His care status was known by some professionals, namely midwifery and not by others, such as both Health Visiting services and GP Practice in B&NES and the housing provider in South Gloucestershire. In B&NES the current GP Practice (as in line with good practice guidance) is to not record care leaver status via the recording system codes unless permission is given by the young person. The GP

practice expectation, which is currently being strengthened in B&NES[8] (see Recommendation 1) is that through conversations between the person who is care experienced and the GP, the context, impact of any care experience and decision about how this record is made. A code may or may not be then added to the GP records based upon informed consent with the adult who is a patient and who is care experienced. Leaving care support and services were provided as in line with statutory duties in B&NES[9].

Baby M's paternal family history in B&NES is well documented in Children's Social Care electronic records with evidence of extensive historical adverse childhood experiences. Despite information being readily available on children's social care systems, the Review finds the care experiences were not understood in any detail by any service or professional working with Baby M. The Review Group discussions have centred upon the importance of ensuring a joined-up approach when working together, especially when key parental information becomes available. In this situation Children's Social Care and Health Services needed to have had discussions at key points in Baby's M story regarding Mr M's childhood and care experiences and assess the impact of his experiences, if any, upon his parenting. There has been debate seen as to which agency should have ensured these conversations were held once Mr M's care leaver status was identified, as Children's Social Care held extensive information, but this was not joined up with its own systems and Midwifery became aware of basic information at the booking in appointment. This reminds of the importance of checking out further information once some basic information is known so as understand a fuller picture and determine what this might mean in terms of risk or resilience factors and is explored further in Key Learning 1. The Care Leavers Service became involved in multi-agency work once the rapid review process[10] began.

Piecing together a picture of what day to day life was like for Baby M during the 1st three months has been difficult as the information seen as part of this process has often lacked detail to understand the narrative of Baby M's lived experiences. It has taken time to clearly establish from health professionals a simple timeline of where Baby M lived, and it is apparent that this story was not factually held by any one professional until pulled together by this LCSPR. This shows evidence that health agencies assumed Ms M was providing the day-to-day care for Baby M and once this assumption was made, it was not checked further as to where Baby M was living or who was caring for him. This Review finds this was not the likely reality from factual evidence gathered, as despite what records show, it seems more likely from practice discussions that Baby M lived for most of his first three months of life in B&NES with his paternal family.
The long-term impact of Baby M's injuries remains unknown; there are likely lifelong health implications as a result of the injuries sustained.

3. What we Found

To all initial appearances during the antenatal and postnatal period, a professional picture was seen of Baby M progressing as expected in his parents' care, with no obvious safeguarding concerns identified. The recorded evidence is clear that Baby M's physical health care needs were being met with Ms M and Mr M are described as providing "*loving care*". Such observations and records are not disputed.

Assessing risk is extremely complex work and requires making judgements on the likelihood of harms, when in this situation a wider contextual history is not fully known and understood

[8] B&NES GP & Practice Staff resource Pack July 2022

[9] See Children (Leaving Care) Act 2000 www.legislation.gov.uk

[10] A rapid review is a multi-agency meeting that is undertaken in response to a serious and significant child safeguarding incident and needs to happen with 15 days of being notified as a serious incident occurrence.

by health agencies during pre and post birth times. It requires time to probe further with families; to find out more information when there are gaps seen and time to read historical information held on systems. Alongside this, there needs to be a reflective space available to stop and think, with dedicated supervision sessions for busy professionals to consider all the domains of a child's life. Much documented research and previous local and national reviews[11] show how risk can change very quickly and with dire consequences, especially for very little babies.

This Review provides a salutary practice and system reminder of the impact of working in health systems which focus upon the need to complete essential tasks, such as taking blood pressure, testing urine, evaluating, and recording medical history. This can mean there is limited professional capacity to have sufficient opportunities to also ensure a relational approach which focuses upon considering the wider risk factors than a child's physical health needs alone when working with families. Such systems operate at the detriment of building meaningful connections with families. This is further compounded when there are added complexities then faced by busy professionals, such as when families move between areas. In such systems when on "*the face of things*" all appears well for very little children, no further questioning is undertaken, and a fixed view can be adopted. Of course, it is unrealistic to think all risks will be known in every situation and in some situations, risk cannot be predicted – working within these levels of complexity and system priorities is the harsh reality faced by health professionals in their day-to-day practice with families.
What is required is professionals who are well supported in the systems in which they work to ensure they are enabled to adopt a probing lens. Such inquisitive, open-minded practice should ensure a holistic picture of day-to-day life is obtained. This is needed when working with very little children in particular, due to their innate vulnerabilities, which ensures parental needs, including their own histories are understood and supported and wider family context is considered to safeguard all babies effectively. If a full a picture as possible is known of a baby's day to day life, along with their wider family systems, this increases the chances of risks being managed, with multi-agency actions taken to keep children safe and support provided to their parents during this time.

The purpose of any Child Safeguarding Practice Review is to identify improvements that need to be made locally and nationally to safeguard, promote the welfare of children and to seek to prevent or reduce the risk of recurrence of similar incidents occurring[12]. This section provides a summary of findings which centre upon three key practice and system areas.

3.1 In summary the findings are - <u>Identifying and responding to the vulnerability of babies:</u>
Health services were task focused on Baby M's physical health needs and this was not balanced sufficiently with ensuring relationship-based approaches to build a connection with parents.

- As the focus was on the general physical health and development of Baby M, insufficient attention was given to understand the parents' contextual history to gain a comprehensive picture of need.
- Mr M attended some meetings and appointments: this work could have been strengthened to understand his needs as a 1st time father and what support he needed.
- Father's contextual family history in particular needed joining up with other parts of the professional network so as to understand risk and resilience factors.
- Health systems did not support effective working for busy NICU staff, midwives, GPs, and health visitors.

[11] National Review into the murders of Arthur Labinjo-Hughes and Star Hobson, The Child Safeguarding Practice Review Panel 2022 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf

[12] Child Safeguarding Practice Review Panel Guidance September 2022 www.gov.uk

- Limited conversations were held by health professionals with parents to understand their relationship, despite concerns being seen in hospital. Parental mental health needs remained unassessed.
- Concerns regarding the paternal family's language and behaviours seen in different parts of the safeguarding system were not joined up effectively for Baby M.
- As a result of different pieces of information being seen in isolation, the levels of intervention were set at too low a level as all assessments of parental abilities were typically made on one-off agency observations and not within a multi-agency context.
- This meant statutory partner agencies (Early Help Services/Children's Social Care) did not work with the family to share information, assess parenting capacity, identify any likely risks, and provide parents with support.
- There has been some impact from 2 previous local reviews in South Gloucestershire seen around ICON messages, but further work is required.

Keeping a focus on the child when there are moves between geographical area:

- Information was not clear about where Baby M lived before or after birth and this meant a picture of his day-to-day life was not known.
- No one professional had a grip of who the main carer was for Baby M and assumptions were made likely based upon stereotypical views on parenting roles.
- Child Health Records were the primary point of contact to understand moves. The transfer of information between health systems when Baby M moved local areas was reliant on the family/Ms M informing of the moves.
- Typically, agencies were reliant on Baby M's parent informing them of moves.
- The focus on the baby got lost, and at times Baby M was hidden in plain sight as assumptions were made that he was living with Ms M despite not being seen by the Housing Provider.
- Information sharing was too variable between areas and health services and with housing providers and more collaborative approaches were required.

Critical Thinking in Practice

- Health professionals did not ask sufficiently probing questions to understand the families' contextual histories, with current parental needs and unsettled living arrangements pre and post birth in terms of impact on Baby M.
- Health visiting record keeping was poor at times, with limited detail seen to provide any story or purpose to the intervention.
- The language used at times was factually incorrect / or did not distinguish fact from opinion and was not specific enough to describe what was being seen.

3.1 Impact of Previous Local Learning: South Gloucestershire

This LCSPR has analysed the impact on practice and systems of 2 local learning reviews undertaken in South Gloucestershire[13]. South Gloucestershire health colleagues are able to demonstrate how messaging around AHT and strategies given to parents via the ICON[14] programme are beginning to show traction in practice as this was shared by various health practitioners at the Learning Event. The action plans for both local reviews need aligning with this review to ensure messages are cascading across the wider safeguarding network as housing colleagues in South Gloucestershire had not heard of ICON or the messages from either local review.

This LCSPR does not make any connected learning with South Gloucestershire Health Visiting Services in relation to previous local reviews as Baby M moved areas just prior to birth and therefore no direct practice undertaken by this service.

[13] Serious Case Review Toby, Serious Case Review: Baby E and F 2019

[14] The ICON Programme is aimed at helping parents and carers with young babies to cope with infant crying

This LCSPR finds some parallels with the SCR Toby around how systems are designed; how well different parts of community and hospital health services work effectively with each other and share information. Key Findings 1 & 2 in Toby's Review are mirrored in this LCSPR which show maternity services being task focused on maternal and baby health which resulted in a holistic view not being taken, along with children's vulnerabilities not being properly understood or responded to due to ineffective collaboration between hospitals, community midwives and health visitors. This Review also concurs with the following statement in Toby's Serious Care Review (June 2020):

"*At the heart of this case lies the difficulty for professionals of working in a fragmented maternal and child health system that has limited capacity to provide the opportunity to assess and understand…. different elements of information tend to be seen in isolation rather than being collated to form part of a jigsaw that might lead to a holistic assessment and analysis of parenting capacity and need*"

The action plan for SCR Toby and Babies E&F demonstrate that progress has now been made, however this has been slow and requires SGCP to ensure continued tracking of actions to ensure impact is seen for children. The delay in progress has been impacted by changes in personnel and the impact of Covid-19. A standard operating procedure has been developed to improve and assure on the quality of communication and information sharing between midwifery and health visiting. The original iteration was complete, however following this review, it was identified that primary care inclusion needed to be explored with health partners to triangulate information sharing. The completion of the action has therefore been delayed. The use of ICON messaging has been rolled out across health colleagues, and there is evidence that is being used however this needs to be further embedded across partner organisations. An event to begin this work is scheduled for April 2023.

Analysis, with Learning for Practice & Systems

This section considers system and practice learning arising from the three main finding areas. The details of the agency support are not provided at length, but rather specific practice episodes are analysed so that learning points can be highlighted, along with a rationale and analysis of the practice barriers found in individual agency systems and across partnership working.

4.1 Key Learning 1: Recognising and Responding to the Vulnerability of Babies

This section highlights the key system need to ensure all professionals working with very young children feel confident, skilled, supported, and have effective systems in place to assist them to recognise and respond effectively to ensure all babies safety and range of needs are met.

4.2 Pre and Post Birth Levels of Need

The Review Group and those attending the Practitioner Event considered why the levels of support to Baby M were consistently set via the Healthy Child Programme at a universal level of need[15] with no consideration at any point to involve other partners such as children's social care via early help pathways or statutory assessment and services. The multi-agency policies and procedures[16] which are embedded in all partnerships across the country to provide unborn babies with protection were not seen to be needed in this situation as no health professionals involved during the antenatal period saw any warning signs or significant risk indicators; in their view there was nothing unusual about the pregnancy or the presentation of either parent recorded.

[15] A Guide to Thresholds in B&NES (2022) https://bcssp.bathnes.gov.uk/sites/default/files/2023-01/thresholdsinBaNES.pdf , South Gloucestershire Children's Partnership The right help, in the right way, at the right time (2021)
[16]. https://bcssp.bathnes.gov.uk/sites/default/files/2020-09/pre-birth_protocol.pdf

This Review finds it would have been helpful to have recognised, collated, and interpreted the contextual family history and assess parenting vulnerabilities further to inform the levels of support required as they were first time, young parents, with some level of housing need, with significant paternal adverse childhood experiences including care experience. This could have been undertaken during the pre-birth period to inform practice direction likely through early help pathways or via statutory children's social care assessments[17] or at key times following birth, where concerns were raised. The reasons as to what got in the way to providing a more effective enquiring lens are further considered in Key Learning 3.

One practitioner who knew Mr M well reflected *"I think there were a number of indicators that caused a level of concern, and I would question the level of intervention remaining at the universal support level. I thought there should have been a referral to social care even if under the remit of Child in Need as there was a lot of instability for mum (as she was more visible) to health and accommodation services and a lot of unknowns re: dad at the time as he wasn't really that involved. I thought that there wasn't a lead professional pulling information together and co-ordinating knowledge and support which would have been really useful to get a holistic overview".*

Another health professional said: *"I can see that it is hard to piece everything together with mum moving, Covid-19 and differing health reporting systems however a systemic approach to practice – linking social economic factors and thinking about family relationships and connections to professionals - may have been really useful for this family and therefore other families moving forward".*

The LCSPR finds that at times the lack of multi-agency information sharing and decision-making incorrectly contributed to Baby M remaining at a universal support level. The practice example of the Domestic Incident Review Meeting (DIRM) in May 2022, following an incident when Ms M's coat was cut by a member of the paternal family, illustrates how more checks and enquiries were needed to triangulate information with parents, the wider family, and the professional network when Ms M's coat was cut, and she described feeling worried about being with the paternal family member as he was "*unpredictable*". The outcome of the DIRM was analysed in terms of practice thinking. Police information appears not to have been shared in the meeting regarding the adult paternal family members, which arguably resulted in decision making which was set too low. This then negates the need for any further actions to be taken to check concerns through a more thorough multi-agency meeting as Children's Social Care were not able to "*connect the dots*" in the DIRM with other paternal adult family members as they were not linked to Baby M.

In B&NES the purpose of a DIRM is to triage safeguarding children reports and domestic incidents (crime and non-crime) that have been referred to the Police Lighthouse Safeguarding Unit (LSU) in the 24hr period preceding the meeting.

The Terms of Reference are explicit in stating DIRMs are not a replacement for MASH, Strategy or MARAC meetings and they should not be considered as such. The aim of a DIRM is to perform an initial, brief assessment as to which agencies require a Niche report for each given incident based upon their own agency information. Any further assessment of risk is outside the scope of the meetings and should be deferred to the appropriate forum.

With the benefit of hindsight, there was a need for more effective coordination between the different multi-agency processes of the DIRM / MASH[18] / MARAC[19]. It would seem that assumptions were made that Baby M was not often in the paternal family home in B&NES with

[17]Children in need of support may be assessed under Section 17 of the Children Act 1989 or under Section 47 of the Children Act 1989 to decide whether the child is suffering or likely to suffer significant harm

[18] Multi Agency Safeguarding Hubs (MASH's) are co-operative arrangements formed between numerous safeguarding organisations with the aim of collaborative working to safeguard children

[19] A Multi-Agency Risk Assessment Conference (MARAC) is a meeting whether information is shared on domestic abuse situations deemed to be high risk

the adult of concern, and lived with Ms M, Mother. There was need to check this further given the previous CSC referral concerning this adult's previous convictions, along with additional Police information raising concerns of a criminal history and poor mental health of the adult who often frequented the paternal family home. A more thorough assessment of the facts and a multi-agency discussion and decision could have led to greater curiosity across agencies. It would have been helpful to be sure at this reachable practice episode that those adults caring for Baby M had the ability and courage to stand up to any adults who may pose a risk or present as intimidating or coercive.

It is evident in this Review that the DIRM, in its current structure, where individual discussions are short and last approximately 5 minutes, did not consider the historical paternal parental family factors as the Police did not highlight concerns regarding a member of the paternal family. This information would have been readily available via Mr M's records as a child in the care of B&NES local authority but was not triangulated. At the Practice Event the Leaving Care Team professionals were surprised they were not consulted at this point for further information to be shared as this would have been typical practice in such a scenario for a family who were described as "*well known*" to their services, albeit Baby M was not known to this triage service. It has been shared by Children's Social Care that the current DIRM triage system does not have the capacity to interrogate the different agency systems to understand the level of history and connection between adults in families from the number of Police domestic abuse incidents that are reported on a daily basis.

In considering the rationale behind this decision-making the Review requested minutes from the DIRM. It is the typical practice that incidents discussed at this meeting are recorded using a table format and there is a box for the practitioners to record brief notes, but there are no formal minutes. It is therefore difficult to unpick with any great certainty how individual decisions are made and what they are based upon. DIRMs are attended by Senior Practitioners from Children's Social Care, LSU staff, and IDVAs on behalf of their organisations, rather than managers attending and this may have contributed to this threshold decision of Children's Social Care not accepting this referral in this situation with the information shared by the Police.

4.2 The Importance of Understanding Contextual Parental Factors

When understanding how professionals reached decisions about what level of support and intervention was required the LCSPR finds that there was a focus on current, day to day observations of parenting and not any analysis of the contextual history. The cumulative social factors experienced in Baby M's maternal and paternal family required a more enquiring stance and this is an unanimously shared view from the Practitioner Event and Review Group discussions as leading to support remaining at the Universal Support Level of Need.

Social factors which required further in-depth discussions with both parents and within agencies and across agencies included:

- Family relationships and dynamics, including any experiences of parental coercion and control
- Wider maternal and paternal family support networks
- Adverse experiences during childhood and how this shaped culture and identity and parenting capacity
- Parental mental health needs
- The impact of being care experienced upon parenting
- The impact of poverty upon parenting
- The role, expectations and assumptions concerning fathers and mothers in parenting
- The parent's housing situation

The first opportunities to begin to understand parental contextual factors would have been with midwifery services in July 2021. The "*booking in*" midwifery appointment happened in line with procedures with Ms M and due to COVID-19 restrictions was split between a phone discussion and follow-up face to face appointment by the same professional. The purpose of this 1st antenatal appointment is to have a detailed discussion about personal and maternal and paternal family history, and any relevance this may have upon pregnancy. A pregnancy care plan, and options for screening tests are usually discussed. Midwives explained there is often a lengthy discussion at this appointment to gain a picture of the unborn baby's family and its situation.

In this situation, Health Professionals shared openly that this 1st appointment was shorter than usual and not typical practice due to COVID-19. Care was taken to ensure a face-to-face meeting was held after the initial phone call, but due to time constraints and system pressures there was a focus on medical need as opposed to wider social factors. The split appointment between a shorter telephone conversation and then home visit meant that there was less time to observe or engage Ms M and the focus tended to be more upon carrying out set tasks and completing forms. Mr M's history of being care experienced was recorded as part of the routine booking questions, but no other information was obtained to warrant further exploration of his experiences. Upon reflection, health professionals have requested further guidance to develop their skills regarding when and how to gain a fuller social picture of parents who have various experiences such as being in care.

The culture of Baby M is largely invisible in the health records seen, apart from typically seeing a tick box to show he was a white British child. This Review has sought to understand the impact on Baby M of Mother and Father's childhood experiences upon their parenting styles and behaviours and finds very limited written evidence of discussions held with either Ms M or Mr M regarding their own identities and how this shaped them as parents. The LCSPR considered how being a care experienced parent might have influenced the father's life, his experiences, and views on parenting. It was considered at the learning event how this was understood by health and housing practitioners in particular and how it did, or did not, guide actions, decisions and any services put in place. The general conclusion from those health professionals that knew father was care experienced, was that they knew this fact but not any detail.

Understanding Mr M's contextual history was not given the time or attention as it should have been so as to build connection further with Mr M and assess whether a referral to any other services might have been helpful to keep Baby M safe and support the parents. The Leaving Care Service who attended the event shared invaluable information and insight which highlights the practice importance of piecing together a family story and deciding when there is a need to include further multi-agency professionals so as to understand and assess any risk factors that might be present. This of course depends upon parental consent if at an early help or child in need of support level, though it would seem from reflections of both parents by professionals that they would have been open to receiving support and services at early help or statutory levels. Evidence shows that professionals and parents tended to work effectively together, (as seen with Mr M being involved in Care Experienced Groups over time), which would tend to suggest if more dedicated time had been spent building more effective connections with both parents, a picture might have been obtained of Baby M's day to day life and any potential parental struggles might have been clearer.

The Review Group have considered the role of the Children's Social Care (CSC) and in particular the knowledge held by Care Experienced Service in B&NES, when understanding when and how information was known about Mr M becoming a father. Baby M was referred to CSC on two occasions, the first in relation to a police referral about paternal family member and a previous conviction, and the second as a result of Ms M reporting an incident with the same family member. On both occasions no further action was taken and significantly the connection did not seem to be made that Mr M was B&NES Care Experienced and therefore the information was not shared with the relevant team. These were opportunities to learn more

about Baby M's situation, the relationship between his parents and Ms M's parenting capacity as extensive records were held on Mr M and his wider family.

CSC have reflected and in hindsight have acknowledged this connection should have been made, and more exploration and assessment undertaken. This LCSPR makes the recommendation to check the current DIRM processes to ensure information is shared within CSC Teams and structures and when working together, particularly in needing to discuss with Mr M the benefits of sharing information with GP, midwifery and health visiting services regarding his care experiences and what support/assessments may be required as a new parent.

As highlighted in Baby M's story of what happened, the LCSPR has struggled to find any information about the reasons why Mother was living in supported housing. There are some contradictions seen which remain unexplained as it describes maternal wider family as supportive and loving and also makes references to asking her to leave their homes. It is therefore an appropriate conclusion to wonder about how professionals made sense of this information and what weight, if any, they gave to understanding more about parental contextual factors and the implications these may have upon parenting Baby M.

The Review also sees evidence when analysing what information, the Neonatal Intensive Care Unit (NICU) had regarding the parental contextual factors and how the various IT systems used by midwives/hospitals/health visitors and GPs do not link or align and therefore operated in isolation. NICU staff shared their frustrations at the system issues which result in them having very limited paperwork or information shared via systems as they do not have access to midwifery computer systems, which means they often do not receive the midwifery "*booking in*" forms or any other relevant documentation concerning parents. One comment made was how this means often "*things will slip through the net*". NICU staff shared how they have to chase for information and when working in busy intensive medical situations. Things can get missed as there is a reliance on staff to spot things and request information. In this situation it impacted as NICU staff did not knowing about Mr M's care experience or that Ms M had previously lived in supported accommodation.

There is work underway at the Hospital concerned to remedy this situation as it is known that there are information sharing and feedback issues between midwifery teams and NICU. A new computer system will be introduced in the summer of 2023 which it is hoped will resolve this and ensure the information flow is in place. If a child in NICU is subject to statutory assessments or interventions via children's social care, or there is parental need identified, then multi-agency meetings are held each week to discuss individual needs, including safeguarding – these are seen as helpful by NICU staff. This LCSPR notes the significance of these meetings which are held on a Tuesday; Child M was not inpatient on NICU on a Tuesday as his admission was Wednesday to Monday.

4.3 How we support families, understand parental need and keep babies safe

Healthy relationships and the risk of domestic abuse are key areas which midwives are expected to consider in ante-natal discussions with parents. The timing of when such mandatory discussions should or can take place was a feature of this Review as during one visit Mr M was present and it was decided to be inappropriate to discuss the nature of the parental relationship. There is evidence that during the booking-in face-to-face meeting with Ms M the routine screening for domestic abuse was completed. However, it has also been highlighted by professionals attending the Practitioner Event that having such conversations should not be a one-off initial enquiry and tick box procedure undertaken at this 1st meeting and more-so a series of conversations as the professional and parent get to know each other. It is arguably not the best approach adopted by professionals as parents may feel reluctant to share such sensitive information on a first meeting, especially when the purpose tends to be task focused on physical health matters.

To raise such conversations when first meeting an individual is a tall order for any professional as they will need to understand relationship history and understanding of safe and healthy relationships with both parents. The opportunities to continue discussions were further impeded by the moves between areas and changes in worker. The Review finds this should have been a more focused area of assessment and especially given the later concerns observed by NICU staff regarding Mr M's allegedly "*controlling*" behaviours towards Ms M and was not effective via a one-off routine screening enquiry. The Review Group heard evidence that health visiting records prompt for a question to be held regarding domestic abuse at the new birth visit, but the "*institutional*" practice of most health visitors is to not to ask any questions about relationships, stress of a new baby and the impact it may be having on the family, if "*the partner is present*". This is further considered in Recommendation 1.

Becoming first time parents can feel and be over-whelming and daunting and the extra pressures of coping with the additional responsibilities can in some situations lead to post-natal depression[20]. The Review has identified that Ms M had some self-reported low mood, which would have benefited from further understanding by the professional network. Ms M self-reported to midwifery services and the GP to feeling psychologically well during most of the pregnancy. Ms M did disclose low mood at her last midwife appointment and was given appropriate advice, with Mr M also signposted to local services for dads. The historical housing records show Ms M described having some level of post-traumatic stress on her initial housing application following a previous relationship experience, along with becoming homeless due to reported family issues. She told her housing support worker on three occasions how she felt "*low*" during her pregnancy due to physical health conditions and not wanting to live in the hostel. This information was not shared with a wider network.

Similarly, during a routine health visitor home visit in March 2022 when Mr M is seen with Baby M, he shares information about his own mental health needs in the past and apparent "*paranoia*". Although assurances are given by health professionals this was discussed in detail with Mr M at the time, with signposting to seek further support from the GP, no follow up is evident in any health records reviewed and this was not flagged to the GP.

NICU records show Ms M was nervous around handling Baby M and in particular is described as appearing reluctant to hold her son; these are not typically unusual behaviours seen in any new parent tasked with caring for their new-born child. Baby M remained on NICU to ensure parents were provided with support and advice on caring for their child. It is particularly reassuring to see how focused work is in place around ICON training for new parents. As one NICU staff member affirmed: *"All staff on NICU have now had or will soon have ICON training and safer sleeping and will be able to train and speak to all parents and care givers prior to discharge from NICU".*

What the Review wanted to unpick further whilst Baby M remained in NICU was the request from Ms M to go home 12 hours following birth to have a shower and rest; in returning back to NICU late and then asking for a separate room to Baby M due him being described as making lots of noise and Ms M was unable to sleep. Through debate at the Practitioner Event, experienced NICU staff all concluded these were not unusual behaviours seen in new parents on the intensive unit and so did not cause any professional alarm bells to ring. This view was not shared with other health professionals as part of the Review Group and is a practice reminder of the need for single and multi-agency discussions when there is a difference of professional opinion to ensure the needs of the child remain the paramount consideration. Monitoring of Baby M and support was given to both parents before discharge to ensure confidence levels were adequate to ensure day to day needs were being met.

Some new parents can often look to their own parents or wider family for support during the first few weeks of a baby's life. The wider family support networks available via the maternal

[20] Soothing a crying baby www.nhs.uk

family were not evidenced in any records seen for this Review and the paternal family, although well known to B&NES children's social care, remained unassessed in terms of providing wider family support. There was a general assumption made that as no risk indicators were identified and support was set at a universal level of care, there was not a need to understand the levels of wider family support further and whether there were any concerns pertaining to this. This was required and particularly on the paternal side, given concerns raised on two separate occasions regarding a male paternal family member and his behaviours and convictions.

4.4 Working with Fathers

Most services provided across the UK during antenatal and the early months of life remain predominately woman-facing, and less accessible to fathers. For example, there are often limited flexible approaches to providing out of hours or at weekend provisions to maximise a father's involvement. As a result, fathers are not provided with important information about becoming a parent and how to safely feed and handle new-borns and meet their range of needs during the first few weeks of life and beyond. There is a general expectation that mothers will share important/relevant information with their partners/fathers, and it is not known in this situation whether Ms M did or did not share information, such as safe sleeping. Much research, along with local and national reviews[21] show that engagement with fathers is often characterised by shallow assessments and weak engagement, with services often not knowing who fathers are nor the risks or resilience factors they present.

This Review shows that midwifery services and health visitors from B&NES area did consider Mr M and he was involved in some meetings pre and post birth. The general consensus shared by all multi-agency practitioners and the Review Group is that more assessment of Mr M's history and current situation was required through adopting a more probing lens and building a greater connection with him to ensure he was supported as a new father and any risks were understood. Mr M is described in records as a polite and amenable young man who accessed services and it is likely he would have taken the opportunity, either with the support of his care leaver worker or on his own, to work more closely with health services if this had been offered.

The Review Group considered the impact of possible professional unconscious gender bias which may have arisen through stereotypical views on parenting which are still seen in society to be split via gender roles. Assumptions were made by professionals that Ms M was undertaking all the main parenting role for Baby M and without further checking out the professional view was adopted that when the parents' relationship ended and Ms M was allocated a further supported home in South Gloucestershire, she remained the main carer for her child. Through analysis in this Review, it is likely this was not the situation and Baby M remained with his father, Mr M in the extended family home in B&NES. The Review highlights the need for high quality supervision where discussions can be offered which provide support to professionals and challenge to their work, including around any possible unconscious or conscious bias based upon gender, class, race, identity, or sexual orientation.

The LCSPR analysed the provision of safeguarding supervision to maternity/community midwives at the time that Child M's mother was under the care of maternity services at NBT (July 2021-March 2022). In July 2021, the Named Midwife for safeguarding was unable to offer the frequency of safeguarding supervision required (as per the safeguarding supervision policy) of quarterly (to community midwives) due to operational pressures in the maternity unit, caused by sickness absence. During this period, group supervision was not provided to either of the community teams who provided care to Child M's mother. The maternity unit responded to the operational pressures, and since April 2022, a consistent offer of quarterly provision has

[21] The Myth of Invisible Men: safeguarding children under 1 from non-accidental injury caused by male carers, The Child Safeguarding Practice Review Panel September 2021 HMO: Gov

been made, with all community teams participating in safeguarding supervision (Sept-Dec 2022). There continues to be one member of staff (the named midwife for safeguarding) who delivers safeguarding supervision to maternity staff, which is a limitation on staff choice of supervisor and also means there is no provision when the named midwife is away from work.

In analysing the health visiting supervision during the period under Review in B&NES it appears that there was not any systematic review of complex situations or empowerment of practitioners to reflect on their practice, identify strengths and other protective factors within families as well as risks. There is no evidence that record keeping was reviewed, and no assurance that practice standards were being met. It also appears from a sample of the records seen that fixed views were not challenged, hypotheses and evidence base were not assessed or tested for assessments and decisions and action plans were not formulated to contain risks.

The situation today is different. 1:1 Safeguarding Supervision was introduced in November 2022 and B&NES practitioners are aware that they need to bring a family situation; it is protected time and takes place quarterly. Ad hoc supervision is also offered as required and this is now documented.

5. Key Learning 2: Focusing on the child when families move between areas

When a family moves between geographical areas and between local authorities and health service boundaries it can be a particular system and practice challenge. This was a significant factor in this LCSPR and one highlighted both by various health and housing professionals who attended the Learning Event and identified by the Review Group. The impact of the geographical moves of Ms M upon professional understanding are considered in this section.

This review finds confusion as to where Baby M lived in the first 3 months of his life. This was not clearly understood by any one agency, and this meant at times there was insufficient professional curiosity about Baby M's day to day experiences. In practice reality, professionals did not think they needed to intervene in Baby M's life as no safeguarding concerns had been identified and living in supported accommodation and having care experience was seen as not unusual or of significance to professionals to check what this may have meant to Baby M via further enquiries. The need to adopt a more enquiring stance to ensure baby are kept safe and support and services are provided to parents is covered in Key Learning 3.

5.1 The role of housing providers in understanding risk

The Review identified three homes which offered support and services to Ms M by two housing providers in South Gloucestershire during the period under review; two being during the ante-natal period (short initial period in a hostel before moving to more secure supported housing) and one following birth when the parental relationship ended. Ms M was initially referred to the housing association by South Gloucestershire Council Housing Needs Service. The provision offers homes for young families or single people who have approached their local authority saying they are homeless or at risk of being homeless. The application paperwork seen for this LCSPR provides limited information as to the reason why Ms M was homeless and contradicts other reports which assess the maternal family home as being providing support.

The attempts at providing Ms M with support and advice in the ante-natal period show a determined approach by the support worker as missed appointments are seen and followed-up, with connection often seen as more effective via text messages or phone calls.

The Review finds that the flow of information sharing to and from the housing provider was ineffective with gaps in following up matters seen by the housing association and similarly midwifery and health visiting services not sharing key pieces of information to the housing provider. This can be evidenced in the following practice examples:

- When Ms M leaves the supported home in the ante-natal period as she is unhappy and says she is feeling "*low"*, this information is not shared by the housing provider to any health services, such as GP or Midwifery
- The fact that Ms M was often not staying at the home during the ante-natal period and Baby M was not seen by Housing Support Staff in South Gloucestershire in the supported home following birth did not raise sufficient curiosity. The Housing Provider was not pro-active in thinking further regarding whether a referral to health services would have been helpful to understand who was caring for Baby M
- The Housing Association was not made aware by Midwifery Services of Mr M's care status and at the Practitioner Event expressed their "*shock*" at learning more of the contextual family history, which if known the Manager commented would have meant a more diligent approach by the Housing Association and probably a decision that the supported housing being not suitable for a young mother and her baby

In discussion with various professionals working in the housing sector it is evident that in South Gloucestershire the key messages arising from previous local reviews concerning non-accidental injuries in non-mobile infants has not been cascaded to inform and strengthen practice.

5.2 Health Services Information Sharing

Health professionals attending the Learning Event shared some practice examples when information sharing between midwifery services and health visiting resulted in a good handover of information. However, this was either not recorded or not recorded fully enough and so needs to be taken at face value.

The Review Group has considered how health systems are reliant upon parents telling professionals of moves between areas and completing the transfer forms when they move. The Review debated how only children identified with additional support needs, including safeguarding concerns, would have a handover discussion and Baby M was not identified as having any additional needs. It is seen in records that information was shared between South Gloucestershire health visiting services and B&NES regarding the paternal family member.

This LCSPR also finds gaps in information sharing or ineffective information sharing between health services which confirms the previous learning in South Gloucestershire and also apply to health systems in B&NES. There were various reasons why information sharing regarding Baby M was at times not as it needed to be in health agency networks, and which failed to then "*connect the dots*" in gaining a full picture of need. This was due to different community and hospital systems for recording which were incompatible and especially when transferring data between areas or, due to an inaccuracy in recording of information. At the time there was not a formalised process for administrative staff to report to the Health Visitor when an antenatal visit was declined. There is a new Standard Operating Procedure agreed with maternity services (signed off on 14.12.2022 but not yet fully embedded) and a new Sirona Antenatal visit pathway (signed off Feb 2023 but not yet fully embedded) which describe a new process to ensure admin staff share information with a Health Visitor when an antenatal visit appointment is not booked (this include declined offers for contact) and ensures an opportunity for Health Visitors to discuss identified women with midwives at a monthly liaison meeting.

Midwifery and health service capacity issues and how systems are structured when at a universal service of need were considered. Since 2011 Health Visitors have offered a Public Health Service which includes 5 routine contacts: pre-birth, new birth, 8-week check, 1 year check and 2.5-year check. The opportunity was missed to build relationships with health visiting and parents prior to the child's birth as the antenatal home visit (as recommended in the Healthy Child programme guidance[1]) was declined by Ms M who was moving imminently

to B&NES. An Antenatal home visit invite letter was sent to Mrs M at 32 weeks' gestation with a follow up phone call 2 weeks later. During the phone call Mrs M declined the visit offer.

Antenatal contacts are offered to all women in South Glos from the Health visiting service from 28 weeks to just before their expected due date. Letters to invite women to an antenatal visit are sent when women are 28-32 weeks' gestation where they are known to the health visiting service. Midwifery services were involved and assessing the family strengths, needs and risks and would have been able to identify what additional support may be required as new parents. Ms M delivered her baby within 2 days of South Glos health visiting being aware of her move of address. Even with a reasonable and proportionate response by all in health, this may not have enabled a contact in her new residency prior to delivery. The South Glos health visiting team did update change of residency on the central computer spine systems that can be viewed by Primary Care/Midwifery and health visiting. A flag /alert system may have been beneficial but would only alert staff if systems are checked routinely by staff prior to contacts.

This meant that any trusting relationships with Ms M, were restricted as she was not seen by South Gloucestershire health visiting professionals prior to birth and had a delayed start with midwifery and B&NES health visitors due to missed appointments with the family explained by the" *busyness of Christmas*". The move in area, and professionals being reliant upon the family to inform of the moves, further slowed down joining up the dots between midwifery services and health visiting services.

6 Key Learning 3: Supporting critical thinking in practice

This Review has tried to understand the reasons why Child's M journey through his first three months of life were not understood in more depth in order to keep him safe. As previously analysed, the main likely reasons centred upon the impact of the moves between local areas coupled with the parental contextual factors not being unpicked with a sufficiently inquisitive lens. The practice reasons why limited critical thinking was likely applied is considered in this section. As detailed in the health records from midwifery, health visitors and GP, Baby M was seen to be well cared for; growing and developing as expected, and with warmth observed when in his parent's care.

When busy, task focused health professionals who observe and are given assurances that all is going well by parents, it is understandable to see why practitioners might not sufficiently probe beyond what is in front of them, and especially when feeling under pressure. The parallels in SCR Toby[22] are noted as when a busy professional is faced with competing demands "*a trade-off*" in priorities can take place.

When there is a tendency for a practice culture of focusing on tasks as opposed to being person or child focused, the risk is that professionals can narrow down their focus, which can result in "*tunnel vision*". This tends to make the job feel more manageable to the busy professionals as they can complete the form and tick the box but can mean wider issues outside of that narrow focus are not seen or are given the attention they require. Health practitioners reported at the Learning Event that they knew that being a care leaver was a flag to unpicking further, however, they did not have the time to do this and did not know what factors would be considered as a "*red flag*" and did not want to appear to make assumptions about the experiences of those who had been in care. Such feedback is important when understanding safeguarding cultures and how effective specific training is, when the likelihood of ensuring it is embedded in practice can be limited due to pressures on practitioners' workloads to do the more probing, analytical work, along with not knowing in practice how to apply the learning.
The importance of critical thinking in practice is well cited[23] as a cornerstone of working effectively with families and in and across agencies. This LCSPR has focused upon key

[22] Serious Case Review: Toby 2020

[23] Child Safeguarding Practice Review Panel 2021 Annual Report : Patterns in practice, key messages and 2022 work programme 2022 HMO: Gov

practice episodes when professionals were either working directly with the parents or with single or inter-agency colleagues to understand whether sufficient enquiry was seen to understand day to day life for Baby M. This section analyses what facts and information were available during the period under review and how and what professional observations were undertaken to form the judgments reached and subsequent actions taken.

In providing a rationale for why certain matters were not discussed in more depth needs setting within the systems within which multi-agency professionals operate each day. It is not the intention of this review to make any individual feel they did anything "*wrong*" by not probing further but rather to illustrate the importance of self-reflection in practice. It is also to consider what opportunities there are for individuals to have space and time to discuss their thinking with supervisors or multi-agency colleagues so as to remain open-minded to different perspectives or hypothesises and to develop a confidence in practice. This was the approach used in the Practitioner Event to ensure a multi-agency reflective dialogue to consider together what happened and what might have been done differently.

It is complex work to do and unpick as part of this LCSPR as it requires a process whereby the Reviewer and Review Group interpret the information gathered at the time, alongside what individuals recall they saw in practice along with their own professional experiences and skills which are set within their own agency systems. Critical thinking is of course not problem solving and this Review seeks to understand the thinking patterns of those professionals working with the family and pay attention to these so as to understand how they may have been hindered by barriers in the systems in which individuals work.

It is within this context that the following underlying system issues were raised by practitioners at the Learning Event and through Review Group analysis:

3.1 Key Learning: Acknowledging the realities of day-to-day frontline practice: "*There is no time to think*"

As highlighted in the Annual Review of LCSPR[24] many of the issues that undermine the effectiveness of safeguarding practice are to do with high volumes of work and serious resource shortages, along with staff turnover or use of agency or "bank" workers. This Review identifies a consistent theme shared by many practitioners from a range of agencies present at the Practitioner Event, and particularly health services who talked with courage and honesty about their realities of day-to-day practice. It is important for senior leaders locally and nationally to listen to these reflections as it shines a light on the pressures faced by many frontline professionals when working with children and their families. The aim is to set this review and its findings within a wider contextual organisational understanding of why certain things happened in the way that they did and why certain actions and decisions were taken. The reasons given by practitioners from health agencies attending the Learning Event as to why there was an over reliance on taking information at face value and not asking more probing questions or showing a more inquisitive stance when working with both parents is consistently described as "*workload demands*". Workers described often feeling "*overwhelmed*" by the number of demands on their day or shifts. One community health professional described this as "*ricocheting from one visit to another*".

A mixture of texts/ telephone discussions / face to face appointments at paternal home and in clinic are seen – with some patterns of appointments that did not take place as Ms M or the wider family explain there was maternal ill health, both physical and mental. The Midwife and Health Visiting Services showed diligent approaches in following up these missed appointments and although some gaps in time were seen, eventually Ms M was met with, and no concerns were identified. Such practice examples show despite the system challenges,

[24] Child Safeguarding Practice Review Panel 2021 Annual Report: Patterns in practice, key messages and 2022 work programme 2022 HMO: Gov

there was a persistent approach to work undertaken, as in the midwifery service adopting a flexible approach during COVID19 during the "*booking in*" appointment. Determined work like this needs to be highlighted as the "norm" to ensuring creative professional practice and not as seen in this LCSPR as an example of good practice.

The Review considered what the purpose was of the various housing, midwifery, and health appointments and visits with Ms M. As detailed, the community health focused work with parents and Baby M tended to be to complete a physical health task, with more limited time to build a more meaningful relationship to understand how life was going for a young new mother to be / mother, and a father with some adversity known in his childhood. The practice shared by health visitors and midwives who attended the Learning Event can be summarised as task focused and ensuring there is "*a tick in the box*" to complete what is required of that visit or discussion with the parent. If effective relationships are built in practice, it enables more possibilities for asking the more difficult questions as a connection has been established. The professional needs to connect first before entering into discussions of content as this provides an effective framework from which a professional might pursue why something is or is not happening or unpick any parental worries.

This LCSPR finds that health professionals in particular needed more focused time to spend building a connection with both parents before completing the task requested and to feel less pressured to move on to the next task at hand. In enabling this culture of practice, alongside ensuring opportunities for informal and formal supervision discussions, is more likely to yield results which look beyond an observational approach which focuses on the presenting behaviour and allows a more analytical style to probing into other contextual factors, when relevant to do so.

In the Review of Child Protection undertaken by Professor Eileen Munro[25] we are reminded of how "*instead of doing things right"* (i.e., following procedures) the systems in which professionals practice needed to be focused upon "*doing the right thing*" (that is checking children and families are being helped). This review shines a light on how staff morale is impacted when working at all levels of need when there are pressures felt from lots of demands to do and complete as opposed to empowering professionals to feel they are helping families and in so doing making a difference to day to day lives. Professionals talked of the need to have time to think and slow down, build the relationship rather than merely "*doing*" as being important to job satisfaction.

Hearing professional reflections provides a more probing and critical lens so as to answer why there may have been shortcomings in practice, which are not intentional but more likely as a combination of factors. This Review also suggests the answers to addressing some of the issues outlined sit with Senior Leaders nationally and locally in partnerships and organisations who are committed to problem solving some of the harsh day to day realities of practice. There are, of course, no simple solutions or written action plans to resolve these organisational issues and creativity is required if practitioners are to be supported to do the best that they can and in doing so ensuring children are kept as safe as possible and for their families to feel and be supported.

6.2 Key Learning: Record Keeping

Good quality record management is important when working with families because it tells a child's story over time in a cultural context, which can be shared with others, when necessary, alongside ensuring compliance with policies and procedures, data collection and data protection. Having concise, analytical records also helps identify gaps in what is and isn't known and helps professionals understand immediate and cumulative risk factors – in short, good quality records positively support critical thinking and focuses discussions for practitioners in supervision and when working in a multi-agency forum.

[25] The Munro Review of Child Protection: Final Report, 2012 DfE: Assets Publishing

The Review sees several examples in both geographical areas of poor-quality record keeping and detailing when handover conversations have been held which suggests there is a system wide issue which requires a more focused approach than is currently in place in community health (hospital, midwifery, and health visitors). The Review has heard there are ongoing management supervisory discussions or training opportunities in both geographical areas as a practice reminder of the need for good quality record keeping, ensuring what information has been shared and to whom and for what purpose, but this is currently having limited impact on what is being recorded as evidenced in this review.

The review finds basic information missing on several records seen such as which family member was present for the visit/appointment; where the intervention took place; what the purpose was and what was agreed. The poor quality of the records seen in this review means during the period analysed, other professionals who may have needed to read the notes or reports written by health colleagues following a telephone call, appointment or home visit would also not have been clear of what was seen or discussed and with whom. The records would have benefitted from more than just the basics being noted, with further analysis of the topics discussed, such as details about safe sleeping and how the ICON messages were understood and received. A more detailed written explanation of what discussions took place concerning healthy adult relationships and domestic abuse would also have been beneficial as again these were lacking. As previously highlighted in Key Learning 1 further practice consideration should have included more exploration of the family's cultural identity and what meaning was given to Mr M's adversity in childhood and care experiences and whether other cumulative social-economic factors influenced parental interactions. This was not seen in any records.

6.3 Key learning: The importance of checking what language and phrases mean to assess impact on children

The language we use can impact how we view children and their families and how we form our professional judgements, and this may result in how risk is seen, and support is given. It is important as it can also alter how realistic the picture is of a child's day to day experiences. In the Review there has been analysis regarding what and how language or certain key phrases have been used and considered in terms of professional levels of understanding or weight given to certain key pieces of information.

Following birth and when in NICU the word *'controlling'* was used to describe Mr M's behaviours and was recorded in documents. This phrase needed more description attached to it so as to understand whether this referred to words used or physical actions or a combination of the two. With a simple phrase with no analysis of what was being reported by the professional in terms of risk for Ms M and of course Baby M's safety, it can be left open to various interruptions and different levels of weight can or cannot be attached to it. In some situations, such statements can take a precedent when based on single pieces of evidence or assumption and in other situations they can lose their significance if not recorded specifically, with some level of analysis and professional curiosity provided.
In this scenario a situation arose of "*Chinese whispers*" whereby the phrase was passed to some professionals, but significant others were missed such as the next NICU Nurse who could have checked the information more closely had it been shared appropriately. The result being that as the original understanding was not clear, it became even less clear and confused as it passed down the professional network and assumptions can then be made. The community midwifery team is seen sharing the information with the health visitor that a "*verbal altercation*" has taken place but is not able to add any further context. The practice danger is that the incident either loses importance and risk is not seen or leads professionals to think there is risk when there is not. It is important to unpick such comments made and this was not done – this meant there was a potential unassessed risk of coercion and controlling behaviours from adult to adult and to Baby M. When working to understand a child's world it

is important to use factually correct language as this too can affect how risk is or is not seen by the professionals group. The key is in accurate, timely, recorded descriptions when considering all aspects of a child life. For example, this LCSPR has seen various health records which state Ms M lived in a "*mother and baby unit*". There are many significant differences between supported housing for young adults and a mother and baby unit, and although likely made as a simple practice error in recording, can have significant consequences in terms of being clear about a child's journey and what level of support or monitoring may be required. In this situation it held no significance which adds further weight to the need for a more curious approach to have been adopted and to probe further to understand why a "*mother and baby unit*" might have been needed for Baby M, but as previously analysed this inquisitive approach was not seen.

Recommendations – For South Gloucestershire and B&NES Children's Partnership
Both BCSSP and SGCP will ensure the following recommendations are translated into a smart and achievable action plan which is overseen in the respective partnership's quality assurance groups. Given the previous learning reviews in South Gloucestershire concerning non-accidental injuries to children under 1 years, a critical focus is now required to ensure change is made, monitored, and embedded in practice and systems with the hope of reducing the likelihood of similar situations happening again for babies who move between areas.

<u>Systems & Practice which Focus on the vulnerability of babies</u>

1. **Recommendation**: **Health Recording Systems include a holistic assessment of a child's needs which includes contextual maternal and paternal family factors**

   Action: Work to improve understanding about support available to Care leavers from the action plan for CSPR Family A, along with the GP & Practice Staff Resource Pack are shared by Bath & North East Somerset, Swindon & Wiltshire Care Board to all health agency leaders to ensure all health professionals have access to information to guidance when assessing any adults who may be care experienced

   Action: Training for NICU staff about increasing confidence and knowledge when working with Domestic Abuse and how to ensure curiosity and response to Domestic Abuse. This needs to take place within 9 months of publication of Baby M review.

   Action: The HCRG Care Group for Health Visitors and South Glos Public Health Health Visitors to ensure through broad discussions at the new birth visit the routine question of domestic abuse is recorded and covers healthy adult relationships at every health visitor contact. This should include further training for all health visitors on how to identify and discuss domestic abuse and healthy relationships in light of new legislation.

   Action: Current work underway in B&NES that strengthens information sharing between GPs and midwifery about fathers' risk and resilience factors is replicated across all health agencies in South Glos and B&NES (SIRS - Sharing Information regarding safeguarding)

   Action: B&NES Children's Social Care to review their DIRM procedures to ensure the pathways for information sharing between all CSC Teams and with other statutory agencies (when relevant/required) are effective for children. B&NES CSC to assure the BCSSP of their work within 6 months of publication

2. **Recommendation: The ICON Programme & increasing awareness of Non-Accidental Injury in Babies**

   Action: Further embedding of the ICON Programme across South Glos agencies (statutory and voluntary) which links to the previous South Glos LCSPR action plans

and pays particular attention to training for non-health partners including Housing Support Workers in South Glos. The housing provider to share learning from this review with practitioners to promote critical thinking in practice. A multi-agency event "ICON: Working Well Together" to take place on 19th April 2023.

Action: BNSSG Non- Mobile Baby Policy update, and associated family leaflet needs to be signed off in Bristol and North Somerset. When this work is done all documents will be uploaded to the partnership website.

Action: B&NES to ensure their non-Mobile baby leaflet is available to all practitioners on the partnership website.

Action: B&NES Public Health Senior Leaders to decide whether or not to implement the ICON programme.

Systems & Practice when Children Move between Areas:

3. **Recommendation: Effective Transfer of Information between areas and services**

Action: BNSSG Working Group work further on developing a communication pathway between midwifery, health visiting, and GPs which will ensure the learning from this review is included in the Standard Operating Procedure (SOP) to ensure it adequately covers when families move between areas

Action: B&NES current SOP needs to be reviewed in light of the BNSSG SOP development to ensure it covers the effective transfer of information between GPs, midwives and health visitors

Action: HCRG Care Group process for transferring health information from Health Visitor to Health Visitor when family move area needs to be shared with South Glos Public Health Health Visitors so that this approach can be considered

Supporting & Strengthening Critical Thinking in Practice:

4. **Recommendation: Safeguarding Supervision arrangements for community health professionals which ensures there is a safe space for critical thinking in practice, promotes professional curiosity, and is a trauma informed approach to the family's needs when working with pre and post birth situations.**

Action: Decision to move from group to 1:1 safeguarding supervision for health visitors needs to be implemented and embedded by South Glos and B&NES and assurance given to both Partnerships that this is a guaranteed offer. Work will be undertaken to establish how impact of the new system is measured by referral rates & quality and staff retention.

Action: NBT and UHBW Maternity services to review its supervision offer and ensure all community midwives can access high quality, sustainable safeguarding supervision (either 1:1 or group) and the frequency of this is checked.
Action: B&NES HCRG mandatory training package will continue to be rolled out to all practitioners in health visiting service to set standards and expectations when recording information about individual family members. The B&NES HCRG will quality assure this training package by undertaking an audit of records within 9 months of publication of this review.
Action: B&NES to ensure the routine MORS tool to understand perinatal mental health assessment for both parents (**HCRG Care Group/Wiltshire PIMH Pathway - Mild to Moderate Symptoms Pathway)**, which includes the use of all questions regarding contextual history, are followed by auditing of a sample of situations to check it is being applied