Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Serious Case Review

Overview Report

Holly

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Contents

This report has been written so as to preserve the anonymity of the child. The Children's Safeguarding Assurance Partnership has:

- Represented the children by different names and adult family members by role;
- Not necessarily reflected the children's true gender;
- Avoided the use of exact dates where possible; and,
- Removed details about services which could lead to the recognition of the children and family.

1. Background to the review

1.1 When Holly died, aged 8 months, her death was initially unexplained. An ambulance had been called in the early morning to the family home, where Holly lived with her mother, (MH), her father (FH), and her 2-year old sibling, Olivia. Both parents were 19 years old. The family's ethnicity and language are reflective of the majority local community.

1.2 MH reported having fed Holly in the night and wrapping her in a blanket as she was cold. In the morning, she found Holly, unconscious and not breathing, with the blanket wrapped round her face and neck. Holly was taken to hospital where she was pronounced dead, shortly after arrival.

1.3 The Sudden Unexplained Death in Childhood process was initiated and police attended the family home. Due to circumstances presented to officers, both parents were arrested on suspicion of murder. Olivia was taken into police protection and placed with local authority foster carers.

1.4 Five days after Holly died, a referral was made to the Local Safeguarding Children Board (LSCB). The LSCB undertook a rapid review of information readily available to agencies and organisations. At that point, the initial post-mortem was inconclusive and the results of further tests were awaited.

1.5 Agency chronologies indicated that Holly and family members had open involvements only with universal services. A pattern of inconsistent engagements with health services was found but there was no evidence either of child neglect or that the children had been otherwise at risk of harm in their parents' care.

1.6 A month later, following communication with the national Child Safeguarding Practice Review Panel, it was agreed that a 'proportionate and focussed Serious Case Review' should be undertaken.

1.7 In January 2019, the LSCB commissioned an independent reviewer to facilitate the review. It also appointed a panel of senior representatives of key agencies to contribute to the case analysis and to oversee the conduct of the review.

1.8 At the first SCR Panel meeting in March 2019, the methodology for the review was agreed. It was intended that the review would be conducted using a hybrid systems approach which would include single agency case analyses and a learning event for practitioners and managers from relevant local agencies and organisations. As the police investigation was current at that point, however, it was agreed that the practitioner learning event would be delayed due to the potential for practitioners to be called as witnesses.

1.9 Parents and grandparents would be informed that a serious case review was to take place but the nature of the police involvement precluded family participation at that point.

1.10 In the meantime, using a bespoke template, single agency case analyses were completed by the local teaching hospital NHS Foundation Trust; Holly's GP practice; MH's GP practice; education services; and, the police. Due to their very limited involvement with MH in the past, children's social care (CSC) was not asked to provide an agency report. Representatives from CSC, however, provided information to the following SCR Panel meeting which was held in June 2019.

1.11 At that meeting, Panel members considered the single agency analyses of practice. No safeguarding issues were identified and there were no immediately obvious lessons for multi-agency practice. It was reported that the police were preparing to pass the case investigation file to the Crown Prosecution Service (CPS). It was also noted that care proceedings in respect of Olivia were continuing. Appropriate reporting links between care proceedings and the criminal process had been established.

1.12 The Panel proposed that the practitioner learning event take place in September 2019 when, it was anticipated, the criminal investigation would have concluded. Panel members were asked to confirm how agencies would be represented.

1.13 In the event, decision making in respect of the criminal investigation was not completed by that date. Communication between the police and CPS continued throughout 2019 and into the New Year 2020. Concerned about the delay, the Partnership Business Manager and the Independent Reviewer agreed, therefore, that the SCR panel should be re-convened, formally to consider what steps needed to be taken to ensure that the review was completed. A panel meeting was arranged for 20 March 2020.

1.14 On 18 March 2020, however, the local authority and partners were required to prioritise their responses to the COVID-19 outbreak. The upcoming panel meeting was, therefore, cancelled. At that point, it was thought that multi-agency review processes could be resumed by May 2020. This, however, proved not to be the case as the operational impact of COVID-19 continued to be significant. A virtual panel meeting, therefore, took place on in June 2020.

1.15 At that meeting, it was noted that both care proceedings and the criminal process were still active. It was not known whether new information had come to light during either process which could have had an impact on learning for agencies, had it been known before Holly's death. Concerns were expressed by Panel members about the time that Holly's sibling had been in foster care, with her permanent living arrangements uncertain. Police and CSC undertook to provide further information to the review.

1.16 Since this review was commissioned, there have been a number of local and national changes to the process of undertaking multi-agency safeguarding reviews. LSCBs in the area have been replaced with a local safeguarding children partnership which includes Blackburn with Darwen, Blackpool and Lancashire. Serious Case Reviews have been

replaced by Child Safeguarding Practice Reviews, although this report has been published as an SCR to reflect its designation at the time of commissioning.

1.17 The key lines of enquiry for the SCR are as follows:

a) How well did agencies understand family circumstances prior to Olivia's birth?
b) How effective were services to family members following Olivia's birth and prior to Holly's birth?
c) How effective were services to family members following Holly's birth?
d) How effective were safeguarding measures taken immediately following Holly's death?
e) What work by agencies had a positive impact on family members?
f) What steps could have been taken to improve the service provided to family members?
g) What actions have agencies taken or do they propose to take as a result of what they have learned from their reviews of practice?
h) What impact does information obtained during the course of legal proceedings have on learning?

1.18 In the early autumn of 2020, with the difficulties in meeting with practitioners and managers remaining, an interim report for the partnership was completed based on the information available.

1.19 It was anticipated that the interim report would form the basis of a future practitioners' event which would explore whether there were particular factors that influenced decision-making and practice in this case which could provide learning for practitioners providing universal services to children. It was also acknowledged that, in the circumstances, participants might benefit from sharing their perspectives, thoughts and feelings with other professionals who were involved with the family.

1.20 When criminal matters in respect of Holly's death were resolved at the beginning of 2021, arrangements were put in place to hold a virtual learning event with practitioners who had been involved with the family at the time. Unfortunately, for a variety of reasons, only the most recent health visitor and a manager from midwifery services were able to attend.

2. Key lines of enquiry

2.1 *How well did agencies understand family circumstances prior to Olivia's birth?*

2.2 When Olivia was born, MH and FH were themselves children; aged just 17. Both parents were living in FH's family home. MH and FH had attended the same high school from Year 8. No significant pastoral concerns were noted by the school in relation to either young person. There was no involvement either with Pupil Welfare Services.

2.3 In 2014, MH was the subject of child protection enquiries. These followed allegations made by another individual against a member of MH's family. No allegations of abuse had been made by, or in respect of, MH. Enquiries were undertaken by CSC to assess the risk of significant harm to MH. MH, aged 15, was found to be 'fully aware' of the allegations and was reported to have no unsupervised contact with the alleged offender. Adults around her were considered to be protective. No adverse childhood experiences were identified during this process. MH was made the subject of a child in need plan for three months.

2.4 On leaving school, FH enrolled twice at college, but did not complete either course. Although outreach was made to FH, his attendance remained poor. FH was still on roll at college when Olivia was born, but the baby's birth was unknown to the college. The college was not in a position, therefore, to offer FH targeted pastoral support.

2.5 MH is reported to have attended further education for a period, after Olivia was born. She did not, however, complete the course. Olivia attended nursery when MH was at college.

2.6 MH is well known to GP Practice 1 where she has been a patient since she was a baby. She is the only member of the family registered at that surgery. MH has a chronic health condition and has been described by her GP practice as a frequent user of same-day health services, a pattern which is '*unusual for a young person of her age*'. The GP analysis states that this suggests a young person who does not manage her health and well-being well. The GP analysis acknowledges that the reasons underlying her pattern of presentation were not explored with MH.

2.7 When MH was pregnant with Olivia, she was offered support through the Family Nurse Partnership. The Family Nurse Partnership is a specialist service for young first-time mothers, providing personalised support through pregnancy and into a child's second year. MH, however, declined this offer as she felt that she had sufficient support from FH and from both their families. MH was seen regularly throughout her pregnancy by community and specialist teenage pregnancy midwives.

2.8 While she was pregnant, MH was twice offered appointments with the allocated health visitor. MH, however, did not attend either. This meant that an early opportunity was lost for the health visitor to talk with the young parents about baby development, their preparation for parenting, and to identify any health, social or family issues which might

have existed. The health chronology indicates that, given MH's age, it would have been good practice to continue to pursue contact with her so that a comprehensive understanding could be acquired of parents' circumstances prior to the baby's birth.

2.9 MH's attendance for ante-natal care was found to be good and no concerns were identified. The record does not clearly indicate, however, what midwives understood about MH's circumstances during her pregnancy. No details have been provided as to who attended ante-natal appointments with her, as this was not recorded routinely at the time. It is not known whether FH was seen or spoken to by any health professional during that time. It is not known to what extent professionals had fully explored MH's needs, as a child herself.

2.10 The health analysis reports that during MH's pregnancy with Olivia '*liaison between midwives and health visitor appeared non-existent and as such is highlighted as an area for great improvement*'. The report comments that '*with enhanced communication, MH's engagement with the health visitor might have improved, providing an opportunity for the health visitor to gain a deeper insight into parents' circumstances and the role of wider family members*'.

2.11 *How effective were services to family members following Olivia's birth and prior to Holly's birth?*

2.12 MH was unwell during labour with Olivia. Olivia spent a short time in the special care baby unit before being discharged with MH two days later. Olivia's birth weight was recorded as being on the 91st centile. Four routine community midwife visits took place in the post-natal period.

2.13 Health visitors provided a universal public health service to MH and Olivia. This meant that the health visitor would undertake 5 'core visits' during Olivia's first 2½ years.

2.14 The health visiting new birth assessment visit took place when Olivia was 9 days old. Both parents and the baby's paternal grandmother (PGM) were present. The health visitor registered Olivia with the local children's centre although the service was not accessed by parents.

2.15 Two further appointments were made to see mother and child face-to-face but both were described as being 'failed'. On each occasion, the health visitor left a note for MH and Olivia to attend clinic. The health single agency analysis notes that there is no evidence in the record of a plan to address what were now four missed visits by the service.

2.16 It appears that Olivia was initially registered with GP Practice 1. When Olivia was 7 weeks old, she was referred by the GP for paediatric assessment with possible viral infection. She was admitted to hospital and remained there for six days.

2.17 A week after she came out of hospital, Olivia was taken for baby developmental review and her first immunisations at GP Practice 1. MH also had her post-natal review where '*nothing of concern'* was noted. On that same day, the health visitor had '*ad hoc'* contact with MH, who was with PGM, in the GP waiting room. MH told the health visitor that while Olivia had been in hospital, staff had told her that she had been over-feeding the baby. MH was screened for depression; no further inquiry was indicated.

2.18 A month later, Olivia spent another two nights in hospital with a chest infection. Following discharge, however, she was not taken by parents for paediatric review. The hospital telephoned MH who said that Olivia was much better.

2.19 In October 2016, the health visitor made a planned home visit to completed Olivia's 3-4 month review. At that point, Olivia was attending nursery while her mother was at college. MH was again screened for depression and no concern was identified.

2.20 Then, when Olivia was five months old, her parents registered her with GP Practice 2 where FH, PGM and other family members were already patients. As Olivia had had her first two rounds of vaccination at GP Practice 1, arrangements were made for her to complete her 3rd round of immunisations. This was not easily achieved.

2.21 In the New Year 2017, MH called the out-of-hours GP service at around 4pm as Olivia's high chair had collapsed. There was no apparent injury but the baby was crying. MH was advised to speak to her GP within an hour, but she did not contact the surgery and did not take Olivia for two follow-up GP appointments.

2.22 The following month, having been taken to the GP about another matter, Olivia was noted to be overweight for her age. Parents were advised to complete a food diary which would be reviewed in 4-6 weeks. There is no evidence, however, that this proposal was followed up. Olivia had not yet been taken for her 3rd vaccinations, despite reminders and offers of appointments.

2.23 At the next planned home visit by health visitor, MH raised concerns about Olivia's weight as '*people had made comments'*. Over the course of the next four months, the health analysis indicates that the health visitor team supported MH to '*manage Olivia's nutritional needs and to establish and maintain a healthy weight'*. During this time, the health visiting offer had been increased to Universal Plus to allow the provision of additional support such as listening visits and extra phone calls. This was a time limited intervention. The allocated health visitor changed during these months.

2.24 Just after her first birthday, Olivia was taken for her third set of immunisations[1]. Unfortunately, not all elements of the immunisations could be administered and obtaining these necessitated further visits to the surgery. Despite efforts by the surgery, however, those final elements were not delivered while Olivia was in her parents' care.

[1] Immunisations are normally completed by the time that a child is sixteen weeks old.

2.25 Around this same time, MH attended her own GP as her second pregnancy had been confirmed. As no risks were identified in respect this pregnancy, universal ante-natal care services were offered. MH and FH were invited to attend Baby Steps, a perinatal educational programme for parents-to-be. This 10-session course is delivered by the NSPCC. MH and FH did not take up the offer of a place on the course. Since then, the Baby Steps programme has changed from an 'opt-in' to an 'opt-out' service. This has the advantage that referring midwives are now informed if parents choose not to attend.

2.26 By the autumn of 2017, parents had moved with Olivia to their own accommodation. A community nursery nurse visited to complete Olivia's 2-year developmental review. There was no response and a contact card was left. There is no evidence of any further contact from health visiting service at that point, either to undertake Olivia's developmental review or to assess whether family need had changed.

2.27 In the meantime, MH had suffered acute exacerbation of her health condition associated with poor compliance medication. Despite this occasioning admission to hospital for three days, MH did not attend follow up appointments with the nurse specialist.

2.28 Following these events, GP practice 1 wrote to MH about having had 11 DNA (Did Not Attend) appointments in the previous 5 months. The GP analysis acknowledges this is a high rate of DNA appointments but notes that it is in the context of approximately 400 missed appointments every month at the same surgery. The practice states that it has since enforced a new 'DNA policy' which appears to be reducing the rates of missed appointments at the surgery. It is generally the view of the practice, however, that patients with capacity carry the onus of responsibility for their own health once they have been offered appropriate care.

2.29 Around this same time, Olivia was seen twice in the course of a week by out-of-hours GP service. At the first visit, Olivia was given treatment for nappy rash with secondary bacterial infection. MH was advised to take Olivia to her GP if her condition worsened. A week later, however, she was taken back to the out-of-hours service with extensive nappy rash and a rash on her face and neck. There is no evidence that these out of hours appointments were followed up by GP or health visitor.

2.30 In the New Year 2018, the health visitor telephoned MH to arrange an antenatal visit. This was the first contact that the practitioner who contributed to the review had had with MH. MH said that she had some 'tightenings' in her abdomen. The health visitor advised MH to make immediate contact with the midwife/ maternity unit. MH was checked by a midwife and medical staff. She was discharged home with advice and given an appointment for a growth scan.

2.31 A week later, the health visitor ante-natal visit was undertaken as planned. MH and Olivia were present. MH impressed as a quiet, somewhat shy person who was polite and friendly. No concerns were identified about domestic abuse, alcohol misuse or MH's mental health.

MH reported that FH worked long hours (more than 12 hours per day) but that, as she was tired, he helped out when he was home. MH said that she had good support from family. The health visitor talked to MH about possible susceptibility to gestational diabetes.

2.32 Although MH was offered growth scans and glucose tests, she did not attend hospital for those appointments. On one occasion, she attended with reduced foetal movements. She declined regular foetal monitoring of baby's heart, however, saying that she would rather come in to hospital if worried.

2.33 Six weeks after MH's visit to hospital with 'tightenings', Holly was born at 37 weeks gestation. Labour appears to have been straightforward. Holly's birth weight was on the 50th centile. FH was present during the labour. Holly and MH were discharged the day after Holly was born, following safe sleeping advice. FH and MH were just 19 years old. Olivia was 20 months, still a young toddler.

2.34 In summary, therefore, prior to and following Olivia's birth, MH was eligible for support through the Family Nurse Partnership programme. Both parents were also able to access perinatal support through Baby Steps as well as family support through the local children's centre. Parents declined these services, citing a supportive family, although professionals appear not to have explored the nature of that support. There is no reference to parents having a wider network of friends.

2.35 Although MH engaged appropriately with specialist teenage midwifery services throughout her pregnancy, as time went on; parents demonstrated a generally reactive rather than a pro-active approach to health matters. When they had concerns about Olivia's health, they took her to the GP or to out-of-hours services. When any immediate problems were resolved, however, parents often did not take her for follow-up or review. This was a similar pattern to MH's engagement with services in respect of her own health needs, including during pregnancy. As mother and child were registered with different practices, however, this would not have been evident to their respective GPs. FH's approach to managing his health needs is unknown.

2.36 There were no indicators during this time either that Olivia was at risk of significant harm in her parents' care or that parents would pose a risk of significant harm to their unborn child.

2.37 *How effective were services to family members following Holly's birth?*

2.38 Information provided to the review indicates that Holly was seen twice by community midwives on discharge from hospital. One of these visits would have been on the following day. When Holly was three days old, however; MH called 111 to say that Holly had had yellow skin for two days. MH was advised to speak to the out-of-hours GP service, but there is no evidence that this happened.

2.39 Two days later, MH made a second call to 111. On assessment, Holly was found not to be very unwell but, given that this was the second call for a young baby in two days, it was thought that '*the mother may need some support'*. Parents were, therefore, advised to take Holly to the hospital ED. There is no record of Holly being taken to the ED on that date.

2.40 The ambulance service has confirmed that it would not routinely contact the ED to provide details of the call or to check whether the baby had been taken. Had there been safeguarding concerns, however, '*111 staff are trained to discuss with a Clinical Duty Manager, to raise a safeguarding alert, to alert the hospital and to call the hospital at the end of the time frame to check attendance'*.

2.41 At that stage, Holly was still under the care of community midwives and should, on this same day, have had her 'heel prick' test. There is no cross-reference to this, however, in the reports available to the review.

2.42 Two days later, now a week old, Holly was taken to see the GP with what was described as a '*worsening condition'*. The GP noted that Holly '*looked quite jaundiced'*. She was also reported to have a 'sticky' umbilicus. Holly was referred to the children's assessment unit for same day assessment. The GP was unaware of 111 calls as parents had not yet registered the baby with the practice. The birth information had been sent to GP practice 1 where MH was registered as a patient. Holly was registered with GP Practice 2 on this visit.

2.43 Holly was taken to hospital and treated with antibiotics and phototherapy. On admission, Holly was found to have a fungal infection in the folds of her skin. A 'wound' in one of the baby's armpits was cleaned and dressed. The chronology notes that it is not clear from hospital records whether staff offered support in respect of infant hygiene and bathing.

2.44 Two days after her admission, Holly was discharged home as jaundice was improving. Oral antibiotics were prescribed for the next five days. The GP practice was informed and information was shared with health visitor.

2.45 The health visiting offer to new-born Holly was again 'universal'. At that time, this meant eight home visits, to include an extra new-birth visit, a 3-4 month review and a school-ready visit. This increase was part of an improved offer to '*help health visitors to identify concerns at an earlier stage and refer to additional support*'.

2.46 After a number of attempts to make an arrangement with MH, the health visitor made her first new-born visit to the family home five days after Holly was discharged from hospital. Both parents and both children were present. The health visitor gained a positive impression of the family. During the visit, the health visitor talked to parents about the safe care of an infant.

2.47 Although notification had been sent to the health visitor from the hospital about Holly's hospital admission, the health visitor did not recall having received it at this point. In her experience, that would not be unusual given how recently the baby had been discharged. The couple, however, did not refer to Holly's having been in hospital. As a result, the health visitor was not able to explore the impact of recent events on parents' confidence and levels of anxiety. She also had no knowledge of potential issues relating to hygiene and skin care. The health visitor would have expected parents to have shared such significant information.

2.48 The next two attempts by the health visitor to see the family at home have been described as '*failed encounters'*. On the second occasion, the health visitor was able to make telephone contact with MH who said that she had been out with her mother-in-law. Holly was said to have '*some vomiting after feeds'*. The health visitor gave MH appropriate advice.

2.49 When Holly was around 2 months old; the health visitor made her 6-8 week review visit to family home. Parents and both children were present. On this occasion, the room was very warm and the health visitor was a little concerned about a rash on Holly's chest. As the room got cooler, however, the rash faded. The health visitor talked to the couple about temperature control and provided a room thermometer.

2.50 All routine aspects of the second new-born visit were completed and no concerns were voiced or observed. Enquiries in respect of MH's mental health had a 'positive response'. MH was seen cuddling and talking to Holly. The health visitor recalled that the couple referred to '*struggling financially'* and that FH was '*returning to work soon'*. It is not known, however, how long the family had been without his wages or what the impact of this had been. Family support was reported to be continuing, but again no detail was noted in the record.

2.51 As before, the health visitor's impression of family life was positive. Parents were friendly and relationships appeared relaxed. The family home was well furnished and the children had age appropriate toys. Although a number of appointments had been missed or re-arranged, the reasons that MH gave for changing arrangements had been reassuring.

2.52 Around this time, GP Practice 1 began efforts to determine at which, if any, GP practice Holly had been registered, given that she was not registered with them. The details of interagency communications were not recorded, but it is noted that MH was spoken to and she confirmed that Holly was now registered at GP Practice 2. GP Practice 1 analysis reports, however: "*It appears that in endeavours to ensure that the baby was registered with a GP, MH slipped through the net for a post-natal appointment".* The practice notes that this is '*something we will look into*'.

2.53 Over the course of the next 2 months, the health visitor made three visits to the family home but was not able to gain access. The health visitor left a calling card on each occasion but she was not alarmed by the lack of response from parents. In the health

visitor's experience, while difficulty in arranging a new-born visit is somewhat unusual; a significant minority of parents begin to disengage from the service as the baby develops. At this point, the health visitor had completed two of the three core visits expected.

2.54 In mid-June 2018, Holly was not brought to GP for her first round of immunisations: the surgery initiated what is described as its 'DNA' protocol. The SCR Panel has discussed the use of 'DNA' in respect of appointments for children who rely on their parents or carers to bring them. Since 2018, health practitioners have been encouraged to change their recording in medical records from 'did not attend' to 'was not brought'. The purpose of this change was to shift focus from the fact that the appointment has been missed and rather to emphasise the potential impact on children of health appointments which have not taken place as planned. This is a significant element of the local strategy to improve the early identification of potential neglect.

2.55 In August 2018, Holly was taken to the GP with a viral infection. This was '*an uneventful examination'*: Holly appeared '*well, happy and smiley*'. The GP analysis states that this and any previous presentations were '*not symbolic of a pattern*' and so were '*not significant'*. At this point, however, Holly was around 5 months old and had not yet started infant immunisation programme. Given Holly's presentation with a virus, this was perhaps a missed opportunity to explore this with parents.

2.56 Two weeks later, MH was advised to attend out of hours GP service following a 111 call in respect of her own health. There is no evidence that she did so.

2.57 When she was almost six months old; Holly had her first childhood immunisations and developmental review by the GP. Although this was significantly delayed, Holly was found to be developing in line with expectations and systemic examination was also normal. By this point, however, Holly had '*missed the window'* for rotavirus vaccination which is usually given in two oral doses for babies aged 8 and 12 weeks. Rotavirus infections are the leading cause of infections causing vomiting and diarrhoea among young children in the UK. An appointment was made for second immunisations.

2.58 The following day, the health visitor attempted unsuccessfully to undertake Olivia's 2-year developmental review. Again a contact card was left. At this point, the family had not been seen by health visitor services for 5 months. The health chronology notes that there was no evidence of a plan in the record to pursue contact or of consideration of the appropriateness of the current health visiting tier.

2.59 During the next five weeks, family members missed four further health appointments. MH did not attend two appointments for asthma review; Holly was not brought to appointment for her second immunisations; and, a re-arranged appointment for final immunisations for Olivia was cancelled by a 'parent' as Olivia was unwell. This latter appears to have been the last contact between parents and agencies/ organisations before the emergency calls when Holly was found to be unresponsive.

2.60 In summary, therefore; from the time that Holly was born, the family's pattern of accessing health services continued in a similar way. When parents were concerned about Holly's jaundiced presentation, they contacted out-of-hours services for advice but they did not follow up recommendations for direct examination. When Holly's condition showed no improvement, however, she was taken to the GP, from where arrangements were made for her to be admitted to hospital.

2.61 Two core visits were completed by the health visiting service. These appear to have met expectations of practice in terms of delivering safety advice through safe sleeping and temperature control. Although discussion identified potential pressures in respect of FH's working arrangements the implications were not explored.

2.62 It is acknowledged that it is difficult to build trusting working relationships with parents when contact is limited, either by the nature of the offer or when gaps develop when parents are not at home when visits are planned. This much reduces the chances of creating an environment in which sensitive issues can be discussed. This does not, however, reduce the expectation that professionals will encourage parents to elaborate when conversations reveal stress factors that could affect their capacity to care for their children.

2.63 Throughout the period, a number of health appointments did not take place in a timely manner. In particular, the children were not consistently brought for childhood immunisations and, as a consequence some elements of protection were not able to be given. Similarly, parents did not ensure that the children's development was reviewed at the usual stages, despite professional efforts. While Holly was found to be developing normally when her early stages development review completed; when Olivia was brought into care, her speech and language were found to be delayed.

2.64 Although parents' pattern of engagement with professionals might have been consistent with underlying concerns about their care of the children; there were no suspicions of additional concerns such parental substance misuse, domestic violence or parental mental ill health. Home conditions were good. No allegations of poor child care had been made by extended family or members of the community. While there was some evidence of poor hygiene practices; on the basis of information known to professionals at that time, there was no evidence that Holly was at risk of significant harm either through abuse or neglect. Holly's death, now confirmed to be the result of a criminal act, appears, therefore, to have been unpredictable.

2.65 *How effective were safeguarding measures immediately following Holly's death*?

2.66 Professional actions following Holly's death were consistent with expected practice. Olivia was taken into police protection. She was taken for a child protection medical where she was found to have an unexplained bruise on her cheek. Non-accidental injury could not be ruled out but the primary concern for her safety was the risk of harm from parents who were suspected of causing her sister's death.

2.67 A child protection strategy meeting was held and child protection enquiries began. Both parents had obtained independent legal advice and they agreed to Olivia being accommodated by the local authority when police protection expired. As noted earlier, Olivia subsequently became the subject of care proceedings.

2.68 *What work by agencies had a positive impact on family members?*

2.69 Good midwifery care throughout both pregnancies ensured that the risks to both mother and infant were minimised, resulting in the safe delivery of healthy babies and a well mother. As already indicated, health visitors supported parents to manage Olivia's nutritional needs when there were concerns about her weight.

2.70 GPs treated the children for minor ailments as they were brought to their attention, initiated immunisation programmes and referred for paediatric assessment when required. MH appears to have had confidence in her GP practice, as she chose to remain there despite the children receiving services elsewhere. As with the children's GP, GP Practice 1 responded quickly when MH recognised that her own condition was becoming critical. The practice was also active in ensuring that Holly was registered with a GP.

2.71 Olivia was protected when concerns were identified about the circumstances of Holly's death.

2.72 *What steps could have been taken to improve the service provided to family members?*

2.73 Professionals recognised that MH and FH were young parents and that this was a vulnerability. As a result, they attempted to engage the couple with the range of resources which are designed to support prospective, new and, in particular, young parents. When offers of services and community support were declined, however; there appears to have little attempt to establish the nature of the support being provided by family or to consider whether there might be outstanding need.

2.74 The midwifery/ health visitor agency analysis acknowledges that midwife records are '*factual and practical'*, reflecting more of a '*medical*' model than a '*person –centred'* approach. As a result, the record gives little sense of MH as a young person or of her experience as a young mother living away from home. At the same time, while the health visiting model of care was more '*holistic*', the records did not provide an understanding of either parent's background or family members' lived experiences. The analysis suggests that a more enquiring approach could have built a better understanding of parents' history and everyday lives.

2.75 The relevant health trust report acknowledges the need to gather clearer information about children's lived experiences and to record these appropriately. It indicates that this

now forms part of mandatory training. It is expected that information on the child's lived experience will be documented within the electronic universal templates.

2.76 Although inconsistent engagement was a key characteristic of parents' habitual response to health services; the reasons for this were never explored. Communication between health disciplines was also less than optimal. In particular, the importance of communication between midwifery and health visiting services is highlighted as fundamental to service delivery. The agency analysis recognises that '*the lack of information sharing in this case, particularly during MH's first pregnancy…may have impacted on her engagement with the health visiting service'.*

2.77 GP Practice 2 has identified that there was no communication between the practice and health visiting services during much of the review period. The GP attributes this to the changes to health visitor provision which meant that weekly visits with a named health visitor no longer took place. In fact, the review has been assured that the practice does have a named health visitor and the Designated Nurse (CCG) has ensured that the practice has been given the details.

2.78 Both GP practices acknowledge that there were some difficulties caused by MH being registered at a different practice from the children and their father. The case review panel commented that this seemed an unusual arrangement although the CCG described it as 'quite common across (the town)'. The Designated Nurse (CCG) has indicated that this practice could be considered to be a weakness from a safeguarding perspective and that, where possible, families are encouraged to use a single surgery.

2.79 *What actions have agencies taken or do they propose to take as a result of what they have learned from their reviews of practice?*

2.80 The health agency analysis has identified there was no pathway in place to support staff in managing this risk of not being able to see children at home. It notes that '*a robust pathway that considers the potential impact of vulnerabilities… would enable staff to persist in their follow-up with families where increased risk factors are identified*'. It has been reported to the review that there has been some progress in respect of this issue but conversation with the health visitor identified that details of a new pathway have not yet made their way to local practitioners.

2.81 GP Practice 1 has identified that review processes for patients such as MH could be improved and also intends to 'look into' a system to minimise the chance of missing post-natal appointments.

2.82 GP Practice 2 has developed a workflow protocol for new born babies and under -5s to ensure that notifications of new born babies are monitored so that they can be registered with the practice, irrespective of whether the mother is a patient. Systems to improve attendance for immunisations are included in the protocol.

2.83 Family members were not known to police other than in the circumstances described within the key lines of enquiry. Practice by officers was consistent with agency expectations and so no additional lessons were learned.

2.84 Education/ the parents' school have not identified any lessons or suggested any actions for change.

2.85 *What is the impact on learning of information about family life obtained since Olivia has been looked after?*

2.86 Two court processes were initiated following Holly's death; the criminal case and public law proceedings in respect of Olivia. The criminal case concluded before trial when MH's plea was accepted by the CPS. Both legal processes have had access to, and the capacity to interrogate, information and testimony which was not available to this review. The local authority has, however, provided the Partnership with some details of family life obtained through assessments commissioned as part of care proceedings.

2.87 It is reported that MH and FH had been a relationship since they were in school. MH moved to live with FH's family when she was 16 years old. As noted above, the couple remained in the household until Olivia was almost 18 months old. FH was one of a large number of siblings and step-siblings. His family is described as having provided '*a stable and supportive family experience with a good network of support'*. CSC indicates that FH and MH relied heavily on support for paternal family, particularly PGM, '*for many aspects of caring for the children*'. When the family moved into their own accommodation, PGM and paternal uncle provided child care, financial help, and assistance with domestic chores, such as shopping and cleaning. MH told CSC, however, that she had been unable to leave the house alone with the two children as '*she did not have a double buggy*'.

2.88 As noted earlier, at the point that Olivia became looked after, her speech was delayed. Although she appeared to have a good level of understanding, she had limited production of language. She has since been referred to Speech and Language Therapy and, at the last report, was *'making good developmental progress with her foster carer'*. Olivia is said to present as '*quite an anxious'* child who took time to settle with her carers and who continued to demonstrate anxiety behaviours when she experienced change. It is not known to what extent this anxiety was an existing condition or was the result of the events which so suddenly changed her everyday life. Information relating to Olivia's understanding of what happened to her sister has not been given.

2.89 CSC records indicate that parents were '*not together as a couple'* prior to Holly's death, but that they continued to live in the same house. This was not known to health professionals.

2.90 In assessments, both parents spoke about '*arguing over money and blaming each other for not being able to pay the bills*'. FH is described as having worked long hours and, as noted above, MH has said that she was unable to leave the house in his absence. It is likely,

therefore, that the primary responsibility for everyday child care was MH's, albeit with support from wider family.

2.91 Establishing a good bedtime routine appears to have been a challenge for parents. MH, in particular, is said to have '*found some elements of parenting difficult'*, including '*Holly screaming at night'*. It is not known to the review to what extent FH or other family members were aware of MH's struggles.

2.92 Overall, new information from CSC confirms that paternal family provided active support to parents in a variety of ways. It also identifies additional pressures on MH and FH which had not previously been recognised. The reported breakdown in parents' relationship, financial concerns and the tiredness induced by everyday living are particularly significant. Those pressures are likely to have had an impact on parents' capacity to provide the children with the care they needed. It is possible that, had a fuller picture of family life emerged, additional community support could have been provided which could have helped alleviate parental stress. The family history suggests, however, that such offers may well have been refused.

3. Analysis

3.1 When multi-agency reviews are undertaken in respect of children who have died as the result of abuse or neglect, it is compelling to believe that there must have been signs, which if responded to differently, could have prevented the loss of that life. As described in the key lines of enquiry, however, there is no such evidence in Holly's case. Although a number of vulnerabilities have been identified (some with hindsight); Holly was not obviously a child in need or at risk of significant harm. This, therefore, '*brings into sharp relief the unpredictability of many deaths or serious harm in the context of child abuse*[2]*'.*

3.2 At the same time, elements of the learning identified by single agency analysis are reflected in a previous local SCR (Child CE) recently published by the Children's Safeguarding Assurance Partnership. That review emphasised the need for professionals to be '*actively curious about members of the household, family dynamics and actual, or potential, risks to children'*. In addition, as analysis in this case reveals, professionals should particularly ensure that vulnerabilities identified at an earlier stage in work with the family reduce rather than increase over time. The importance of reference to records and communication between disciplines are highlighted as significant in supporting this practice.

3.3 This review makes no recommendations for changes to multi-agency safeguarding practice. The dissemination of the report's findings will, however, offer an important opportunity to remind professionals of the particular safeguarding risk factors associated with babies and very young children and what those risk factors mean for practice.

[2] Child Safeguarding Practice Review Panel Annual Report 2020

3.4 Primarily, it should be remembered that children under 1 are the most likely age group to die through abuse or neglect[3]. Children under 1 have also been consistently a high proportion of subjects of serious incident reports and serious case reviews[4]. Learning from such reviews has, over the years, informed changes to midwifery 'screening' for parental risk factors and to the advice given to all new parents in respect of safe handling of babies and safe sleeping. A summary of risk factors and learning for improved practice with infants was published by NSPCC in 2017 and provides a helpful guide for professionals working with families where there are children under 2.

3.5 It is also notable that, as a consequence both of the incidence of serious incidents involving non-accidental injuries to babies and of the levels of violence involved; the national Child Safeguarding Review Panel intends to make non-accidental injuries to babies the focus of its next thematic national review. It is understood that the Panel has already a commissioned a literature review and undertaken preliminary work. Publication of learning from that review will offer the Partnership another opportunity to reinforce the messages for safeguarding practice with babies and very young children.

4. Recommendation

The Safeguarding Partnership should ask agencies which have contributed to the review to provide evidence that they have completed proposed actions and, where possible, to summarise their impact.

IC 12/04/21

[3] NSPCC Statistics briefing, child deaths by abuse and neglect September 2020

[4] Ofsted, Ages of Concern 2011 and Child Safeguarding Practice Review Panel: Annual Report 2018-2019