OVERVIEW REPORT

CHILD E

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This report is the property of Portsmouth Safeguarding Children Board.

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1. INTRODUCTION

1.1. This is the overview report from a Serious Case Review (SCR) conducted by Portsmouth Safeguarding Children Board (PSCB). The matter under review is the death of a baby aged 18 days in December 2014. The exact circumstances surrounding the death are not clear but the pathologist recorded the cause of death as 'head injury'.

1.2. The case pertains to and highlights the following issues:

- The sad and untimely death of Child E aged 18 days old due to suspected abuse
- The vulnerability of the adults involved in the children's care including historic alcohol misuse, associated mental health difficulties and domestic abuse
- Issues of concealed pregnancy

1.3 The following is a summary of the circumstances leading up to Child E's death.

1.4. On the 1st December 2014 an ambulance was called to the family home were Ms X (mother) had given birth to a baby boy (Child E). Mother and baby were transported to hospital where they remained for approximately four days. There were no complications and mother and baby were well on admission. Ms X however had received no antenatal care and claimed to hospital staff that she did not know she was pregnant.

1.5. Whilst in hospital on the 2nd December there was an altercation between Ms X and Mr W (father) whereby Ms X was seen by the midwife to have blood around her mouth – no assault was witnessed but midwives in the hospital were concerned that the argument was protracted and causing distress to other patients and moved the family to a side room. Child E's older sibling Child F was also present during the argument.

1.6. Mother and baby were discharged home on the 4th December.

1.7. On the 19th December at approximately 10:26 hours Ms X called an Ambulance and stated that Child E had stopped breathing. Ms X was instructed how to perform CPR and Child E was transported by paramedics to Queen Alexandra Hospital and then to Southampton General Hospital where he subsequently died at 21:23 hours.

1.8. Child F was removed to the care of the Local Authority where she remains.

1.9. Mother was charged and found guilty of murder and Grievous Bodily Harm (GBH). She is currently serving a lengthy prison sentence. Father was charged, tried and acquitted of causing or allowing the death of a child.

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1. After the death of Child E PSCB took the view that the criteria for an SCR had been met which is entirely consistent with the guidance in 'Working Together'[1] (WT) 2013.

2.2. The case meets the two criteria below set out in Working Together,

5 (2) (a)	Abuse or neglect of a child is known or suspected

and

5 (2)(b)	(i) The child has died and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Working Together (2013) Chapter 4 Para 10 states a Serious Case Review should be conducted in a way which;

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

The purpose of the review is to:

- Look at what happened in the case and why and what action will be taken to learn from the review findings
- Provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children.

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[1]Working Together to Safeguard Children (Working Together) is the government's overarching guidance on safeguarding. It has recently been revised but the terms of reference for this review were in place before the publication of Working Together 2015

- Identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.

2.3. Arrangements were made to appoint the independent people who are required to contribute to the conduct of SCRs. Ms Louise Boyle was appointed as the Chair of the SCR panel. Ms Boyle is the Business Manager at Home-Start Portsmouth. She has represented the voluntary and community sector on the Portsmouth Safeguarding Children Board since 2007 and is the vice chair of the Board. She is completely independent of the case being reviewed. Ms Jane Doherty was appointed to produce this overview report. Ms Doherty is an Independent Social Work Consultant with substantial experience in Child Protection and Quality Assurance. As an Independent Consultant she now specialises in practice development, multi-agency learning reviews, partnership reviews and SCRs.

2.4. PSCB arranged a panel to manage and oversee the review. The membership of the panel is set out below;

2.5

Name/Designation	**Organisation**	**Role**
Louise Boyle, Business Manager	Home-Start Portsmouth	Independent Chair of the panel
Jane Doherty	Independent	Overview author
Designated Nurse	Portsmouth CCG	Panel member
Serious Case Reviewer	Hampshire Constabulary	Panel member
Safeguarding Monitoring Manager	Portsmouth Children Services	Panel member
Business Manager	PSCB	Panel member

2.6 It was determined through the emerging facts of the case that the following agencies had contact with the family and should therefore contribute to the review;

Agency	**Nature of contribution**
Children's Social Care	Chronology and Narrative report
Hampshire Constabulary	Chronology and Narrative report
Portsmouth Hospitals NHS Trust	Chronology and Narrative report
Solent NHS Trust	Chronology and Narrative report
PCC Early Support (Children's Centres)	Chronology and Narrative report
General Practitioner	Chronology and Narrative report

2.7 It was agreed by the panel that the period under review would be from the birth of Child E's older sibling in 2013 to cover the eighteen-month period prior to Child E's death in 2014. Agencies were asked to include information about the parents and Child F.

2.8 To add context to the report, agencies were further asked to summarise any other relevant information to add context and background to their report. In line with this, some background information about events prior to April 2013 and the current position of the sibling is also included in the report.

2.9 A consultation and learning event was held in July 2015 to enable those practitioners who worked with the family to contribute to the overall findings and lessons from the review. Where relevant their views have been incorporated throughout the report.

2.10 A further practitioner event was held in February 2016 prior to the full version of the report being ready for publication. This event provided a forum to share the emerging findings and to promote learning opportunities and reflection on these for the practitioners who knew and worked with the family.

2.11 Following the publication of this review, the PSCB will hold learning events for all those who work with Children & Families in Portsmouth.

3 FAMILY INVOLVEMENT

3.1 Consideration was given to involving the family in the review process and family members were notified that the review was underway. During this process the parents were invited to contribute their views to the review.

3.2 Seeking and including their views was delayed by the lengthy police investigation and criminal trial.

3.3. The panel were mindful of the very stressful and distressing position the parents found themselves in and that any consultation with the parents would need to be conducted with sensitivity.

3.4. After several attempts to contact parents neither were willing to take part in the review and as a result the report has been published without their views being included. Whilst this is not ideal and represents a gap in the information, it is understandable at what must have been a very distressing time for all the family. The panel were satisfied that all avenues to engage the family had been explored. Relevant extended family members were made aware of the contents of the report prior to publication.

4. METHODOLOGY USED TO DRAW UP THIS REPORT

4.1 This report is informed by

- The agency chronologies, narrative analyses and original scoping documents
- Background information from agencies involved in the review
- Panel discussions and analysis
- Dialogue with narrative authors
- Input from family members
- Input from practitioners via the consultation and learning event held on the 13th July 2015
- Research findings.

The report consists of:

- A factual context
- Analysis of how the agencies worked together from the information provided in their narratives and chronologies
- Commentary on the family situation and their input into the SCR
- Analysis of the specific issues identified in the ToR
- Lessons learned
- Recommendations

4.2 The review has been conducted and written with the benefit of hindsight that often distorts the reader's view of the predictability of events, which may not have been evident at the time. It is important to be aware as Munro (2011)[2] states just how much hindsight distorts our judgement about the predictability of an adverse outcome. Once an outcome is known we can look back and believe we can see where practice, actions or assessments were critical in leading to that outcome. This is not necessarily the case and information often becomes much clearer after an event has occurred. This review is therefore sensitive to this 'bias'.

4.3 The review is also sensitive to pressures on agencies and the demands of the work, which are sometimes overwhelming for even the most capable of workers. The pressures are felt more keenly in the face of a tragedy such as the death of a baby therefore it is important to disseminate the learning and reflect on how the lessons can help change practice rather than apportion blame to agencies or individuals.

5 FACTUAL NARRATIVE CHRONOLOGY

5.1 The Family Structure

Name	Relationship	Age at time of incident	Ethnicity
Child E	Subject	18 days	White British
Ms X	Mother	41	White British
Mr W	Father	42	White British
Child F	Subject (sibling to Child E)	1 year 8 months	White British
Child G	Half sibling (maternal side)	17	White British
Child H	Half sibling (maternal side)	13	White British
Child I	Half sibling (paternal side)	6	White British

5.2 Introduction

5.2.1 Each of the agencies involved in this review submitted a detailed chronology of their involvement with the family members in the period under review. Those submissions have been coordinated into an integrated chronology, which is summarised here. Further factual information is provided in some subsequent sections where relevant.

5.3 A note on concealed pregnancy

5.3.1 During the SCR process the panel debated the term 'concealed pregnancy' and indeed whether this case concerned a concealed pregnancy or whether the mother genuinely had not known that she was pregnant. The term 'concealed pregnancy' refers to women who have some knowledge of their pregnancy but seek to actively

[2] The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro Crown Copyright 2011

conceal the facts from those around them. In this case the author has used the term 'concealed pregnancy' because it is the one most commonly used and because the evidence gleaned from the review strongly indicates that this was the case. The evidence includes;

- Ms X's withdrawal from all appointments particularly in relation to her own health between the period when she was most likely to have become aware that she was pregnant up to Child E's birth – a period of approximately 8 months

- During this period Ms X stopped taking her prescribed medications for depression and hypertension

- Ms X did not respond to a letter from the GP enquiring as to whether she was pregnant

- Ms X's own later admission that at least a small part of her knew she was pregnant but she put it to the back of her mind

- Ms X's acknowledgement that she was finding it difficult to leave the house

- Ms X's resumption of her normal pattern of attending appointments once Child E was born

5.4 The Family background

5.4.1 The family in question consists of Ms X who is mother to Child E and Child F and her partner Mr W who is father to both children. They lived in privately rented accommodation. Ms X also has two older children from a previous relationship who lived with other family members at the time of the incident. Ms X had regular contact with them. Mr W also has a child from a previous relationship also living with other family members at this time.

5.4.2 The family are White British and their first language is English. Little information is provided in the narratives about their socio-economic background and there was no knowledge of either of the adult's current employment status though Mr W is referred to as working long hours.

5.4.3 From the records provided for this review it would appear that the relationship between Ms X and Mr W contained incidents of domestic abuse (both were involved in incidents of domestic abuse with previous partners) and Ms X described their relationship as volatile. Ms X has a history of anxiety and depression but struggled to access services that could assist her in getting this under control. She also suffered from hypertension which caused her some medical difficulties, but she was

not always compliant with treatment.

5.4.4 From information provided for the review it would appear Ms X had some behavioural difficulties as a child and was referred for anger management as a young adult. The exact nature of these difficulties has not been established for this review but up until the point of her pregnancy with Child E she did have regular contact with a number of services, mainly health visiting and her GP. She received routine antenatal care throughout her pregnancy with Child F with no apparent problems.

5.4.5 According to information provided Mr W also had a troubled childhood and from early records it is believed he lived in children's homes from the age of approximately 15. Further records indicate hospital attendances due to excessive drinking also from about this age, which continued into his early adulthood.

5.5 Summary of agencies' Involvement with the family

5.5.1 As part of the review information was obtained from agencies and the following is a factual summary of the information provided.

2013

5.5.2 Child F was born in hospital by caesarean section. There were no concerns noted about the baby in the postnatal care provided by midwives.

5.5.3 A few days after the birth of Child F, Mr W was taken by ambulance to hospital due to a sudden unexplained collapse and had banged his head. It was noted at the time that he drank 6-8 units of alcohol per day (NB it is not clear if this was a self-disclosure).

5.5.4 Immediately after the birth routine visits were conducted by midwives and the health visitor (HV) and mother and baby were developing well. Child F was bottle fed, was gaining weight appropriately and sleeping well. The following day Child F and Ms X were discharged from midwifery.

5.5.5 In early summer of 2013 Mr W failed to attend a planned medical appointment. There was apparently no explanation for this and a further appointment was offered for a month later.

5.5.6 During the next few weeks Child F received her routine 6 week health surveillance check with the GP with no reported concerns and later that month a further routine health visiting appointment took place to review Ms X's postnatal depression (PND). There was no sign of low mood on this occasion and no concerns noted re Child F or the care that she was receiving.

5.5.7 Later in the summer there was some concern that Mr W had missed important medical appointments and although he did consult with the GP the issue was never investigated. He discussed his current smoking and drinking habits and he reported smoking up to 30 cigarettes a day and his drinking had increased. He also mentioned that he was stressed with a small baby in the house. The GP gave advice re smoking and drinking but was unable to persuade him to continue with the medical investigations.

5.5.8 Ms X also attended the GP surgery requesting an increase in medication for her hypertension. This was not prescribed as she had previously not attended for blood tests.

5.5.9 Later on in the summer of 2013 Ms X presented to the GP with symptoms of depression. She put this down to her grandmother having recently died (during her pregnancy with Child F). The GP prescribed sertraline[3] and gave advice about seeking help from CRUSE[4]. A review appointment was attended whereby Ms X reported that her depression was improving and that she had an appointment with 'Talking Change'.[5]

5.5.10 Child F's routine developmental checks were carried out and she was said to be developing well.

5.5.11 In early September an anonymous referral was made to the Emergency Duty Team (EDT) in Social Services. The caller stated that they lived in the same road and stated that she could hear a baby crying continually and the parents arguing. Other children have been seen at the address but only at weekends.

5.5.12 The referral was passed to day time services and they liaised with the HV who agreed to do a home visit. The visit took place later that month. Ms X acknowledged suffering from depression and disclosed that she and her partner had had an argument. She reported that they have been able to talk about this and that their communication was improving. The HV discussed the impact of this on their baby and offered health visiting support through 'listening visits' and a referral to the local Children's Centre. The help was accepted by Ms X and the visits happened over the next few weeks.

5.5.13 Ms X referred herself to 'Talking Change'[4] and engaged in 6 sessions of Cognitive Behavioural Therapy (CBT). The sessions (all conducted by phone) had the effect of reducing her anxiety and depression. However at the end of this treatment she was still displaying moderate levels of both. Ms X was referred on for face to face therapy.

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[3] Sertraline is primarily prescribed for depressive illnesses in adults and can be used for panic and social anxiety disorders

[4] **Cruse** Bereavement Care provide support for people after the death of someone close

[5] Talking change is a free service providing support for anxiety and depression, serving the people of Portsmouth

5.5.14 During this time the HV accompanied Ms X and Child F to the Children's Centre to register. Further visits throughout this period elicited that Ms X was feeling anxious and isolated from her family.

5.5.15 The HV continued her visits and the situation appeared to have been much improved. Ms X had attended a 'Stay and Play' session at the Children's Centre earlier in the month and appeared much better.

5.5.16 In October the police were called to a domestic disturbance at the family home. Mr W had called the police stating that Ms X was 'freaking out' and he was concerned about their baby. Both parties were heard arguing and accusing each other of assaults whilst the baby was heard to be very distressed. The Police made no arrests, as it standard practice when a child is present, and the passed this information to Children's Social Care (CSC). The information was reviewed by CSC and this resulted in No Further Action (NFA) due to the recent HV involvement.

5.5.17 Less than 3 weeks later Ms X contacted the police via 999 and reported that Mr W had assaulted her whilst she was holding their baby. Ms X reported that father was 'in drink' at that time. Police attended and Ms X stated that she had been hit in the face three times during an argument. She had no visible injuries. Mr. W was arrested for assault but no charges were brought as Ms X was not prepared to press charges. Mr W acknowledged that he had hit Ms X but he had done so because she hit him first. Mr W also acknowledged that he had been drinking although he was assessed by police officers as not being drunk.

5.5.18 The police passed this information to CSC who in view of the seriousness of the alleged violence, the presence of a young child and the previous incident only weeks before they allocated the family to be assessed under section 17 of the Children Act 1989.

5.5.19 The assessment was conducted and the family were co-operative showing an appropriate level of remorse and disappointment in each other for allowing the situation to escalate to such an extent. No further role for CSC was identified and the case was closed. No 'step down' process or support plan was implemented.

2014

5.5.20 Early in 2014 Ms X attended for a routine health screening appointment which required further follow up treatment.

5.5.21 Ms X undertook the last of her allocated 6 telephone sessions of CBT. At their conclusion 'social anxiety' was identified and further in depth assessment was arranged for early spring.

5.5.22 At the same time Child F had her one year developmental check where she was said to be developing well but Ms X was anxious as one of her older children had

been identified as having additional needs. The HV requested some assistance from the Children's Centre in encouraging Ms X to use the services there such as 'Stay and Play'. The Children's Centre arranged for Ms X and Child F to be accompanied to 'Stay and Play' that week and she attended with Child F. No concerns were expressed and Ms X said that she was happy to attend on her own in future. However, she did not attend again.

5.5.23 At around this time Ms X attended a follow up appointment to discuss her previous routine health screening appointment. The consultant gave advice about appropriate intervention and Ms X gave consent for this to go ahead.

5.5.24 The planned appointment with the Cognitive Behaviour Therapist at Talking Change went ahead and Ms X was thought to have 'social phobia'. She was offered further one to one CBT and support via 'books on prescription'[6]. The first appointment was planned for a few weeks later but she did not attend this appointment and was discharged back to the GP.

5.5.26 In April Ms X continued to see the GP for several issues and had a number of appointments for chronic back pain, high blood pressure and preparation for a routine surgical procedure due to take place. Child F received some immunisations during this month with full consent from Ms X.

5.5.27 For a period of six months prior to the birth of Child E Ms X's contacts with agencies ceased and it is significant to this review that after several appointments with the GP and the HV during the preceding 12 months Ms X was not seen at all by either of these services. Several appointments for the planned medical procedure were not attended. The consultant believed this may be as a result of pregnancy and passed this information to the GP.

5.5.28 The GP wrote to Ms X about the missed appointments and to enquire if she was pregnant. There was no reply from Ms X and she did not seek further medical attention in respect of her ongoing medical issue.

5.5.29 On the 1st December Ms X called an ambulance as she was in the later stages of labour – Child E was born almost as soon as the ambulance crew arrived and they assisted in the birth before transporting mother and baby to hospital. There were no complications during the birth and Child E was said to be in good condition on arrival at the hospital. Midwives were however concerned about the nature of the birth and the fact that Ms X had received no antenatal care. In view of this they made a referral to CSC. CSC did not accept the referral at this stage due to it not meeting their threshold for intervention and the Team Manager advised that a

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[6] Books on Prescription is a national scheme, designed to help adults manage their mental wellbeing using cognitive behavioural therapy-based self-help books, all written by experts. The scheme is endorsed by health professionals and supported by public libraries.

Common Assessment Framework (CAF) should be undertaken.

5.5.30 While on the hospital ward on the evening of the 2nd December there was an altercation between Ms X and Mr W, whereby Ms X was seen by the midwife to have blood around her mouth. No assault was witnessed but midwives in the hospital were concerned that an ongoing argument was becoming heated and causing distress to other patients. Staff moved the couple to a side room. Child F was also present during the argument.

5.5.31 The midwife on duty at the hospital rang CSC's Emergency Duty Team (EDT) in the early hours of the 3rd December to report this incident. The call was passed on to the daytime team who linked it to the previous referral. The Team Manager made the decision that a CAF was the most appropriate way forward and this was communicated to the hospital midwives on the same day. The Joint Action Team (JAT) allocated a worker to oversee the task and the CAF was to be completed by the community midwife.

5.5.32 The hospital midwives were unhappy about the decision to initiate a CAF and referred to their Safeguarding Team for advice and support. As a result of this on the 4th December the Safeguarding Midwife completed a comprehensive Interagency Referral Form (IARF) and faxed it to CSC. The information included details about the recent incident, some historical information and information about how Ms X had presented on the ward. Ms X had also refused help and support under the CAF process.

5.5.33 From the 4th December up until the 10th December there continued to be a dialogue between the JAT and the hospital midwives about the status of the case. The Health Visitor based in the JAT, who had been allocated to support the CAF, also felt that the referral met the threshold for CSC and communicated this to her colleagues in the JAT. The Practice Lead reviewed the referral on the 8th December and a decision was made to allocate for CSC assessment under section 17 of the Children Act 1989. The case was allocated to a social worker on the 10th December.

5.5.34 Mother and baby were discharged home on the 4th December and between then and the incident on the 19th December the family had 8 contacts with agencies. Ms X and Child E were seen 4 times by community midwives, twice by the GP, once by the social worker and once by the health visitor. The social worker had also started the process of gathering information for the assessment. Nothing remarkable was noted on any of these contacts. Ms X had been to see the GP as she again was feeling low and she was re-prescribed Sertraline. The health visitor discussed the lack of antenatal care and Ms X offered the explanation that only a small part of her thought that she was pregnant and she had put it to the back of her mind.

5.5.35 On the 19th December Ms X called the South Central Ambulance Service (SCAS) and stated that Child E had stopped breathing. He was transported by paramedics

to hospital where he subsequently died later that day. The explanation for the injuries to the baby was not consistent with the type of injuries Child E had and the hospital referred to CSC and the police. The Child Death Rapid Response for unexpected deaths process was put in place and a police investigation commenced.

6 ANALYSIS FROM AGENCIES' NARRATIVES

(NB some sections have been merged together where relevant)

6.1 Were childcare or safeguarding concerns recognised and responded to appropriately?

6.1.1 There were no noted concerns in relation to the pregnancy or the birth of Child F and the care of the baby in the following months did not raise alarm bells with professionals. In the summer of 2013 agencies in contact with the family were predominantly the GP and the HV and some low level concerns in regards to the parents came to the fore. Mr W failed to attend planned appointments in relation to a medical issue earlier in the year. He did not proceed with investigations despite advice from the GP that he should do so. Mr W also told his GP that he was increasingly stressed with a small baby in the house and that his drinking and smoking had increased. However none of these things were thought to be particularly concerning and appropriate advice was given.

6.1.2 At around the same time in 2013 Ms X presented to the GP (same practice) ostensibly to request an increase in her medication for hypertension. This was denied by the GP due to Ms X not having undertaken routine blood checks first, and about a month later she presented to the GP feeling low. She cited the cause as the death of her grandmother during her pregnancy and that she was feeling isolated. The GP prescribed medication and appropriately advised that Ms X also seek some counselling. It appears that this information was not passed to the HV to provide additional support to Ms X but in any event an anonymous referral was received by CSC at the beginning of September and the HV did then become more significantly involved.

6.1.3 The referral came via an anonymous route so it was not possible to clarify the information but the referral was low priority (see section 5.5.11) and did not meet the threshold for CSC intervention. What was agreed was that the HV would visit and offer Ms X support. This was an appropriate response as the HV had a positive relationship with Ms X and knew the family.

6.1.4 The HV was proactive and offered assistance by the way of 'Listening Visits' and help with a referral to the Children's Centre. This again was entirely appropriate and pitched at the right level. Ms X confided in the HV to some extent and the situation seemed to be improving. Ms X attended the Children's Centre (albeit occasionally) and her mental health (possibly as a result of the medication and the intervention of

the HV) seemed to have improved.

6.1.5 In October 2013 the police responded to a call from Mr W. Child F was present during what appeared to be a heated and fraught argument between the couple (see 5.5.16). No arrests were made and no one was removed from the property. The incident was rated as 'Standard Risk'[7] by the attending Police officers but later raised to Medium Risk[8] by Hampshire Police's Central Referral Unit (CRU). This meant that the Police's Safeguarding Team were tasked to offer safeguarding measures to Mr W. Telephone contact was attempted but there was no response so a 'Domestic Violence Information Pack' was sent and the incident filed. The victim in this case was seen to be Mr W.

6.1.6 In the narrative submitted by the police there is considerable analysis of this incident that concludes that the officers were right not to make arrests or remove any person from the property but further checks should have been sought on the day to enable officers to assess the situation using historical information to assist this. This was not done and the incident was recorded as a 'non crime domestic', which in its analysis the police report states that it should have been recorded as a 'domestic assault with neither party wishing to proceed with the matter'. Further to this, information about historical domestic incidents in relation to Mr W had been included in the information exchange between the police and CSC but not Ms X as the research had been conducted using her previous surname. In 2013 it was not standard practice to routinely pass information of this kind from the police to health colleagues.

6.1.7 The manager in CSC reviewed the information and made the decision that, as with the previous referral, it was appropriate that the HV follow this up. There is no record however of any information being passed to the HV from CSC or the police and consequently this incident was not followed up by any agency save the DV information pack sent by the police. It would have been beneficial for CSC to have made contact with the HV to ensure that she was aware of the domestic incident so that she could plan some intervention. It is likely, given the work already being carried out by the HV, that the decision would have remained the same but liaising with the HV directly would have ensured that the decision was informed and may have provided some more targeted support in relation to the family's difficulties.

6.1.8 The first safeguarding incident requiring intervention from CSC was towards the end of 2013 when the police were called to a further domestic incident. On this occasion Ms X called the police and she alleged that Mr W had punched her in the face 3 times whilst she was holding Child F (see 5.5.17). This was the third referral in as

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[7] In the Hampshire Constabulary Standard Risk is defined as "Current evidence does not indicate likelihood of causing serious harm".

[8] Re above: Medium Risk is defined as "There are identifiable indicators or risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances".

many months. In relation to the information from the police they again analysed the event in some detail and acknowledged that the incorrect risk rating had been given and was again raised from 'Standard' to 'Medium'. Attempts were made by the police Safeguarding Team to contact the family but they did not respond to their contacts. In risk assessing the incident information about Mr W and previous domestic incidents was included but omitted to mention Ms X's history.

6.1.9 The information was followed up by CSC and the family were rightly allocated to a social worker for assessment. The assessment resulted in 'No Further Action' and according to the CSC narrative the assessment was poor in quality. It lacked analysis and relied heavily on the parents self-reports of the incidents without considering the experience of the child. Furthermore there was little cross referencing with other agencies and no formal handover or step down plan arranged.

6.1.10 The assessment was hindered by the missing information from the police and the GP. Both these agencies had relevant information to share in regards to the adults – the GP held considerable information about the adults going back some years. It is not clear what information was sought by the social worker completing this assessment but of particular significance to share would have been the GP's knowledge of Mr W's previous alcohol difficulties and current information regarding this. This is relevant given that alcohol was a factor in the domestic dispute. Also some confirmation of Ms X's mental health difficulties and the likely impact of that on her parenting would have made useful additions to the assessment. There is no information gleaned during the course of this review to suggest that this information was available to the social worker.

6.1.11 The assessment was conducted under s17 of the Children Act 1989 and therefore would have required consent from the parents which may have not been granted. It would have been reasonable to try and ascertain this information particularly since the health visitor had some historical information to share.

6.1.12 The CSC narrative is clear that since this assessment was undertaken practice expectations have changed and there should now always be a clear step-down process. This is important to note as there was an opportunity here to provide more coordinated, targeted support to assist the family at this time via a CAF as there were by now several indications that Child F's needs were not being consistently met. There were concerns about parental mental health, alcohol misuse and domestic abuse – sometimes known as the Toxic Trio[9]. The health visiting service were key in the family's life and had had some success in supporting them, as such it would have been beneficial to share the assessment with them and agree a way

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[9] The term '**Toxic Trio**' has been used to describe the issues of domestic abuse, mental ill health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people

forward. The HV was not aware of the domestic abuse in the family. Audit work has taken place within the partnership to strengthen multi-agency assessment of the impact of domestic abuse within families. The panel were satisfied that this work is well under way and that assessments of are now of a much higher quality.

6.1.13 The final practice episode prior to Child E's death where safeguarding concerns were raised by agencies were those that arose as a result of the birth of Child E (see 5.5.29). Although there were no health concerns about Child E the hospital midwives were immediately concerned about the lack of antenatal care particularly in view of Ms X's medical history. They rightly made a referral to CSC. The referral was however of poor quality and did not contain detailed information or the context of the situation. The midwives were also concerned about Ms X's other medical conditions such as hypertension, risks associated with prescribed medication e.g. Sertraline and the risks associated with giving birth alone with no contingency plans. The fact that Ms X disclosed that she had been in labour for almost 3 days was particularly concerning in terms of her health and that of the unborn baby. Post birth other risks involve women finding it difficult to adjust having made no preparations for the baby and, in some cases, women feeling embarrassed and isolated which in turn impact on their self-confidence (Conlon 2006). This level of detail as to why the midwives were concerned did not feature in the referral and the decision that a CAF should be initiated was made.

6.1.14 The argument between the parents on 2nd December caused further safeguarding concerns for hospital staff (see 5.5.30) and it has been acknowledged that although it was good practice that the family were moved to a side room, security should also have been alerted to the argument. There was an emerging picture of concerns building and the argument caused further worries on a number of levels including;

- The fact that Child F and Child E were present throughout the argument and at some points Ms X was holding Child F whilst arguing with Mr W
- It was unclear (and remains so) how Ms X came to have blood on her face
- It seemed that despite being in a hospital ward the couple did not respond to requests to stop arguing and had to be moved for the safety and comfort of the other patients
- Ms X denied the presence of domestic abuse in their relationship despite previous involvement from police and CSC. Later that night she disclosed that there had been domestic abuse

- After the incident Ms X disclosed long standing mental health difficulties and separation anxiety which she had struggled to deal with.

6.1.15 The argument was not referred to CSC straight away (bearing in mind the incident happened in the evening) but a call was made to the EDT in the early hours of the morning who passed the call to the daytime team. This call was made by a different midwife to the one who had dealt with the incident. Again it appears that the full context of the situation and its severity was not conveyed in the details to CSC with the outcome that the decision stood for the midwife to conduct a CAF. This decision was also made with the erroneous piece of information that the family were not known, thereby missing critical information about the previous domestic abuse. This was overlooked due to Child F's record having not been checked.

6.1.16 There then followed a series of telephone exchanges between midwifery services and CSC about the decision to undertake a CAF rather than a CSC assessment. As pointed out in the narrative provided by CSC, the information provided to support the referral was 'piecemeal and fragmented' which did not assist the information exchange. In response to this the midwifery service were proactive and appropriately escalated the matter to their Safeguarding Team and on the 4th December a full and detailed referral was made by a member of this team. This included historical information and disclosures by Ms X that she had suffered from depression and that there had been domestic abuse in their relationship. It also included some detail and analysis about the incident between the parents on the ward. This information, coupled with the fact that Ms X had refused to engage with a CAF, led the Practice Lead in CSC to review the information and on the 8th December a decision was made to allocate for assessment under s17. This was a sound decision which was supported by the JAT manager and the JAT health visitor. The social worker was allocated on the 10th December.

6.1.17 In analysing the above event it would seem that the information exchange between CSC and hospital staff was not tight or timely and there was an initial lack of understanding between the two agencies about the level of concern. CSC treated the original referral at face value i.e. there were no immediate concerns about the baby, without perhaps questioning the wider implications of a concealed pregnancy though these had not been explicit in the original information. This became more complex by the disjointed way in which the information became available to them via midwifery.

6.1.18 The situation was resolved when the midwifery service utilised their escalation process which proved to be a successful and positive intervention. By contacting their safeguarding team and in turn this resulting in them making a comprehensive referral, the two agencies reached agreement about the way forward. This was a helpful process as it clarified the risks succinctly combining all of the information

held by midwifery and forming a coherent rationale as to the potential risks posed to the children.

6.1.19 As details of Ms X's presentation and history emerged it became pertinent for CSC to review the information and consider an alternative course of action, which they did. The lack of clear procedures in respect of concealed pregnancies was also a factor in the misunderstanding between the agencies and the situation could not be moved forward by clear multi agency policy to guide practitioners, as the current guidance is not explicit. Having reviewed the information the manager agreed that the family needed to be assessed and, having reportedly refused a CAF, made the pragmatic decision to allocate for assessment. It is to the manager's credit that this was her decision as the level of risk did need to be assessed. The decision to assess under s17 'with a view to a step down plan at a later point' rather than s47 was appropriate and proportionate.

6.1.20 When Ms X and Child E had been discharged from hospital Ms X resumed her usual pattern of contact with agencies. Ms X and other members of the family were seen a number of times throughout December including 2 appointments with the GP (Child E and Ms X) who was unaware of the recent safeguarding concerns. However, even with all the information available to practitioners at no point was the imminent risk to the baby apparent and, during this period, professionals conducted their duties appropriately.

6.1.21 Since the death of Child E the PSCB have worked to improve processes and procedures concerning concealed pregnancies. This now includes a mandatory reporting protocol to CSC for assessment for suspected concealed pregnancies. Training for staff about the risks associated with concealed pregnancies is now integrated into courses offered by the PSCB as well as briefings about the learning from this case due to take place.

6.2 Did actions accord with assessments and decisions made? (Please include comment on the quality and timeliness of any assessments)

Were appropriate services offered/provided, or relevant enquires made, in light of the assessments?

6.2.1 Much of this has been covered in Section 6.1 but there are other factors worthy of comment over the review period.

6.2.2 There were very few formal assessments conducted in relation to the children – the HV assessment on the birth of Child F and the Initial Assessment conducted by CSC being the main ones. The assessment commenced by CSC in December 2014 was not concluded before the death of Child E so falls outside of the terms of reference for this review. The HV acted promptly and appropriately in relation to the family after the anonymous referral in September 2013 but no agency except the

police responded to the referral in October 2013. The assessment that subsequently took place in November 2013 was timely but as described in section 6.1 did not result in a plan being put into place to assist the family.

6.2.3 These were all early indications that the needs of Child F were not being fully met. Early Intervention (EI) through universal services or more targeted provision is the nationally identified mechanism by which families can be encouraged to accept help from a range of agencies. The Common Assessment Framework (CAF) is the most widely used route to provide services to families whose needs fall below the threshold for intervention from CSC.

6.2.4 No agency conducted a formal CAF assessment or coordinated services to provide support. There were increasing signs of concern about Child F's well-being from September 2013 and there is evidence that the HV addressed some of these issues with her and linked Ms X in to other services which was good practice. However, a more coordinated approach particularly with domestic abuse services could have been beneficial. Services such as these that target the parent or carers ultimately benefit the child and can improve their outcomes. The HV was however unaware of the further domestic abuse incidents in 2014.

6.2.5 Eileen Munro in her review in 2011 identified the challenge for professionals working with families 'parents who voluntarily engage with support services tend to make more progress while a more coercive approach can deteriorate into an adversarial relationship which blocks progress.' The benefits of a CAF can be assessed as it being the opportunity for agencies to gather information and have a more structured multi agency response to the presenting issues and create a Team Around the Family (TAF). This in turn may have uncovered further evidence associated with parental habits such as alcohol misuse, more information about the relationship between the parents and the impact of Ms X's mental health. It may also have elicited more information about Child F and her lived experience. The absence of this process meant that Child F was never identified as a Child in Need.

6.2.6 It is possible of course that Ms X (and Mr W) would have refused such an intervention, as can be seen in the latter stages of this review period when Ms X withdrew from agencies completely. However much of the evidence from this review suggests that up until the point of her pregnancy in 2014 Ms X sought and engaged well with many services. As many of these were adult oriented services dealing with her mental health and medical problems, these went unnoticed in relation to the needs of Child F and subsequently Child E as an unborn child. The involvement of the Children's Centre would have also been key in this process.

6.3 To what extent were the child/ren's needs, views and wishes taken into account?

6.3.1 Child F was a very young child at the point of the incident so would not have been

directly consulted by any agencies but the expectation would be that any assessment undertaken would have the child at its centre. Assessments should include the child's voice and information about the impact of the parents' lifestyles e.g. the child's lived experience. Most of the information from agencies provided to this review are silent on this issue. The impact of the parental behaviours and lifestyles were largely unassessed.

6.3.2 Ensuring that the voice of the child is assessed and analysed becomes trickier when the child is preverbal as was the case with Child F (though would have been becoming more vocal) and Child E. In situations where children are not verbal professionals rely on other cues such as observations, eye contact and physical contact between parent and child. Further, in the case of a newborn baby professionals may also consider whether or not they were planned and what preparations had been made for their birth. The lack of preparation for the birth of Child E was initially not considered to be a concerning factor warranting intervention by CSC but was put right by the agreement to an assessment by mid-December. Parents' lifestyles should be assessed and as we have seen there were gaps in the information known so these did not have as much bearing as they might have done.

6.3.3 Child F's medical and developmental needs were attended to throughout the period under review. Ms X attended all routine appointments and immunisations were up to date. What is not known however is whether or not Child F required any medical attention during the period in 2014 when Ms X withdrew from services. Given that she did not see any professionals during this period, ostensibly due to her anxiety, it is difficult to predict what she would have done. It is reassuring to note however when Ms X finally faced the fact of her pregnancy she did seek medical help in the end, albeit at the stage that she was very close to delivery.

6.3.4 Again, save the input from the HV, the impact of mother's mental health and the domestic abuse were not assessed from a multi-agency perspective.

6.4 To what extent was family history sought and was the information given due weight and consideration. Was it used effectively to inform decision making and inform subsequent actions?

6.4.1 A complete history of this family was not well known by agencies working with them. From information gleaned through the process of this review the GP practice held the most history having access to the parents' childhood and early adulthood as well as recent medical information. Significantly, the GP held information about Ms X's mental health and subsequent treatment and Mr W's alcohol intake. The opportunity for the GP to share this information (with consent) would have been the assessments conducted by CSC in 2013 and 2014. In relation to the former it is not clear if this information was not sought, or sought and not provided. In relation to the latter, some information was provided but not about the history of alcohol concerns. Further opportunities were also missed by the lack of a CAF process. Consequently

it meant that assessments were completed without a full history.

6.4.2 Good practice to avoid some of these pitfalls is liaison meetings between GPs and HVs, and work has taken place in Portsmouth to strengthen these meetings and produce positive interventions for families with young children.

6.4.3 Similarly the police gave incomplete historical information regarding domestic abuse incidents that has been discussed elsewhere in this report. This had the same impact of assessments being conducted without the complete picture.

6.4.4 The CSC narrative makes the point that their assessment relied too heavily on the parents self-reports and the above information would have served as a useful cross reference point to provide more robust analysis.

6.5 Is the rationale for decision making clear and accord with subsequent actions taken

See section 6.1

6.6 Were all appropriate family members involved?

6.6.1 The majority of the services offered to the family revolved around Ms X and Child F. Mr W was seen by professionals on occasions but contacts tended to be around mother and baby. It was unclear whether or not the couple lived together as Ms X disclosed to the social worker in December 2014 that their relationship was volatile and for that reason they were unable to live together. This is an aspect of their relationship that was not assessed due to the couple not disclosing this information. It is significant as it adds weight to the concerns about domestic abuse and the couple being ‘volatile’ with each other.

6.6.2 It is possible that a formal CAF process would have elicited more information about Mr W and possibly other family members but the focus would still most likely have been Ms X due to her particular circumstances and the fact that Mr W worked long hours. Professionals were aware that Ms X felt isolated from her family but there was no particular reason to involve them in the work being carried out.

6.6.3 The GP appropriately followed up with Mr W when he refused further investigations in relation to his health issues, but was unable to convince him that the exploration was in his best interests and Mr W chose not to attend the appointments.

6.7 Was disengagement recognised and responded to?

6.7.1 During the review period under scrutiny the family had a number of contacts with professionals so it is significant to note that in the period leading up to the birth of Child E there were no notable contacts with any members of the family – a period of 8 months. As the outcome of this was particularly poor (in that Child E received no

antenatal care) it is necessary to examine professionals' part in this.

6.7.2 Ms X had regular contact with the health visitor prior to this period. They had developed a good rapport and the HV noted improvements in Ms X's mental health as a result of this work. Similarly the HV had no concerns about Child F. Her developmental checks and immunisations were on course. There is no evidence in the information provided that health visiting had been increased beyond the statutory universal service so the pattern of visiting and contact were consistent with that. However the question does arise as to whether or not given these circumstances contact should have increased. As discussed in Section 6.2 more targeted support may have been beneficial. As previously noted the HV was unaware of the domestic abuse in the family and had that information been shared it is possible a different course of action may have been followed.

6.7.3 Ms X also had some contact with the Children's Centre having been introduced to their services by the health visitor. Child F's routine visits and developmental checks took place there but it was by no means regular established contact and was on a very informal basis. Ms X attended two 'Stay and Play' sessions but this was a voluntary service and the fact of her subsequent non-attendance did not cause undue concern.

6.7.4 Prior to the period leading up to the birth of Child E, Ms X sought advice from the GP about various medical complaints or routine checks on average once or twice a month throughout that period. Her behaviour was not however always compliant or consistent. The most significant factor of her disengagement came in relation to her non-attendance at appointments relating to a health issue. Having had the first round of treatment she failed to attend significant follow up appointments having consented to the treatment offered. The consultant treating her suspected that she may have been pregnant and passed this information to the GP. The GP was proactive in writing to Ms X and enquired as to whether or not she was pregnant but received no reply. Ms X continued to isolate herself from professionals and did so until Child E was born in December.

6.7.5 The GP having been proactive in writing to Ms X did not follow it up any further. There would have been limited options available to the GP in following this up but some liaison with midwifery or the health visitor would have been a beneficial course of action particularly in view of her medical history. It is of course possible that by that time Ms X's position and reasons for her non-engagement had become entrenched and contact from the HV may also have been avoided. The fact of her disengagement may then however have become more apparent. The pregnancy would have been considered high risk due to Ms X's medical conditions and she would have received appropriate advice and care to deal with this. As it was Child E was born in in difficult circumstances. Despite that he was healthy at birth with no apparent complications for either him or Ms X.

6.7.6 In 2014 Ms X did not attend her follow up appointment with 'Talking Change' and was discharged back to the GP. This is significant as this had been a service that she had previously found beneficial. There was however no statutory obligation for Ms X to attend any of these services and the emerging picture has been gained with hindsight, and would not have been evident or significant to any of the practitioners involved at the time. Both parents can be said to have been sporadic in their attendance with appointments throughout this period and this is another reason practitioners would not have noticed anything out of the ordinary.

6.8 Were issues of diversity considered, including any issues of vulnerability with adults and children in the family? (Mental health, emotional wellbeing, domestic abuse etc.)

6.8.1 There were no particular issues raised in the agency narratives about diversity and much of this has been covered elsewhere in the report when considering issues about mental health and domestic abuse but other issues should be noted in this section.

6.8.2 Issues of identity, e.g. sense of self, self-esteem and sense of belonging for either of the children, were not assessed by any agency. However the GP and the health visitor responded well to Ms X's mental health needs up until the point of disengagement. This also included the health visitor recognising how isolated Ms X felt especially in relation to her family and attempted to link her in with services. She also spent some time talking to Ms X about the impact of domestic abuse on children – Child F in this instance.

6.8.3 The adults' vulnerability in relation to their childhood experiences was not assessed as the information was known only to the GP. Of particular relevance here would have been the incidences of excessive drinking for Mr W which began in adolescence and carried on into early adulthood.

6.8.4 The social worker allocated to the family in December 2014 was male. The CSC narrative recognises that women who experience domestic abuse may respond more favourably to being allocated to a female social worker. Whilst this should always be an issue to consider, the allocating manager felt that the worker had the necessary skills to be able to engage with the family as a whole and nothing from the review led the panel to conclude this was not the case.

6.9 Examine and analyse the level and effectiveness of recording and exchange of information and communication between agencies and across areas. Identify any gaps that may have impacted upon assessment, service provision or outcomes.

6.9.1 Issues about exchange of information and communication are largely covered elsewhere in the report particularly in section 6.1. In relation to recording it would

appear that this was consistent and contemporaneous for the majority of agencies with the exception of the assessment completed by CSC in November 2013. The narrative noted that the visits to the family had not been written up separately which would have been an expectation.

6.9.2 Another point worthy of note here is that as a family unit there was no evidence within the documented GP notes that Mr W's increased drinking and stress, and mothers low mood where joined up or if indeed they were linked as a family on the records. The identification of the two parents struggling with their own issues and the impact of that on a young child were not assessed. The review has highlighted the need for GPs to 'think family'.

6.10 Was the work in this case consistent with each agency's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards

6.10.1 All agencies worked within their current guidelines with no significant omissions in what is currently available. One issue relating to policy arising from the review is the lack of clear guidance for working with families where concealed pregnancy may be an issue. The relevant LSCB procedures for Portsmouth that were operational at the time of the review contained a section about concealed pregnancies. While they clearly spelled out the risks associated with it they did not direct practitioners to a particular course of action and so needed to be strengthened.

6.10.2 The PSCB procedures identified a number of risk factors present in this case which would have indicated a referral to CSC was necessary. These are namely;

- Where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.
- Domestic Abuse
- Concealed pregnancy
- No preparation for the baby's needs[10]

6.10.3 The circumstances of this case clearly met the criteria for referral to CSC which was completed thoroughly by midwifery (after the escalation to their safeguarding team). Where the procedures are not so explicit is the circumstances in which CSC must proceed with an assessment either under s17 or s47 Children Act 1989 and these

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[10] P5 Hampshire, Isle of Wight Portsmouth Southampton 4LSCB Maternity and Children's Services Unborn Babies safeguarding Protocol

needed to be clearer. As detailed elsewhere in this report, the procedures have now been updated.

6.10.4 The only other specific multi-agency document referenced in agencies reports to this review was the "Embedding Inter-agency Help and Safeguarding Practice across Portsmouth Protocol and Guidance'. This did not contain specific guidance for concealed pregnancies; however this document has been superseded by a new Thresholds Document and a '4LSCB Unborn/Newborn Baby Safeguarding Protocol' which has recently been revised.

6.11 Were there any organisational difficulties being experienced within or between agencies?

Were there any professional disagreements and if so how were these resolved?

6.11.1 No agency reported any difficulties experienced either within or between agencies and no concerns regarding on going professional tensions of this nature have become apparent during the course of this review.

6.11.2 Professional disagreements about the application of thresholds were raised between Midwifery Services and CSC at the beginning of December 2014 and these were resolved by escalating to the midwifery service's Safeguarding Team. This issue is covered in section 6.1.

6.12 Was there sufficient management accountability and oversight for decision making? If accountability was lacking what would have assisted in this taking place?

6.12.1 Appropriate supervision policies are evident in the agencies involved in this SCR but as this was not a high priority case very little formal supervision took place. Supervision however did take place for Children's Social Care and the Health Visiting Service.

6.12.2 CSC highlight weaknesses in the work completed by them in 2013 and note the corresponding lack of management oversight in not correcting the work at the time. The view from CSC (and this was accepted by the panel) is that this is a historical issue and that supervision is now much stronger. There is no evidence from the review process which suggests this is not the case.

6.12.3 The issue regarding the different application of the threshold for intervention between Midwifery Services and CSC in December 2014 was successfully resolved through the escalation process and management intervention. This was a result of practitioners seeking appropriate advice from managers in a timely way.

6.12.4 The Multi Agency Safeguarding Hub (MASH) was introduced in November 2015 to

better facilitate early decision making arrangements and information sharing via colleagues from a multi-agency network. The advantage of this model is the shared decision making which is at the heart of its success in other places (notably London Boroughs) and the move away from single agency decision making which often relies on one or two individual managers.

6.12.5 The review highlights the lack of safeguarding supervision for GPs and other agencies who deal with difficult decisions and circumstances on a regular basis.

7. LESSONS LEARNED FROM THE REVIEW

7.1. Better use of early help and intervention

7.1.1 Children are much more likely to have a positive outcome if their difficulties are recognised at an early stage and they receive help. The importance of early intervention processes that are understood and owned by all agencies are crucial. Early signs of neglect were not shared between professionals because no use was made of the current mechanism for doing so e.g. a CAF assessment. Individual agencies offered support to the parents but this was not coordinated.

7.2 The role of supervision for all agencies

7.2.1 The review highlights the necessity of good reflective supervision and management scrutiny in all agencies. The role of managers to stand back and help practitioners unpick and fully appreciate the complexities of a situation was missing. This is particularly prevalent in families such as this where the issues are complex. There is good evidence in this case of a shared understanding of the importance of escalation processes when there are disagreements between professionals. It was used to good effect in this case and this is to be commended.

7.3 Assessment of the impact of specific parental issues (DA, alcohol misuse, parental mental health)

7.3.1 Fathers and other significant males can be very influential in families and as such there is need for all agencies to ensure that relevant information about them and any specific issues relevant to them is collected during the assessment process and kept under review. Very little information was known or considered about Mr W, particularly in relation to his history or the extent of his alcohol use. His early history is troubling and the domestic abuse associated with a previous relationship was not considered fully. Professionals should take time in establishing the role of fathers and to assess the meaning of their presence in children's lives. While much more was known about Ms X, the impact of these factors was not assessed in depth nor on these adults as a couple. The dynamic between these parents was (by Ms X's own admission when interviewed by the SW after the birth of Child E) one of volatility, with each one being seen as perpetrator and victim alike in domestic disputes. This brought a further element of instability to the children's lives.

7.4 Exchange of information between agencies

7.4.1 In the referral and assessment process the exchange of information between agencies is crucial. Poor exchange of information is likely to result in the wrong application of thresholds and subsequently flawed assessments. In this case the exchange of information between agencies was left wanting particularly in relation to the adults' respective histories. Some incomplete exchanges of information between the police, CSC and the HV about the historical and current issues relating to domestic abuse meant that more targeted services were not offered to the family at an early stage.

7.5 Risks associated with concealed pregnancies

7.5.1 The risks associated with concealed pregnancies are well documented within literature. Within SCRs families where concealed pregnancy is an issue form a small but significant number. Agencies need to have a shared understanding of these risks and their role in dealing with them. Hospital staff did have an understanding of these risks but failed to adequately convey them to CSC staff in the first instance leading to a delay in the assessment of the family. The review has highlighted the importance of agencies making detailed and thorough referrals. The circumstances surrounding any concealed pregnancy should be subject to detailed multi agency investigation and where appropriate, support in terms of psychological or psychiatric input should be considered as part of any assessment.

8.1 RECOMMENDATIONS FROM THIS OVERVIEW REPORT

8.1.1 These should be read in conjunction with the recommendations from the agency narratives detailed in appendix 1

8.2 Recommendations for the LSCB

8.2.1 PSCB to review and report on the effectiveness of Early Intervention in enabling front-line professionals to provide early help to vulnerable families.

8.2.2 In line with the above PSCB to oversee a review of current MASH arrangements to ensure effective targeted support to families in need of Early Intervention services.

8.2.3 PSCB should ensure that partner agencies have an agreed step-up/step-down protocol concerning the use of the CAF

8.2.4 PSCB should oversee the strengthening of multi agency procedures in relation to the identification, referral and assessment of concealed pregnancy

8.2.5 PSCB to review its learning programme to ensure it includes multi agency training on concealed pregnancy

8.2.6 PSCB to oversee a review of multi agency guidance to assessing the impact of domestic abuse, alcohol misuse and mental health difficulties

8.2.7 PSCB via the Section 11 process should require all agencies to report on the effectiveness of their supervision and management processes in ensuring that the work of front-line professionals is scrutinised and challenged.

8.2.8 PSCB to oversee and receive feedback from the proposed Clinical Commissioning Group (CCG) audit of the use and effectiveness of the GP/Midwife Liaison Form

8.2.9 PSCB to seek assurances from GP practices that they have HV/GP link meetings in place and that these are effective in identifying vulnerable families at an early stage so that the appropriate help can be offered.

8.2.10 Through the Safeguarding Adults Board (SAB), PSCB to consult with GP practices and other adult services to promote a more joined up approach to vulnerable families. The first stage of this would be for the lessons for this review to be shared with the SAB.

8.2.11 PSCB to undertake an audit of the quality of referrals received into Portsmouth's 'front door'.

8.2.12 The lessons learnt from this Serious Case Review to be disseminated and incorporated into future multi agency training.

Jane Doherty

Independent Social Work Consultant
January 2018

Appendix 1

Recommendations from agency narratives

These recommendations have been taken from the agencies narrative analyses and have been accepted by the panel

Children's Social Care

- A review of guidance on assessing domestic abuse and roll out to staff
- Audit to be undertaken on the quality of assessment practice in domestic abuse
- Managers to ensure there is reference to previous history on recorded decisions on the child's record and audit to be undertaken to confirm improvements and progress made

Early Years

- With all frontline stakeholders; review induction and supervision processes to better support the culture of 'hand-over' to ensure cases are followed up. All practitioners should be alert to 'checking-in' and ensuring they are aware of progress where they make requests for support from colleagues.

GP

- In April 2015 a GP/Midwife liaison form was developed and launched. It is expected this form will be shared for every woman presenting to the GP / Midwife and then shared. The use of the form will be audited in December 2015.

Portsmouth Hospital Trust

Within PHT:

- Continue current support of specific safeguarding team – this case is a very good example of how prompt / specialist advice and supervision is vital in supporting 'front line' staff who are trained to recognise risks but often have relatively little experience in analysis of the level of risk, escalation/challenge of Children Social Care decisions ensuring appropriate action is taken
- Current discharge process does not share information with GP regarding safeguarding children concerns; this has been shared with the named Midwife and the process is to be reviewed.
- While staff clearly need to use discretion to diffuse more minor incidents that are inevitable in healthcare, 'zero tolerance' perhaps needs to be clearer for more significant incidents (e.g. with escalation to security and/or police).

Across wider safeguarding:

- Consideration of how all referrals can be made clearer so that agencies perceive the same information. There is no easy answer to this problem that is also seen e.g. in aviation and in medical care. Standardised processes may be part of the solution e.g. the 'SBAR' process that allows clear escalation around physiological deterioration when ward nursing staff request medical review which has clear parallels to this case. NB This is not a substitute for senior staff who can make judgement decisions, but may at least ensure they are better involved and informed
- Concealed pregnancy appears to be such an overwhelming risk factor for poor outcomes that I would regard it as requiring an approach similar to Strategy Meetings that occur when significant acute physical abuse of a child is suspected (NB: This is not a criticism of care in this case, but my opinion for consideration in future)
- Increase focus on 'pro-active' safeguarding rather than so much on 'reactive' after an event has occurred. Identifying high risk pregnancies seems a logical place to start. This requires much better information sharing / availability and IT is essential to this. CP-IS is a step in the right direction, but needs to be developed further.

Hampshire Constabulary

No recommendations

Solent NHS Trust

- The process and effectiveness of the CYP information sharing, including the use of the System One IT child health records, needs to be evaluated once the MASH has been fully implemented

Appendix 2

ACRONYM	MEANING
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
CSC	Children's Social Care
CRUSE	A voluntary organisation who assist people have had a close relative die
DNA	Did Not Attend
DA	Domestic Abuse
EI	Early Intervention
GP	General Practitioner
HV	Health Visitor
LA	Local Authority
MASH	Multi Agency Safeguarding Hub
MH	Mental Health
NFA	No Further Action
PSCB	Portsmouth Safeguarding Children Board
SAB	Safeguarding Adults Board
SCR	Serious Case Review
SW	Social Worker
WT	Working Together to Safeguard Children

Appendix 3

Family Genogram

Child E - Genogram