Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Serious Case Review

Overview Report

Child LT

Author: David Mellor

Date: 19th December 2019

Publication Date: 5th October 2021

Serious Case Review – Child LT

Contents

Introduction	**1**
Terms of Reference	**2-3**
Glossary	**4-5**
Synopsis	**6-16**
Family contribution	**17-18**
Analysis of Learning Themes	**19-33**
Findings and Considerations	**34-39**
References	**40-41**
Appendices	

1.0 Introduction

1.1 On 21st June 2018 a child who will be referred to in this report as Child LT was taken to the local acute hospital with injuries consistent with having been severely shaken and from impact with a hard surface. His father was arrested, and, at the time of writing, the criminal investigation is ongoing.

1.2 Lancashire Safeguarding Children Board (now succeeded by the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership) decided to conduct a Serious Case Review (SCR) on the grounds that Child LT had suffered significant harm and abuse was suspected.

1.3 The SCR was commissioned under the 2015 Working Together statutory safeguarding children guidance. Since the SCR was commissioned the 2018 Working Together statutory guidance has been implemented which replaced SCRs with local and national child safeguarding practice reviews and replaced Local Safeguarding Children Boards (LSCBs) with 'safeguarding partners'. This SCR was commissioned, and has been completed, under the 2015 statutory guidance.

1.4 Lancashire Safeguarding Children Board appointed Kathryn Bonney as chair of the SCR Panel established to oversee this review. She is Head of Safeguarding for the East Lancashire Hospitals NHS Trust which had no involvement in this case. David Mellor was commissioned as the independent reviewer for this SCR. He is a retired chief police officer and former independent chair of safeguarding children and adults boards who has seven years' experience of conducting SCRs and other statutory reviews. He has no connection to Lancashire or any of the agencies involved in this case. The membership of the SCR Panel and a description of the process by which this SCR was carried out is shown in Appendix A.

2.0 Terms of Reference

2.1 This SCR focusses on the period from 1st March 2016, when agencies first became aware of father and mother's relationship until 21st June 2018 when Child LT sustained serious injuries.

2.2 The following specific questions will be addressed by the SCR:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies
- Examine the involvement of other significant family members in the life of the child, and family support provided to the subject family
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children
- Determine the extent to which decisions and actions were focussed on the subject children
- Explore whether opportunities to consider and analyse the lived experience of the subject children were taken particularly in relation to exposure to domestic abuse and adult mental health issues
- Analyse whether risks to the unborn child were assessed sufficiently including consideration of use of the pre- birth protocol
- Examine the quality of assessments regarding the subject children, particularly in relation to the impact of parental mental health issues (including maternal pre/post-natal periods) and domestic abuse on parenting capacity and their ability to protect
- Examine whether Adult Services utilised a 'think family' approach including whether mental health risk assessments were sufficiently holistic and robust
- Determine the extent to which professionals identified domestic abuse and what action was taken in response to disclosure

- Explore professional understanding of coercive control and disguised compliance on patient engagement and potential for minimising of risks

- Determine the extent to which there was management oversight and due consideration given to escalating concerns

- Explore whether additional risk factors within the family were consistently and appropriately considered including housing issues/ conditions

- Were responses to adults with language barriers appropriate, did agency policy and procedures support professionals to engage with interpretation services

- In relation to interpretation, did professionals recognise the potential risks of using family / friends as interpreters and was due consideration given to the language and communication skills of 'untrained' interpreters when providing information or making requests

- Identify any actions required by the LSCB to promote learning to support and improve systems and practice

3.0 Glossary

Asylum seeker - a person who has claimed asylum under the 1951 United Nations Convention on the Status of Refugees on the ground that if they are returned to their country of origin they have a well-founded fear of persecution on account of race, religion, nationality, political belief or membership of a particular social group. They remain an asylum seeker for so long as their application or any appeal against refusal of their application is pending.

The **Care Programme Approach** (CPA) is a package of care for people with mental health problems. Service users will have a care co-ordinator (usually a nurse, social worker or occupational therapist) who will manage their care plan and review it at least once a year.

A **Child in Need (CiN)** is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

The purpose of the **Child and Family Assessment** is to determine if there is identifiable evidence of risk or identifiable significant harm to the child or whether they are unlikely to achieve or maintain a reasonable standard of health or development or they have a disability.

The **Common Assessment Framework (CAF)** is a process for gathering and recording information about a child in respect of whom practitioners have concerns in which the needs of the child and how those needs can be met are identified.

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

The term **Early Help** describes the process of taking action early and as soon as possible to tackle problems and issues emerging for children, young people and their families. Effective help may be needed for at any point in a child or young person's life.

Independent Domestic Violence Advisor (IDVA) Their main purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

The **perinatal period** refers to pregnancy and the first 12 months after childbirth. Specialist community perinatal mental health teams offer specialist psychiatric and psychological assessments and care for women with complex or severe mental health problems during the perinatal period.

SafeLives DASH (Domestic Abuse, Stalking and "Honour"-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required.

Team Around the Family (TAF) is a model of multi-agency service provision. The TAF brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. The members of the TAF develop and deliver a package of solution-focused support to meet the needs identified through assessment and multi-agency planning.

Think Family is an agenda which recognises and promotes the importance of a whole-family approach. Services work with both adults and children and take full account of family circumstances and responsibilities. Practitioners work in partnership with families with the aim of promoting resilience and building on family strengths.

4.0 Synopsis

4.1 At the time his relationship began with mother in early 2016 father was 46 years of age and appears to have entered the UK as an asylum seeker from either Pakistan or Afghanistan and subsequently been granted permanent leave to remain. It is understood that he has two adult children living in Pakistan. He speaks Farsi and Urdu and some English. It is reported that mother was 29 years old when her relationship with father began. She was born in Afghanistan where she had been married previously and given birth to a child. She entered the UK on a spousal visa. She is a Farsi speaker with very little or no English.

2016

4.2 During March 2016 mother registered with father's GP practice. It was documented that she originated from Afghanistan and that she had recently 'moved over from Ireland' and 'therefore' there was no access to her prior medical records. Mother spoke no English and signed a document to authorise the sharing of information by the GP practice with father 'for interpreting purposes'. She was only to be seen by the two doctors at the GP practice who spoke Urdu. Mother was pregnant and the GP referred her to midwifery for booking in.

4.3 On 22nd April 2016 mother was seen for a midwifery booking appointment at the local acute hospital. Interpreting services were obtained via Language Line – an approved telephone interpreting service. Mother was accompanied by her mother and younger siblings. The pregnancy was considered to be low risk.

4.4 On 27th June 2016 mother attended a further midwifery appointment. On this occasion she was accompanied by an un-named friend who interpreted. During this appointment mother disclosed that she had given birth to a child in her native Afghanistan approximately two years earlier which had been removed from her care at birth. She appeared unsure about who was caring for the child. The midwife referred mother to the Enhanced Support Midwifery Team (ESMT). (The Named Midwife for Safeguarding and Safeguarding Midwives sit in this team within Maternity which has close links with the Lancashire Teaching Hospitals NHS Trust Safeguarding Team).

4.5 On 30th June 2016 father was referred to the then Lancashire Care NHS Foundation Trust (LCFT) START (Specialist Triage Assessment Referral and Treatment) Team which provides a triage, assessment, onward referral/signposting and treatment for referred service users without the need for multiple assessments. The referral, which was described as 'routine' was received from father's GP and documented father's low mood and reporting of auditory hallucinations.

4.6 On 7th July 2016 father was assessed by the START team and a mental health practitioner, the outcome of which was that his medication was to be discussed with the consultant psychiatrist. The waiting time to see a consultant psychiatrist was around six months at that time. Additionally, father was provided with the contact details of the Lancashire Wellbeing Service, which provides a targeted service helping adults with long term health conditions, low level emotional health, and lifestyle or social issues, regarding 'social issues'. It is not known what was meant by the reference to 'social issues' and whether they may have included mother's pregnancy. There is no record of father contacting the Wellbeing Service.

4.7 During the early hours of 20th July 2016 father rang the police on three occasions to complain about noise from his neighbour. The first call was treated as a concern for father's safety as he sounded very distressed when he made this call, via the 999 system, to the police.

4.8 On 21st July 2016 a specialised safeguarding midwife visited mother at home to obtain further information about her first child born in Afghanistan. The booked interpreter failed to attend and so Language Line was used. Mother disclosed that she became pregnant shortly before her divorce from her ex-husband in Afghanistan and he removed the child from her shortly after the birth. She said that in Afghanistan, 'the father has more rights and can keep the child'. Mother added that her ex-husband was a 'very cruel man towards her' and that she had had no contact with her first child since the child's removal. She denied any attempt to mislead the midwife at the initial booking appointment when she had answered the question about other children in the negative and had simply misunderstood the question. Mother was seen alone and stated that unlike her first marriage there was no domestic or alcohol abuse in her current marriage. At the end of the visit father returned and 'in broken English' disclosed ongoing racial abuse from their upstairs neighbour. As a result, the midwife made a referral to the Police Diversity Unit. The midwife also contacted children's social care in respect of mother's first child and was advised to monitor the pregnancy and advise of any concerns, should they arise. The GP and health visitor were also subsequently notified. During the conversation with the latter service midwifery advised that as mother had become upset during the consultation with midwifery, they would be monitoring her mood antenatally.

4.9 On 9th September 2016 a member of the Lancashire Police Diversity Unit followed up on the referral from the specialist safeguarding midwife and saw father at a local disability resource centre which works with black and minority ethnic disabled people and their families. Father stated that their upstairs neighbour shouted at, and racially abused him and his wife when they came out of their house

and banged on the door and made it impossible to sleep during the night. Father said he had previously reported the matter to the police and his housing provider. Father said that the housing provider planned to move him and mother to another property but this would take 'a couple of months'. The neighbourhood policing team were notified of father's concerns and they visited father the following day and spoke to him through an interpreter. Father stated that he had not had any further problems with the neighbour since his previous contact with the police in July 2016 and the incident was closed. The Police Diversity Unit later advised midwifery that the reported problem with the neighbour had been resolved and that father was receiving support from the local disability resource centre referred to above and that mother would also be attending to learn English.

4.10 On 14th October 2016 father was seen by the consultant psychiatrist to whom he had been referred in July 2016 by START. The consultant documented that father had previously sustained an injury at work which adversely affected him both physically and mentally and had caused him financial hardship. He was considered to be 'fairly stable' on the medication prescribed to him but the consultant set out a plan of potential medication changes should there be 'difficulties in the future'. No risks to self or others were identified nor were any safeguarding issues. Father's case was closed to START at that point.

4.11 On 3rd November 2016 a health visitor made an antenatal visit to mother accompanied by an Urdu speaking key worker from within the health visitor team. However, it was established that mother was a Farsi speaker which meant that the visit could not continue and it was rearranged for the following day when the health visitor was accompanied by a Farsi interpreter. Father was also present and so the health visitor concluded that it was not appropriate to discuss her first child with mother. There were no concerns identified in respect of the pregnancy or mother's mood. Both mother and father raised concerns about their upstairs neighbour who they stated drank alcohol all day and made noises at night, stole clothes from their washing line, threw beer and takeaway boxes in their garden and racially abused them. The health visitor contacted mother and father's housing provider in respect of the neighbour concerns who advised that they would send a community support officer to visit.

4.12 Later in November Child 1 was born and on 1st December 2016 the health visitor, accompanied by a Farsi interpreter, visited the family at home. No concerns were identified other than the need to provide safe sleeping advice as mother advised that Child 1 was being placed on a large cushion. ('Furniture' in the living area consisted primarily of large cushions).

4.13 Between 19th December 2016 and 25th January 2017 the health visitor made six further home visits. Safe sleeping advice was provided on the first of these visits as Child 1 was swaddled extremely tightly and when in the moses basket was covered from head to toe in a thick blanket. The risks of restricted breathing and overheating were explained. When Child 1 began experiencing discomfort from an umbilical hernia, the health visitor arranged a GP appointment which the parents did not take the child to as it clashed with an appointment for father in Manchester (no further details of father's appointment). The health visitor experienced considerable difficulty in arranging interpreting services for each of these home visits. On three occasions the booked interpreter did not attend necessitating the use of a telephone interpreter on one of those occasions and on another occasion the booked interpreter was unable to understand the dialect 'of the parents'. During the penultimate visit father disclosed that he could speak Urdu, which in the view of the health visitor contradicted what the family had told her during the 3rd November 2016 visit accompanied by the Urdu speaking link worker.

2017

4.14 On 27th January 2017 father contacted the local disability resource centre to report that he continued to experience problems with his upstairs neighbour. The police were called and, with the assistance of an interpreter, were told by father that the neighbour shouted at him 'every time his three month old baby cried', that the neighbour's loud music disturbed the child's sleep and that the neighbour had threatened him with a knife the previous evening. Father said he had called the police at the time but had been unable to explain the situation because of the language barrier. (No record of earlier call to the police shared with this review) The police recorded that father 'suffered from mental health problems' and asked them not to speak to the neighbour in case this further inflamed the situation. Father was advised to contact the police and his housing provider if further problems arose and not to contact the neighbour. The police completed a Protecting Vulnerable People (PVP) referral which was shared with children's social care, 'health' and midwifery. The risk was assessed by the attending officer as 'medium' although reference to Child 1 was initially omitted from the referral but subsequently appended by the Multi-Agency Safeguarding Hub (MASH).

4.15 In his housing provider's record of the above incident they have documented that father subsequently withdrew his allegation that the neighbour had threatened him with a knife, acknowledging that he had said this to help expedite a move to another tenancy.

4.16 No agency appears to have had any relevant contact with the family between February and June 2017.

4.17 On 26th July 2017 the GP referred father to the START team citing low mood and referring to a history of depression and psychotic symptoms. The referral also documented a disability in his left upper limb arising from an accident to which current pain in his lower back was attributed. On the same day father was seen for a triage appointment and placed on a waiting list. The normal waiting time was 10 days but at that time was longer as a result of lack of staffing. Father does not appear to have been seen until 11th October 2017, a waiting time of over two months.

4.18 On 17th August 2017 the GP referred mother to midwifery as she was pregnant with Child LT. The referral stated that neither mother nor father spoke English and that father suffered from 'severe depression with psychosis' but was 'currently stable and on treatment'.

4.19 On 1st September 2017 mother attended antenatal clinic for the initial booking in appointment. She was accompanied by an un-named female friend who she said she wished to use as an interpreter and Child 1. Mother declined the offer of the use of Language Line. During the appointment mother referred to father having other children who were living in Afghanistan. A referral was made to ESMT as a result of father's history of 'severe depression and psychosis' which had been cited in the GP referral. The midwife documented that father's depression was 'controlled'.

4.20 On 15th September 2017 mother's pregnancy was discussed in a 'weekly allocations meeting' (LTHTR) with a 'social work manager' and it was planned to see mother at the next clinic to find out further information about father's children and establish if there were any safeguarding concerns. (Mother did not attend her next clinic appointment on 2nd October and so this was rearranged for 16th of that month).

4.21 On 23rd September 2017 father telephoned Lancashire police and left a message on their answer phone reporting that he and his family had been victims of racist abuse whilst travelling on a train between Blackburn and Preston. The incident was transferred to British Transport Police. The outcome is not known.

4.22 On 5th October 2017 the health visitor, accompanied by a Farsi interpreter, carried out a home visit for the 8-12 month development assessment of Child 1. No development or health concerns were identified. Father was not present but persistently telephoned mother to seek the assistance of the interpreter to translate letters from a large bag of general mail. This made it difficult to engage mother in the review. The health visitor noted that this was not the first time that father had behaved in this manner.

4.23 On 11th October 2017 father was assessed by a mental health social worker following the 26th July 2017 GP referral to START. Father disclosed that his mood had deteriorated over the past 2-3 months. He said he was experiencing thoughts of self-harm and visual and auditory hallucinations. He said that he experienced both male and female voices outside his head telling him to 'kick them' or 'eat them' referring to other people. Father was not in compliance with his prescribed medication (Olanzapine and Quetiapine) and was advised to continue taking this medication. The plan was for father to by seen by a psychiatrist for urgent review. The assessment of father noted that he had a one year old child and it appears to have been decided that the child's health visitor should be contacted but there is no record of any such conversation taking place in either mental health or health visitor records.

4.24 On 16th October 2017 mother attended antenatal clinic. Language line was utilised and mother disclosed a history of postnatal depression although she reported feeling well at that time and 'well supported living with her husband and son'. There is no reference to the enquiries with mother proposed at the 15th September 2017 'weekly allocations meeting' being made.

4.25 The urgent review referred to in Paragraph 4.23 took place on 23rd November 2017 when father was assessed by a community psychiatric nurse (CPN) from the complex care and treatment team and a doctor who interpreted in Urdu. Father was noted to be experiencing auditory hallucinations which appeared to periodically distract him during the assessment. He expressed concern about his continuous low mood and difficulty in controlling his anger. Father disclosed thoughts of suicide but said he had not acted on these as a result of his parental responsibilities towards his one year old son. He was assessed as not being at immediate risk to himself and no risk to others as he had never attempted to harm others although incidents in which he had smashed household items were noted. Father had been referred to the community mental health team (CMHT) for allocation of a care co-ordinator.

4.26 During December 2017 mother continued to attend appointments with the community midwife.

2018

4.27 On 9th January 2018 mother attended a community midwife clinic accompanied by father who was used as an interpreter for mother. However, it was not possible to complete the appointment as father became distressed about the family's housing and left. The midwife arranged for a community midwife to carry out a home visit to assess the situation and consider what support the family may need. The GP records

of this appointment also indicate that a Common Assessment Framework (CAF) assessment and planning tool would be completed by the community midwife. (The aim of a CAF is to identify any specialist support children with significant and complex additional needs may require from across education, health and social care.)

4.28 On 16th January 2018 the ESMT midwife contacted the family's health visitor to enquire whether there were any safeguarding concerns. The health visitor replied that no safeguarding concerns had been apparent in any of the visits that she had carried out. The ESMT, to which mother had been referred on 1st September 2017 as a result of concerns about father's mental health and the issue of father's two children in Afghanistan, stepped the case down to community midwifery.

4.29 On 24th January 2018 father was seen for review by his care co-ordinator and was said to have reiterated all symptoms disclosed in previous contacts. It was documented that these symptoms were exacerbated by a neighbour who was 'loud during the night' and father's one year old son who was 'loud during the day'.

4.30 On 6th February 2018 mother attended a community midwife clinic. She was accompanied by Child 1 who was recorded to be 'well'. Mother reported 'trouble with housing and noisy neighbours'. She also said that she had seen their housing provider earlier that day, adding that the family was on a waiting list for a move to a new tenancy although the waiting list was more than a year. The community midwife referred the family to the children and family wellbeing (CFW) service for support. The source of interpreting support was not documented.

4.31 On 7th February 2018 their housing provider installed noise monitoring equipment at the family's address.

4.32 On 1st March 2018 the children and family wellbeing (CFW) key worker visited the family for the first time but the lack of an interpreter limited progress. (The referral to the CFW had not identified the need for an interpreter). A joint home visit was to be arranged with the midwife.

4.33 On 6th March 2018 the GP received correspondence from mental health services in respect of father in which he was documented to be compliant with medication to which he was said to be responding well.

4.34 Child LT was born in mid-March 2018 in the Birth Centre at the local acute hospital. It was a normal delivery. Language line and friends were used for interpreting. Mother and baby were discharged home the following day.

4.35 On 19th March 2018, after CFW experienced some difficulties in contacting the community midwife, a joint home visit was arranged for 23rd March 2018 to initiate a CAF assessment.

4.36 On 21st March 2018 father was seen by a new care co-ordinator and a mental health support worker. He presented as extremely agitated and upset regarding the family's home conditions. He said that he wife had just given birth and he 'was left to care' for Child 1. He disclosed that his auditory hallucinations had been extremely accentuated since the day on which his wife had given birth to Child LT. He also reported command hallucinations telling him to do 'various things' which he felt compelled to do. Father reported feeling extremely low in mood. An urgent medical review with the consultant was arranged for 26th March 2018.

4.37 On 23rd March 2018 the community midwife and CFW key worker made a home visit. Father, mother and both children were present. No concerns were noted. Language line was used for interpreting. The CFW key worker was to complete the Family Outcomes Star tool with the family which focuses on seven areas which are key to effective parenting which are physical health, emotional well-being, keeping your children safe, social networks, boundaries and routines, child development and home, money and work. The seven areas are represented in the tool as the points of the Star. This tool was never completed as a result of 'language difficulties'.

4.38 On 26th March 2018 father attended the urgent medical review with the consultant psychiatrist referred to in Paragraph 4.36. Father was noted to be complying with his medication and his auditory hallucinations were said to have subsided. His mood was said to be low due to his (unspecified) 'personal circumstances and issues'. No reports of self-harm or harm to others were said to have been reported or identified. The plan was for his medication to continue unchanged and for a CT scan of his brain in order to rule out any physical health issues. (The CT scan had not taken place by the time of the injury to Child LT). Father had no further contact with mental health services prior to the incident in which Child LT was seriously harmed apart from support from a mental health support worker to find suitable housing between 4th April and 20th May 2018.

4.39 On 28th March 2018 a joint community midwife/CFW key worker home visit took place using Language Line. Child LT was noted to be well.

4.40 On 9th April 2018 the community midwife made a home visit. This was to have been a joint home visit with the CFW key worker but confusion appears to have caused the latter worker to abandon the visit. A friend provided interpreting services over the phone after the midwife had tried to use two different interpreters who had been unable to understand mother's dialect. Mother disclosed that her husband had

been abusive towards her including a physical assault when he had hit her in the face a year earlier. She said he never hit the children but shouted at her in front of them which scared Child 1. She added that father smashed plates and cups when angry. Mother also disclosed that she had photographs and recordings on her phone. During the home visit the community midwife rang the health visitor for advice and subsequently agreed a safety plan with mother which included advising mother of the support available from a local voluntary organisation which provided support for black and minority ethnic (BAME) women, details of Victim Support, English words she could use if she contacted the police via 999 and to visit the local shop for help in an emergency. Mother discussed leaving father but expressed concern that if she did this she would lose her children. A joint visit by the community midwife and the health visitor was arranged for two days later (11th April 2018).

4.41 The joint community midwife/health visitor home visit took place on 11th April 2018. Also present was an advocate from the voluntary service for BAME women referred to in the paragraph above and an interpreter. Father arrived back at the address after collecting the keys to a new property which had been provided for the family. It was documented that it was evident that father was not happy with mother obtaining support from the BAME women voluntary service or with professionals 'snooping into his business'. He frequently interrupted practitioners when they were trying to communicate with mother via the interpreter. Mother could be seen to be disagreeing with father by shaking her head and looked upset at times. Father and mother were advised to speak calmly to each other and not to shout in front of the children. Mother declined the opportunity for the next appointment to be held at the health centre. The health visitor decided that the family would receive enhanced support at 'Universal Plus' as a result of the earlier disclosures of domestic abuse.

4.42 During the late afternoon of the same day (11th April 2018) father was conveyed to the local acute hospital by ambulance after being found collapsed at home by mother. A 'poor history' was obtained from father by ED staff as a result of 'confusion and the language barrier'. There is no record of interpreting services being sought at this point. His presentation was documented as 'query overdose of medication' with no documentation of whether the overdose was intentional or accidental. Safeguarding checks were not carried out nor were the 'mental health status' and 'social circumstances' sections of the admission documentation completed.

4.43 Father was subsequently admitted to a cardiology ward. There he reported that after 'going into town' he complained of double-vision, weakness in his whole body and a feeling of heaviness in the back of his head. He said he could not recall

collapsing or being transported to hospital. He did not disclose an intentional overdose.

4.44 On 13th April 2018 father discharged himself from hospital. This was against medical advice as further medical investigation of his condition had yet to take place. Father was considered to have capacity to decide to discharge himself.

4.45 The GP received a discharge letter from the hospital which gave the reason for father's admission to hospital as 'poisoning (suspected overdose)'. The letter stated that there were no safeguarding concerns. The GP followed up on the discharge letter and saw father on 18th April 2018 when he reported feeling low but denied any suicidal intent.

4.46 On 19th April 2018 a community midwife/CFW key worker home visit took place. The booked interpreter had cancelled and so Language Line was used. Father was not present, having taken Child 1 to the park. Mother said that father had apologised to her and there had been no subsequent issues. She said she had no concerns, felt safe and was aware of the support available to her. Midwifery discharged mother and Child LT from the service and later telephoned the health visitor, who was due to visit on 23rd April 2018, to advise that there were no further concerns of domestic abuse. The CFW key worker was to continue to support the family in respect of benefits, housing and 'any items' that mother needed.

4.47 On 23rd April 2018 a planned health visitor/CFW key worker home visit went ahead without the health visitor who had forgotten about the appointment. An interpreter was used. Father was present and expressed his anger at mother's earlier disclosure of domestic abuse. The key worker was to make enquiries in respect of electrical goods.

4.48 On 3rd May 2018 the health visitor visited mother and Child LT to complete the 4-6 week assessment of the child. An interpreter was used. Good interaction and bonding between the child and mother were noted. Mother reported that 'things had been much better' between father and herself and they had not 'fallen out'. The health visitor decided that the family should continue to receive a 'Universal Plus' service due to additional support required for weaning. No safeguarding concerns were noted.

4.49 The following day (4th May 2018) the family moved to their new tenancy.

4.50 On 10th May 2018 the CFW key worker submitted a CAF assessment in respect of Child 1 and Child LT. The CAF highlighted concerns in respect of social isolation, domestic abuse, financial difficulties and the language barrier. An action plan was

drawn up in an effort to address these concerns and it was decided to progress to a team around the family (TAF) meeting. The assessment was registered on the CAF database on 31st May 2018.

4.51 On 15th May 2018 father saw his GP after sustaining a dog bite to his right lower leg.

4.52 On 11th June 2018 the health visitor and the CFW key worker agreed to arrange a TAF meeting in the family home on 21st June 2018 and a letter was sent to the family to advise of the details. This meeting was cancelled on 20th June 2018 as a result of the absence through sickness of the CFW key worker.

4.53 The family appeared to have been unaware that the TAF meeting scheduled for 2pm on 21st June 2018 had been cancelled. The booked interpreter had not been informed of the cancellation either but was able to assist in establishing that the meeting had, in fact, been cancelled through telephone contact with CFW.

4.54 At 3.55pm on the same afternoon (21st June 2018) Child LT was conveyed to the local acute hospital by ambulance. Family members also attended including the child's maternal uncle who was visiting the family from abroad. A scan showed that Child LT had sustained brain haemorrhages and was critically ill. It was suspected that the injuries had been caused by shaking and that he had also been slammed against a hard surface causing bruising to his buttocks. The police were contacted and a criminal investigation commenced.

5.0 Family Contribution

5.1 At the time of writing, the criminal investigation into the assault on Child LT remained ongoing. However, the police had no objection to father and mother being invited to contribute to the SCR. Mother declined involvement in the SCR but father wished to contribute.

5.2 The independent reviewer spoke to father through a Farsi interpreter. Father said that he had been in the UK for 16 or 17 years and had initially settled in Newcastle before moving to Preston in 2010 because he had friends who lived in the city. He said he was single for most of this time and had little contact with services.

5.3 Father was asked to comment on his contact with mental health services during the period when Child 1 and later Child LT were living with him and his wife. He replied that he had seen mental health services only once during this period as a result of stress arising from back pain. He indicated that his back pain had been caused by an earlier industrial accident. He said that when Child 1 was born he had no mental health problems, adding that at that point in his life he was very happy as his whole life had been changed for the better. He said 'life was good'.

5.4 Father was asked about his contact with mental health services during his wife's pregnancy with Child LT and during the period after Child LT was born. He said that he was taking prescribed medication during this period, but that he was not sure what the medication was for, and that it may have been for pain or to help him sleep. He later added that his doctor referred him to mental health services because he had trouble sleeping and that he (father) was 'good with medication' and that whilst taking the medication, he was no trouble to anyone. (Overall, father's recollection of his contact with mental health services appeared to minimise his involvement with that service).

5.5 Father was asked how effective interpreter services had been in helping services understand his needs. He was very critical of the lack of interpreter services. He said there was never an interpreter when he went to see his GP and that for mental health services there was sometimes an interpreter but they often spoke a 'totally different' language to him. He said he complained about unsatisfactory interpreter services and often asked professionals how they would feel if they went to Afghanistan and a French or a German interpreter was provided. When asked how the lack of adequate interpreter services affected the service he received, he replied that it made his situation 'worse and worse' and that he felt that he had no choice but to accept the situation.

5.6 When asked about his wife's knowledge of English, he replied that she had no understanding of English so he would go with her to appointments because he could understand basic information in English. If an interpreter or Language Line was unavailable, he said he would interpret for her.

5.7 When asked for his views on maternity and health visiting services, father replied that everything was fine apart from the wrong interpreters being used. He became quite animated at this point and said that even with Language Line, the wrong interpreters would be used adding that he complained about interpreters 'a thousand times'.

5.8 Father began to talk at length about the problems he experienced with a neighbour when living with mother and Child 1 in their first address. The independent reviewer asked how services had responded to the neighbour problems he experienced, and he commented on the police response. He said the police attended several times and told him to stay in his own home and that they would speak with the neighbour. Father said that police involvement sometimes annoyed the neighbour and things would get worse the following day.

5.9 When asked if there was anything else he would like to add about his contact with services whilst Child 1 and Child LT were living with him and his wife, he reiterated his concerns about the language barrier which left him unsure about how to access services at times, adding that he lacked the knowledge of how services worked which he felt limited his choices.

6.0 Analysis

6.1 In this section of the report key learning themes will be addressed in turn.

The extent to which practitioners considered the impact of father's mental health issues on his capacity to parent Child 1 and Child LT

6.2 At the time that father's marriage to mother took place in early 2016, he had been experiencing mental health problems for several months. He was the subject of urgent referrals from his GP to the START team in May and September 2015 after presenting with low mood and anxiety. When examined by a consultant psychiatrist the trigger for his low mood appeared to be an accident at work which had left him with a disability which adversely impacted upon his quality of life and financial circumstances. In January 2016 he visited his GP with a rope in his pocket with which he threatened to take his own life. A subsequent assessment found him to be extremely frustrated and unhappy as a result of chronic pain arising from his disability, his accommodation and finances. He was said to become easily angered with his current situation resulting in aggressive outbursts, feelings of hopelessness and suicidal ideation. His presentation suggested depression with possible psychosis. The Home Treatment Team (HTT) – which supports people over 16 who have mental health problems and are living in the community - supported him until his condition appeared to have stabilised and he was concordant with the medication prescribed.

6.3 During his contacts with mental health services in 2015 and early 2016 father would have been perceived to be a middle-aged man who was single with no children living with him. By the time he was referred by his GP to START at the end of June 2016 with low mood and auditory hallucinations (Paragraph 4.5), father was married and mother was pregnant. There is no indication that his altered circumstances were picked up on when assessed by the START team on 7th July 2016, although father was provided with the contact details for Lancashire Wellbeing Services for 'social issues' which were not further defined (Paragraph 4.6). When seen by the consultant psychiatrist to which he had been referred by the START team on 11th October 2016 (Paragraph 4.10) father was assessed as not presenting a risk to himself or others. There is no reference to the impending birth of Child 1 in the risk assessment.

6.4 Father's next referral to mental health services was on 26th July 2017 (Paragraph 4.17). There is no indication that the GP referral mentioned Child 1 who was 8 months old by this time. However, when father was assessed by a mental health social worker in response to the GP referral on 11th October 2017 (Paragraph 4.23), the existence of Child 1 was noted and it was decided that the child's health

visitor should be contacted. This was an appropriate decision given father's disturbing presentation and lack of compliance with prescribed medication. However, there is no record in mental health or health visitor records to indicate that contact with the health visitor was made. Nor is there any indication that the impact of father's mental health on Child 1 (then aged 11 months) was considered as part of the assessment of risks he may present to others. By this time mother was pregnant with Child LT, but father may not have disclosed this to mental health services.

6.5 When further assessed by the complex care and treatment team the following month (Paragraph 4.25), there was again no indication that the impact of his mental health issues on his parenting was considered or whether his role in caring for Child 1 was explored. During the assessment father disclosed thoughts of suicide which he said he had not acted upon because of his parental responsibilities. Father was assessed as being of low risk to others despite acknowledging he had smashed household items in anger. There appeared to be no consideration of the risk of domestic violence and abuse he may present to his wife. There is no reference in the assessment to the unborn Child LT which father may not have disclosed.

6.6 When father met his newly allocated care co-ordinator on 24th January 2018 (Paragraph 4.29), it was documented that all symptoms disclosed in previous contacts were reiterated and that these symptoms were exacerbated by noise from his neighbour at night and Child 1 who was 'loud during the day'. This is the first time that any link between father's mental health issues and the child had been made by mental health services. Despite this there is no indication that father's role in caring for Child 1 was explored or the impact of his mental ill health on the child was considered.

6.7 When father was again seen by a different care co-ordinator on 21st March 2018 (Paragraph 4.36) there is no indication that the risk he could present to Child 1 and the recently born Child LT was considered despite father disclosing that he had been 'left to care' for Child 1 since the birth of Child LT, which had also coincided with an accentuation of his auditory hallucinations. Arguably a safeguarding referral should have been made at this point as a father presented a risk to two very young children (1). At the very least contact with the LCFT duty safeguarding practitioner should have been made.

6.8 When father's was seen by a consultant psychiatrist for urgent medical review three days later (Paragraph 4.38) it was documented that no reports of self-harm or harm to others were said to have been reported or identified. His mood was said to be low due to his 'personal circumstances and issues' which were not further documented so it is not known if these 'personal circumstances' included the care of Child 1 or the new born Child LT.

6.9 Father had no further contact with mental health services prior to the incident in which Child LT was injured apart from the support provided by a mental health support worker to find suitable housing during April and May 2018. There is little detail of the interaction between father and the mental health support worker who it is assumed would have been able to view father in the context of his and his family's housing needs.

6.10 Knowledge of father's mental health issues was largely restricted to his GP and mental health services and was shared with the agencies providing support to the family only once. This was on 17th August 2017 when the GP referred mother to midwifery when pregnant with Child LT (Paragraph 4.18). The GP referral which stated that father suffered from 'severe depression with psychosis' added that he was 'currently stable'. Midwifery appropriately referred mother to the ESMT as a result of the concerns about father's mental health but a plan to see mother to assess whether there were any safeguarding concerns was frustrated by mother not attending her next clinic appointment (Paragraph 4.20) and did not appear to be followed up further. The ESMT stepped the case down after an ESMT midwife contacted the family's health visitor on 16th January 2018 to enquire if there were any safeguarding concerns. The health visitor replied in the negative. There is no indication that the concerns about father's mental health were discussed at this time or was revisited at any point during which the service was caring for mother and Baby LT.

6.11 However, father's admission to the local acute hospital after what was documented as 'query overdose of medication' (Paragraph 4.42) and 'poisoning (suspected overdose)' (Paragraph 4.45) represented an opportunity for concerns about his mental health to be shared with partners. This incident took place after the joint community midwife/ health visitor/ BAME support service advocate home visit following mother's disclosure of domestic violence and abuse two days earlier. Hospital staff did not follow expected policy and practice in respect of safeguarding checks, establishing father's 'mental health status' or considering his 'social circumstances'. No assessment of his mental health was arranged during the two days he spent in hospital before discharging himself against medical advice. This review has been advised that the hospital staff would not have had access to father's patient records (GP or CMHT) although had father been referred to the hospital mental health team, they would have had access to his mental health records as LCFT provide both community and hospital mental health services.

6.12 The GP was notified of what the discharge record documented as 'poisoning (suspected overdose) and followed this up with an appointment at which father reported feeling low but denied any suicidal intent (Paragraph 4.45). The GP did not document any safeguarding concerns arising from father's overdose.

6.13 Research indicates a number of ways in which parental mental ill health can result in children in the household experiencing abuse, particularly emotional abuse and neglect (2):

- Mothers who experience mental ill health after birth may struggle to provide their babies with the sensitive, responsive care essential to their social, emotional and intellectual development.

Parents and carers may:

- experience inappropriate or intense anger or difficulties controlling their anger around their children.
- have rapid or extreme mood swings, leaving children frightened, confused and hyper-vigilant.
- be withdrawn, apathetic and emotionally unavailable to their children. They may have trouble recognising children's needs and responding to cues.
- view their children as a source of comfort and solace, which may lead to children taking on too much responsibility for their age.
- have distorted views of their children. For example, they may believe a child is to blame for their problems or a child has behavioural problems when there is no evidence for this.
- struggle with keeping to routines such as mealtimes, bedtimes and taking their children to school.
- neglect basic standards of hygiene and their own and their children's physical needs.
- fail to seek medical care for their children.
- struggle to keep their homes clean, buy food and clothes and pay essential household bills.
- struggle to set boundaries, discipline and supervise their children, which could leave them in unsafe situations.

- In rare cases of severe mental illness, parents and carers may have delusions related to their children, for example they may believe they are possessed, have special powers or are medically unwell.

6.14 Whilst it is important to note that most parents or carers who experience mental ill health will not abuse or neglect their children, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured parental mental health problems (3).

6.15 Additionally, the risks to children are greater when parental mental health problems exist alongside domestic abuse, parental substance misuse, unemployment, financial hardship, poor housing, discrimination and a lack of social support (4). Together, these problems can make it very hard for parents to provide their children with safe and loving care (5). In father's case he was unemployed following an injury at work which also resulted in financial hardship, he frequently became agitated about his housing, disclosed racial abuse on occasions and he and mother appeared to be quite isolated. Additionally, it is not known how recently father's asylum claim had been decided upon. Research has found that social isolation, dependence and boredom have frequently been found to be present in the UK asylum seeker experience, together with high rates of self-harm and risk of suicide (6). Furthermore, the social model of disability, which recognises the role of disabling environments as contributory factors, recognises poverty as a risk factor for mental illness (7).

6.16 However, the risk that father's mental health issues may present to Child 1 and Child LT was never assessed. A series of mental health practitioners missed the opportunity to assess the risk that father may have presented to his children and other relevant assessments including the Family Outcomes Star and the CAF were not informed by father's mental health issues, although practitioners did observe father become agitated and angry on occasions.

6.17 Had practitioners assessed the risks that father's mental health issues could present to his children, research indicates a number of key issues for practitioners to take into account, including (8):

- The paramount importance of focussing on the child.

- A focus on the needs of each child to help identify any children who have adopted a carer's role within the family.

- The impact of a parent’s mental health problems may vary according to the child’s health, stage of development and relationship with other family members. It is therefore important to treat children, parents, carers and other significant relatives as individuals.

- Assessment should be informed by the parent or carer's background, medical history and current circumstances. As previously stated, attention should be paid to other risk factors alongside mental ill health such as substance misuse, domestic abuse, financial hardship or relationship problems. These difficulties may increase vulnerability and pose a greater risk to the child.

- Really listen to what parents and carers are saying. If they tell you they are not coping well with looking after their children, provide support at the earliest opportunity.

- Always take threats of suicide or threats to kill a partner or children seriously.

- Children are also at risk if the parent or carer has psychotic beliefs about them, or if their mental ill health is isolating them or making it very difficult for them to function on a day-to-day basis.

- Do not over-estimate the ability of a well parent or carer to cope with both parenting and supporting a partner with mental health problems. This impact should be properly assessed and support offered, for example in the form of a Carer’s Assessment.

- It is important to include any extended family members or friends who offer support to the family in assessments.

- Assessment should be a shared task between children’s social workers and adult mental health practitioners. This will ensure professionals fully understand how the situation is affecting children and help identify risks at an early stage.

- Professionals should also seek the views of colleagues from other agencies who are involved with the family.

- Assess factors increasing the children’s risk of harm against protective factors which will increase the family’s resilience.

6.18 In father’s case, mother was the well parent but she was pregnant with Child 1 and then Child LT for much of their marriage and her lack of English and, it is

assumed, knowledge of UK service provision, seem likely to have limited her capacity to cope with both parenting small children *and* supporting father. Father appears to have struggled to tolerate noise as evidence by his frequent complaints about his neighbour and his comments about noise made by Child 1.

6.19 Neither mental health services nor the GP practice appeared to adopt a 'Think Family" approach. 'Think Family' envisages a more holistic and contextualised understanding of people's lives and more joined-up approaches to delivering services – especially for those families who are experiencing multiple challenges (9).

6.20 It is instructive to compare the response of agencies to concerns about father's mental health to the anticipated response had mother presented with similar mental health issues. It seems likely that mother would have been supported through the perinatal mental health care pathway and her care plan should have brought together a range of practitioners.

Mother's disclosure of domestic violence and abuse and the professional response to this.

6.21 Mother disclosed domestic violence and abuse to the community midwife during a home visit on 9th April 2018 (Paragraph 4.40). Father was absent. Mother disclosed that father had been abusive towards her including a physical assault when he had hit her in the face a year earlier. She said he never hit the children but shouted at her in front of them which scared Child 1. She added that father smashed plates and cups when angry. Mother also disclosed that she had photographs and recordings of the abuse on her phone. It is not documented whether this content was viewed or what it consisted of. There was a discussion between the community midwife and mother in respect of mother leaving father to which mother responded by saying that she wanted a few days to decide whether to do this. She expressed the fear that leaving father would result in the removal of the children.

6.22 The community midwife contacted the enhanced support midwifery team (ESMT) for advice as she did not want to leave mother and the children within the home environment without a clear safety plan in place. The ESMT advised her to contact the health visitor for further support and advice. The community midwife contacted the health visitor by telephone and together they developed a safety plan which was communicated to mother which consisted of advising mother of the support available from the voluntary service for BAME women Centre, to call 999 if she felt unsafe (mother was given some English word to use if a 999 call was necessary) and if she felt unsafe to flee the house and/or to go to a local shop to ask for help. She was also given the contact details for Victim Support. Additionally, a joint community midwife/ health visitor home visit was arranged to take place two

days later. It is also assumed that a referral was made to the service for BAME women as an advocate from that service also attended the home visit two days later. The ESMT could have played a more prominent role in decision making than simply advising the midwife to contact the health visitor and could have proposed a risk assessment and followed up with the midwife to check that a sound plan was in place for example.

6.23 The safety plan developed by the community midwife with the support of the health visitor was not informed by any Safelives DASH (Domestic Abuse, Stalking and "Honour"-based violence) risk assessment. Had this risk assessment been used it seems likely that it would have disclosed risk factors such as mother's isolation, that she had recently given birth and that there were financial issues. It may also have disclosed mother's level of fear, the frequency of the abuse, whether or not it was getting worse and whether coercion or control was present in the relationship. Additionally, mother would have been asked about father's mental health and whether he had threatened or attempted suicide.

6.24 The effectiveness of the follow up visit two days after mother's disclosure was undermined by father's presence and attitude. He interrupted when practitioners attempted to communicate with mother who looked upset at times and was seen to shake her head in disagreement with father. The health visitor decided to provide the enhanced level of 'Universal Plus' support to the family as a result of mother's disclosure of domestic violence and abuse.

6.25 Although domestic abuse was highlighted as an issue in the subsequent CAF assessment which was to be addressed through support from the voluntary service for BAME women, practitioners accepted at face value mother's subsequent assurances that father had apologised to her and that she now felt safe and had no concerns. It was unrealistic to largely accept that the risk of domestic violence and abuse had so quickly diminished particularly given father's hostile attitude to practitioners at the 11th April 2018 meeting (Paragraph 4.41) and his expression of anger at mother's disclosure of domestic violence and abuse on 23rd April 2018 (Paragraph 4.47).

6.26 Practitioners do not appear to have given sufficient weight to mother's dependency on father as she was present in the UK on a spousal visa, had little or no English, and lacked support (although her brother was visiting from Norway at the time of the incident in which Child LT was seriously injured). Practitioners appeared to perceive mother as a person with sufficient autonomy to be capable of removing herself and her children from the home she shared with father despite the evidence of his controlling behaviour. This was an issue which provoked considerable debate at the learning event to which practitioners involved in the case

were invited. Whilst practitioners were agreed that mother was responsible for safeguarding her children from the impact of domestic violence and abuse from father, views diverged on the extent to which she had the autonomy to achieve this. The manager of the voluntary service for BAME women was unable to attend the learning event but met with the SCR Panel Chair and the independent reviewer separately. She expressed the view that professional expectations of mother may not have been realistic given her dependence on father, her lack of understanding of domestic violence and abuse and the lack of professional understanding of mother's culture. The SCR panel discussed the extent to which it was necessary for practitioners to acquire an understanding of a person's religious and cultural background in order to understand their needs. The SCR Panel felt that practitioners in this case did attempt to gain insight into the impact of religion and culture on the family which is reflected in the CAF assessment and made appropriate referrals including the referral of mother to the voluntary service for BAME women.

6.27 Although domestic abuse had been highlighted as an issue in the CAF assessment and was to have been discussed at the cancelled TAF meeting, the acceptance of mother's assurances that her relationship with father had improved and that she no longer felt unsafe may have been a reflection of what has become known as the 'rule of optimism' - a tendency by social workers and healthcare workers towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view (10).

6.28 Additionally practitioners may have benefitted from gaining an enhanced understanding of mother's culture and background. Research into the experiences of women of South Asian heritage who move to the UK following marriage found that some of the women became extremely isolated and frightened when things began to go wrong in their marriages. Some had known no-one in the UK outside their husband's family and were in a highly vulnerable position, especially if they did not speak any English or understand how UK society worked (11).

How effective was action to safeguard Child 1 and Child LT?

6.29 As has been seen many of the practitioners supporting the family were unaware of the concerns about father's mental health. At the learning event arranged to inform this SCR, several practitioners expressed frustration that this vital information had not been shared with them and therefore did not inform their assessment of the needs of the children.

6.30 The children were supported at level 2 on the then Lancashire Safeguarding Children Board's continuum of need which is defined as 'evidence of some unmet

needs and low risk, to be addressed by targeted service provision via Common Assessment Framework / Team Around the Family (TAF) / Early Help Assessments' (12). Had father's mental health issues been shared with agencies supporting the children and their family and had practitioners from those agencies concluded that the concerns about his mental health compromised his ability to parent at an acceptable standard then it may well have been appropriate to support the children at Level 3 which is defined as 'Child in Need (CiN) where there are higher levels of unmet needs and medium risk, which have been unresolvable at previous levels and should be addressed via CiN processes under Section 17 of the Children Act 1989' (13).

6.31 However, safeguarding children referrals could have been considered after father disclosed to his care co-ordinator that his symptoms were exacerbated by Child 1 on 24th January 2018 (Paragraph 4.29), when he disclosed to his care co-ordinator that his auditory hallucinations had been extremely accentuated since the birth of Child LT on 21st March 2019 (Paragraph 4.36) and when father was admitted to the local acute hospital on 11th April 2018 (Paragraph 4.42 – 4.44) as the risk that father presented to his children appeared to have increased to a high level.

6.32 When cases are managed at level 2 there is the risk of an absence of rigour in ensuring assessments are completed promptly, plans are monitored closely to ensure progress is made and multi-agency meetings take place when required. In this case the Family Outcomes Star tool was not completed and the initial TAF meeting was cancelled due to the sickness absence of the CFW key worker, when it should have gone ahead as sickness absence cover had been arranged for the worker.

6.33 Safe sleeping concerns arose in respect of Child 1 (Paragraphs 4.12 and 4.13). Advice was given and appears to have been acted upon by mother and father.

6.34 Child LT's injuries have been assessed as being caused by impact and shaking. Shaken baby syndrome or abusive head trauma (AHT) is the leading cause of death and long term disability for babies who are harmed (14). Research suggests a demonstrable relationship between the normal period of peak crying in babies and the incidence of babies subject to AHT. There is a higher level of cases of AHT in the first month of life, a peak at 6 weeks of age and a decline in cases during the third to fifth month of a baby's life. Child LT was three months old when he was injured. There is no indication that Child LT was unwell at the time he was injured, which might have contributed to the child crying, although practitioners had not seen the child for seven weeks prior to the incident. However, excessive crying in babies can be difficult to manage for parents and they need to be advised on how to manage episodes of prolonged crying. It is not known whether mother and father had been

provided with advice on how to handle excessive crying and whether such information is available in Farsi or Urdu. If not then it is incumbent on practitioners to ensure that advice to parents on how to manage episodes of prolonged crying is communicated to parents through an interpreter. This case also indicates a need for adult facing services such as adult mental health services to be aware of such advice which could have usefully been provided to father .

6.35 When the GP referred mother to midwifery in respect of her pregnancy with Child LT, the referral stated that father suffered from 'severe depression and psychosis' adding that he was 'currently stable and on treatment'. This issue does not appear to have been fully explored by the ESMT. Had it been, then a pre-birth assessment may have been a consideration.

6.36 When mother disclosed domestic violence and abuse the health visitor increased the level of support provided to the family from 'Universal' to 'Universal Plus'. The health visitor service provide four levels of service as follows (15):

- *Community*: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.
- *Universal*: health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- *Universal Plus*: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- *Universal Partnership Plus*: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or additional concerns such as safeguarding, domestic abuse and mental health problems.

6.37 When practitioner concerns about domestic violence and abuse quickly (and prematurely) diminished, 'Universal Plus' was maintained because of issues related to weaning.

The effectiveness of interpreter services

6.38 Father spoke Farsi, Urdu and some English. Some practitioners who attended the learning event who had had fairly substantial contact with father felt his ability to speak and understand spoken English was at a level which enabled him to communicate adequately on non-specialised matters. Mother spoke Farsi and her dialect proved difficult for some Farsi speaking interpreters to understand.

6.39 There were several occasions on which interpreters booked by mental health services (LCFT) and health visiting services (then LCFT/now Virgin Care) did not turn up (Paragraphs 4.13, 4.46). On another occasion a referral from one agency to another did not specifiy that an interpreter was required (Paragraph 4.32).

6.40 On other occasions friends or family members were used as informal interpreters (Paragraphs 4.19, 4.40). The risks associated with using friends to interpret include the lack of assurance over the effectiveness of the service provided and the possibility that the person whose communication is being interpreted may be unwilling to disclose personal issues through a friend.

6.41 Father was used as an interpreter for mother on occasions (paragraph 4.27). The risk in using father as an interpreter were that this increased mother's dependency on him which may have contributed to his exerting control over her. Additionally, it would almost certainly have prevented her from making any disclosures of domestic violence and abuse to practitioners. The risks to mother of using father to interpret for her were not always recognised by practitioners. For example the GP practice arranged for mother to be seen only by the two Urdu speaking GPs in the practice (Paragraph 4.13). Whilst this decision may have been prompted by overlaps in the Urdu and Farsi languages, it would mean that father, as an Urdu speaker would have been used as an interpreter for mother. Additionally, the health visitor planned to use an Urdu speaking link worker from the health visitor team for interpreting (Paragraph 4.13) which would again have had the effect of making mother dependent on father to interpret for her.

6.42 The apparent absence of interpreting services may have prevented staff at the local acute hospital fully exploring the background to father's suspected overdose, considering his mental health issues and highlighting safeguarding concerns. The Family Outcomes star tool was not completed because of 'language difficulties' (Paragraph 4.37).

6.43 NHS England set out principles for high quality interpreting and translation services in Primary Care Services (16) but which have wider applicability. The principles are as follows:

- Patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.
- Staff working in primary care provider services should be aware of how to book interpreters across all languages, including sign language, and book them when required.

- Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.
- Patients should expect a personalised approach to their language and communication requirements recognising that 'one size does not fit all'.
- High ethical standards, a duty of confidentiality and safeguarding responsibilities are mandatory in primary care and this duty extends to interpreters
- Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their first of preferred language and formats (written, spoken, signed etc)
- Documents which help professionals provide effective health care or that support patients to manage their own health should be available in appropriate formats when needed
- The interpreting service should be systematically monitored as part of commissioning and contract management procedures and users should be engaged to support quality assurance and continuous improvement and to ensure it remains high quality and relevant to local needs.

6.44 Generally, agencies struggled to achieve these standards. It is not known how significant an issue the availability of Farsi interpreters is, although finding Farsi interpreters who understood mother's dialect proved challenging at times

The lived experience of Child 1 and Child LT

6.45 The 'lived experience' is what a child sees, hears, thinks and experiences on a daily basis which impacts on their development and welfare. Practitioners need to actively hear what the child has to communicate, observe what they do in different contexts, hear what family members, significant adults/carers and professionals have said about the child, and to think about history and context. Ultimately practitioners need to put themselves in that child's shoes and think 'what is life like for this child right now?'

6.46 Child 1 was born in November 2016 and was regularly seen by a health visitor who had no concerns about the child other than safe sleeping. The health visitor advised his parents against placing Child 1 on the large cushions with which the family flat was mainly furnished and also advised them against tightly swaddling the child, which could restrict his breathing, and covering him from head to toe in a thick blanket which could cause overheating.

6.47 The household in which Child 1 was growing up may have been quite a tense place at times. Father was unhappy with the property and wished to move. He became visibly agitated and upset about this issue at times. Father was often in

conflict with a neighbour particularly over noise from loud music played by the latter which father reported to be disturbing Child 1's sleep. Father also reported that the child's crying had further inflamed the conflict with his neighbour. Father prioritised his own health needs over those of his son on occasions (Paragraph 4.13 and 4.22).

6.48 By the time he was eight months old, Child 1's father was experiencing low mood and later reported experiencing auditory hallucinations including voices telling him to 'kick them' or eat them' and an inability to control his temper. He also disclosed smashing household items. Father was not in compliance with his medication for a time. By this time mother was pregnant with Child LT and may have begun to struggle to cope with caring for Child 1 and supporting father.

6.49 As Child 1 approached his first birthday, he was assessed by the health visitor as having no development or health concerns.

6.50 Tensions within the household appeared to mount as the birth of Child LT approached. When mother was seven months pregnant father disclosed to his care co-ordinator that his symptoms were exacerbated by noise from his neighbour during the night and Child 1 being 'loud during the day'.

6.51 Shortly after the birth of Child LT in March 2018 father saw his care co-ordinator in an agitated state saying that he was 'left to care' for Child 1 following the birth of Child LT. His auditory hallucinations had also increased since the birth and he was experiencing command hallucinations telling him to do things which were not documented.

6.52 Around this time mother disclosed domestic abuse and one incident of domestic violence when father had hit her in the face a year earlier, when Child ! would have been around six months old. Mother said that father never hit the children but shouted at her in front of them which scared Child 1. She also said he smashed plates when angry. Father continued to experience mental ill health and was admitted to hospital after a suspected overdose.

6.53 However, good interaction and bonding between the Child LT and mother was observed when the health visitor completed the 4-6 week assessment.

6.54 A CAF assessment completed around this time highlighted concerns in respect of social isolation, domestic abuse, financial difficulties and the 'language barrier'. Father had not worked for some time and the family's financial circumstances left them struggling to provide for their children. They were said to lack support as no family members lived nearby. Child 1 came across as a playful and confident boy who was well dressed and in good health. However, the child enjoyed no social

interaction apart from with his parents and had limited toys to stimulate him and support his development. Mother and father did not access a community centre or a mosque because it was too far for them to travel.

6.55 In early May 2018 the family moved to a new tenancy which may have alleviated some of the problems associated with their previous home. At some stage prior to the incident in which Child LT was seriously harmed, mother's brother, who lived abroad, began staying with the family.

Good Practice

- The midwife made a referral to the Policy Diversity Unit after father disclosed ongoing racial abuse from a neighbour. (Paragraph 4.8)

- When the GP referred mother to midwifery when her pregnancy with Child LT was confirmed, the referral stated that father suffered from 'severe depression with psychosis' but was 'currently stable and on treatment' (Paragraph 4.18).

- Midwifery referred mother to the ESMT as a result of father's history of 'severe depression and psychosis' cited in the GP referral (Paragraph 4.19).

- The GP followed up on the discharge letter following father's admission to hospital after a suspected overdose and promptly saw father in the surgery (Paragraph 4.45)

7.0 Findings and Considerations

Mental Health Service contact with father

7.1 The father of Child LT and his elder sibling Child 1 had been experiencing mental health problems for some time. It is not known when father became mentally unwell but his mental ill health predated the birth of his sons. It is a significant concern that the mental health practitioners who saw father fairly regularly during the two year period from June 2016, when mother was pregnant with Child 1, until Child LT sustained serious injuries whilst in father's care in June 2018, neither explored the impact of his mental health on his parenting of the children or took any action in response to indications that father may present a risk to his young children.

7.2 At no time did a mental health practitioner consider making a safeguarding children referral or seek advice from the Lancashire Care NHS Foundation Trust safeguarding team. Unfortunately it was not possible to explore what the barriers to recognising safeguarding children concerns might be, as no mental health practitioner involved in father's care was available to attend the practitioner learning event which was arranged to inform this SCR. The Welsh Child Practice Review methodology used for this SCR relies heavily on practitioner engagement in learning events. It is understood that the level 3 safeguarding training provided to LCFT practitioners may not be specific enough about the potential impact on children of parental mental health. Paragraph 6.13 of this SCR report highlights the ways in which parental mental ill health can result in abuse or neglect of children and Paragraph 6.17 lists a number of key issues for practitioners to take account in assessing the risks to children arising from parental mental ill health. LCFT safeguarding children training should be informed by these issues.

Consideration 1

7.3 The Children's Safeguarding Assurance Partnership may wish to consider seeking assurance from LCFT that all practitioners involved in providing care and treatment to adults receive appropriate safeguarding children training and refresher training, that all risk assessments address the impact of mental ill health on children in the adult's household and that any auditing of assessments and risk assessments tests whether safeguarding children concerns have been explored and action taken when justified.

Consideration 2

7.4 The Children's Safeguarding Assurance Partnership may also wish to consider promoting awareness of the ways in which parental mental ill health can result in

abuse or neglect of children (Paragraph 6.13) and the key issues for practitioners to take account in assessing the risks to children arising from parental mental ill health (Paragraph 6.17) across the safeguarding children workforce.

Acute Hospital contact with father

7.5 There was a further missed opportunity to consider the potential impact of father's mental ill health on his parenting when he was admitted to the local acute hospital after a suspected overdose of medication a little over two months prior to the incident in which Child LT was seriously harmed. Hospital staff did not follow expected policy in respect of safeguarding checks, or in establishing father's 'mental health status' or considering his 'social circumstances'. No assessment of his mental health was arranged during the two days he spent in hospital before he discharged himself against medical advice. Father's confusion and what was documented as the 'language barrier' appeared to be factors in the lack of professional enquiry during this admission.

Consideration 3

7.6 The Children's Safeguarding Assurance Partnership may wish to consider seeking assurance from Lancashire Teaching Hospital NHS Foundation Trust that hospital staff in the emergency department and on the hospital wards fully explore a patient's presentation after a suspected self-harm, make referrals for hospital mental health assessments and consider any safeguarding issues which arise.

Think Family

7.7 This missed opportunity when father was admitted to hospital and the repeated missed opportunities to explore father's parental responsibilities when presenting as mentally unwell, indicate that awareness of the importance of safeguarding children amongst adult facing services may be a weakness in the 'whole system' for safeguarding children locally. Father's GP practice shared information about father's mental ill health with midwifery after mother's pregnancy with Child LT was confirmed but otherwise did not consider the impact of his mental ill health on the children he cared for.

Consideration 4

7.8 The 'Think Family' perspective appeared to be missing from the adult facing services which came into contact with father and so the Children's Safeguarding Assurance Partnership may wish to consider promoting or refreshing the 'Think

Family' approach, possibly using the dissemination of learning from this SCR as a vehicle for doing so.

Safeguarding the children

7.9 At the time he was seriously injured, practitioners were supporting Child LT and his family at level 2 on the continuum of need. Had practitioners been aware of father's mental ill health and the likelihood that his parenting was compromised as a result and had they not taken an overly optimistic view that the domestic violence and abuse disclosed by mother had quickly diminished, then the family would probably have required support at level 3 (Child in Need). Additionally, the support which was provided at level 2 did not progress with sufficient pace.

7.10 Although practitioners did observe father behaving in an agitated and distressed manner several times the only occasion on which father's mental ill health was shared beyond primary care, acute care or mental health care was when the GP disclosed details of father's diagnosis to midwifery at the time that mother's pregnancy with Child LT was confirmed. The matter was appropriately referred to the enhanced support midwifery team (ESMT) who did not arrange to see mother on her own and did not consider all risks before stepping the case down to community midwifery. LTHFT included this case in a review of four non-accidental injuries to babies in 2018 and developed an action plan which included ESMT not stepping down cases without considering all risk aspects.

Consideration 5

7.11 The Children's Safeguarding Assurance Partnership may wish to consider seeking assurance from LTHFT that the above-mentioned action plan has been successfully implemented and that systems are in place to avoid the premature stepping down of cases such as that of Child LT. The Partnership may also wish to consider seeking assurance from LTHFT in respect of the advice and support provided by the ESMT to community midwives to whom domestic violence and abuse is disclosed (Paragraph 6.22).

Domestic Violence and Abuse

7.12 The community midwife to whom mother disclosed domestic violence and abuse less than a month after the birth of Child LT (Paragraph 4.40) was faced with a challenging situation and received good professional support from the health visitor in developing a safety plan for mother and the children. However, the plan was not informed by a SafeLives DASH risk assessment. LTHFT has advised this review that they now expect the DASH risk assessment to be completed by a

midwife or health care professional to whom domestic abuse is disclosed. DASH risk assessment forms are now carried by midwifes working in a community setting.

Consideration 6

7.13 The Children's Safeguarding Assurance Partnership may wish to consider seeking assurance from LTHFT in respect of the completion of DASH risk assessments by community midwives. The Partnership may wish to consider seeking similar assurance from Virgin Care as the provider of health visitor services.

7.14 Practitioners accepted mother's assurances that father had apologised to her and that she now felt safe and had no concerns despite indications to the contrary observed in father's behaviour. There can be no place for the 'rule of optimism' in responding to domestic violence and abuse concerns. Practitioners may also need a better understanding of the dynamics of coercion and control in relationships, particularly where the partner disclosing the domestic violence and abuse – in this case mother – was so dependent on the alleged perpetrator.

Consideration 7

7.15 The Children's Safeguarding Assurance Partnership may wish to consider sharing this report with Lancashire Community Safety Partnership so that they can consider using the learning from this case to raise awareness of the dynamics of coercion and control in abusive relationships.

Understanding Religion and Culture

7.16 There was debate at both the practitioner learning event and within the SCR Panel which oversaw this review about the depth of understanding of religion and culture practitioners need to obtain in order to work effectively with families. In this case mother and father were originally from Afghanistan and understanding mother's upbringing in that country and the circumstances under which she reportedly was forced to give up the child from her first marriage in Afghanistan might have helped practitioners gain greater insight into her relationship with father and the scope she had to exercise autonomy to safeguard the children and herself.

7.17 Understanding a person's religion and culture is a necessary first step to engaging in a mutually respectful relationship and it may be of benefit for the Children's Safeguarding Assurance Partnership to consider sharing the insights into the law, customs and culture of Afghanistan gained from conducting this SCR as part of the learning brief to be widely circulated to practitioners.

Interpreting Services

7.18 The absence of interpreting services compromised the safety of Child LT. Although it is unclear why no interpreter was requested or available, the apparent absence of interpreting services appears to have prevented staff at the local acute hospital fully exploring the background to father's suspected overdose, considering his mental health issues and highlighting safeguarding concerns (Paragraph 6.42). At other times, the use of father as an interpreter for mother increased her already high level of dependency on him and may have increased the risk of domestic violence and abuse she faced.

7.19 This is not the first SCR completed by the lead reviewer in which challenges in accessing interpreting services have compromised the safeguarding of children. A search of the NSPCC national case review repository found ten published SCRs in which the lack of use of professional interpreters prevented practitioners fully understanding risks to children. A feature of many of the cases was the use of family members as interpreters.

Considerations 8 and 9

7.20 The Children's Safeguarding Assurance Partnership may wish to consider requesting the agencies involved in this case to review the commissioning and provision of interpreter services by their organisation in the light of the learning from this SCR. The Children's Safeguarding Assurance Partnership may also wish to consider advising the National Child Safeguarding Practice Review Panel of the interpretation challenges highlighted by this case and propose that the Panel assess whether these challenges are sufficiently widespread and concerning to justify commissioning a national review.

Preventing Abusive Head Trauma

7.21 It is suspected that the injuries sustained by Child LT were caused by shaking and being slammed against a hard surface. During the course of the SCR, the question was asked about the accessibility of advice on how to manage episodes of prolonged crying to parents for whom English is not their first language. Some web resources such as this 'Handle your baby with care' page on the London Borough of Redbridge website have a google translate facility - https://find.redbridge.gov.uk/kb5/redbridge/fsd/advice.page?id=T_EHffjcBoY although Farsi is not available whilst Urdu is. As a minimum practitioners should use interpreters to communicate appropriate advice. Additionally, adult facing services such as mental health services who must see many parents whose mental ill heath

could place their children at risk, should be trained to provide advice about how to manage prolonged crying in babies.

Consideration 10

7.22 The Children's Safeguarding Assurance Partnership may wish to consider promoting the need for practitioners to provide advice on coping with crying babies to parents for whom English is not their first language when using interpreters. The Partnership may also wish to consider promoting awareness of such advice to adult facing services who see parents who may benefit from the advice.

Information sharing

7.23 The SCR has been advised that the hospital staff who came into contact with father when he was admitted with a suspected overdose did not have access to father's patient records (GP or CMHT) so his history of mental ill health was not visible to them. Had father been referred to the hospital mental health team, they would have had access to his mental health records as LCFT provide both community and hospital mental health services. However, in cases such as this, where a parent with mental ill health is not referred to the hospital mental health team, there is an information sharing gap.

Consideration 11

7.24 The Children's Safeguarding Assurance Partnership may wish to consider requesting LTHFT and the CCG to share any plans which would enable hospital staff to access a patient's medical records when appropriate.

References

(1) Lancashire safeguarding children board threshold of need (Level 4).

(2) Retrieved from https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

(3) ibid

(4) ibid

(5) ibid

(6) Retrieved from

https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2014/working-paper-series/IRiS-WP-1-2014.pdf

(7) ibid

(8) Retrieved from https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

(9) Morris, K, Hughes, N, Clarke, H, Tew, J, Mason, P, Galvani, S, Lewis, A and Loveless, L (2008) Think family: a literature review of whole family approaches. Cabinet Office Social Exclusion Task Force.

(10) Learning Lessons from Serious Case Reviews 2009-2010 -Ofsted

(11) Retrieved from
https://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rg2223finalreport.pdf

(12) Retrieved from http://www.lancashiresafeguarding.org.uk/media/45811/LSCB-Thresholds-Guidance-Final-Oct-2018.pdf

(13) ibid

(14) Abusive head trauma: mechanisms, triggers and the case for prevention – presentation by Dr S. Smith March 2017.

(15) Retrieved from

https://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/

(16) Retrieved from
https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf

Appendix A

Process by which serious case review (SCR) conducted and membership of the SCR panel

A panel of senior managers from partner agencies was established to oversee the SCR. The membership was as follows:

Role	Organisation
Independent Chair	East Lancashire Hospitals NHS Trust
Panel Member	Central Lancashire NHS Clinical Commissioning Group
Panel Member	Lancashire Teaching Hospitals NHS Trust
Panel Member	Children and Family Wellbeing Service
Panel Member	Lancashire Care NHS Foundation Trust
Panel Member	Virgin Care
Panel Member	Lancashire Constabulary
Panel Member	North West Ambulance Service
Business Coordinator	Lancashire Safeguarding Business Unit
Business Support	Lancashire Safeguarding Business Unit
Independent Reviewer	David Mellor

It was decided to adopt a systems approach to conducting this SCR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Specifically, it was decided to adopt the Welsh concise child practice review methodology which focusses on recent practice and places strong emphasis on engagement in the SCR of practitioners and managers involved in the case.

Chronologies which described and analysed relevant contacts with Adult H were completed by the following agencies:

- Central Lancashire NHS Clinical Commissioning Group
- Children and Family Wellbeing Service
- Community Gateway Housing
- Lancashire Care NHS Foundation Trust
- Lancashire Constabulary
- Lancashire Teaching Hospitals NHS Trust
- North West Ambulance Service
- Virgin Care

The SCR panel analysed the chronologies and identified issues to explore with practitioners at the learning event facilitated by the lead reviewer which was attended by representatives of nearly all of the various disciplines involved in this case.

The manager of the voluntary service for BAME women was unable to attend the practitioner event and so the chair of the SCR Panel and the independent reviewer visited her in order to understand the support her service provided to mother prior to and subsequent to the incident in which Child LT was seriously harmed.

The lead reviewer then developed a draft report which reflected the chronologies, the contributions of practitioners and who attended the learning event.

Mother and father were invited to contribute to the review. Mother declined to contribute but father provided an account through an interpreter.

With the assistance of the SCR panel, the report was further developed into a final version and presented to LSCB.