Hampshire Safeguarding Children Board

Child L

Serious Case Review

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About the author

I have been a social worker for 20 years, having gained the relevant Diploma in Social Work from the University of North London in 1995, and have worked in social care for 23 years. Most of my work has been in child protection. Since 2008 I have worked as an independent child protection consultant and trainer and have to date led/authored ten serious case reviews. I am an accredited lead reviewer in the Social Care Institute for Excellence (SCIE) “Learning Together” systems approach to case reviews As well as undertaking consultancy work I also develop and deliver child protection training and am a published author.

1. Introduction

1.1 Circumstances leading to this serious case review

1.2 The Family

Mother – Ms M

Step-father – Mr F

Maternal Grandmother – Ms G

Paternal Step-grandmother – Ms P

1.3 All family members are White/British. There is no mention of any of the family members being affiliated to a particular religion.

1.4 Child L was an eight-month-old child who was living with his mother, Ms M, who was 28 weeks pregnant, and stepfather, Mr F, in a one-bedroom flat at the time of his death.

1.5 In January, 2014 Mr F telephoned the emergency services, having found Child L unresponsive and face down in his cot. Child L was taken to the local hospital where he was pronounced dead. Upon examination Child L was seen to have numerous bruises on his face. Facial bruising is unusual at this age and developmental stage. At post mortem Child L was noted to have a fractured epiphysis (ankle). Ms M and Mr F provided explanations as to the causes of a number of the injuries sustained by Child L. Medical evidence could not establish with certainty that the injuries were non-accidental. None of the injuries were deemed to have caused or contributed to the death of Child L. The cause of death was given as unascertained.

1.6 Initially this case was referred to Hampshire Safeguarding Children Board (HSCB) serious case review committee in February, 2014. At this time they felt unable to make a decision as to whether the case met the criteria for a serious case review (SCR) because the medical evidence at that point was inconclusive. Following the phase three rapid response meeting the case was re-referred

and on 22 September 2014 the SCRC made a recommendation to the HSCB independent chair that a SCR should be commissioned.

1.7 HSCB Independent Chair made the decision the circumstances of the child's death fully met the criteria for a serious case review, as set out in Chapter 4 of Working Together to Safeguard Children, 2015 on 26th September, 2014.

1.8 As was the case with other recent SCRs in Hampshire, Child V serious case review[1] and Child X serious case review[2], unlike many SCRs, there were no evidence that Child L would be at risk of maltreatment however there were some risk indicators during Child L's lifetime that should have been explored further at the time.

2. Criminal investigations and coroner's inquiries

2.1 Ms M and Mr F were arrested on suspicion of Child L's murder. Both suspects were released on unconditional bail whilst a thorough police investigation was undertaken by the Hampshire Constabulary Major Crime Team. A full file of evidence was submitted to the Crown Prosecution Service (CPS). The CPS reviewed the file of evidence and deemed there was insufficient evidence to charge either suspect with any criminal offence(s).

2.2 The inquest into the death of Child L has taken place. An open conclusion was given by the coroner. The injuries sustained to Child L were excluded as being contributory factors in the death.

3. Methodology

3.1 As set out in Working Together, 2015 LSCBs may use any learning model which is consistent with the principles in the guidance. It is a requirement of Working Together, 2015 that professionals must be involved fully in reviews

[1] http://www.hampshiresafeguardingchildrenboard.org.uk/user_controlled_lcms_area/uploaded_files/HantsVSCRfinal%20h1b.pdf

[2] http://www.hampshiresafeguardingchildrenboard.org.uk/user_controlled_lcms_area/uploaded_files/Child%20X%20SCR%20report.pdf

and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and that families, including surviving children, should be invited to contribute to reviews.

3.2 It is also a requirement that SCRs and other case reviews 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

3.3 Prior to the appointment of the independent author HSCB requested agency reports from Hampshire Constabulary, the GP surgery and the District Council and Portsmouth Hospitals NHS Trust. Southern Health Foundation Trust provided a narrative summary of their involvement.

3.4 Following the appointment of Joanna Nicolas as the independent reviewer it was agreed that the review would take a broadly systems approach and the model devised by Joanna and the review panel reflected the nature of this case. Whilst no one child death is more or less tragic than another, circumstances and agency involvement do differ. In this case there was relatively few agencies involved and there were no major concerns, at the start of the process and as we progressed, about how the agencies had worked together. The model employed was considered by all to be proportionate to the circumstances.

3.5 Process

3.6 A review panel was agreed, which consisted of a senior manager from each of the organisations involved, none of whom had had line management of the

case, as well as a senior manager from children's services and the police, both of those being statutory Board partners of the LSCB.

3.7 he key frontline professionals were then identified.

3.8 There was an initial meeting with the review panel, followed by an introductory meeting with the frontline professionals. There were then a number of conversations with the key frontline professionals.

3.9 The review panel then had an analysis meeting. The first draft of the report was written and shared with the review panel and the frontline professionals at a workshop. Amendments were made to the report and changes agreed at a final meeting with the review panel. The report was therefore undertaken collaboratively with the independent reviewer, the review panel and the frontline professionals.

3.10 Limitations of the review

3.11 The mother, step-father and paternal step-grandmother were invited to contribute to the serious case review. None responded to the invitation.

3.12 The B&B landlord was invited to contribute to the review but chose not to.

3.13 The opportunities to generate data with the frontline professionals and the review panel are more limited than in a more extensive, complex review, where there are multiple agencies involved over a long period of time and it is known a child has died as a result of maltreatment. This is relevant when considering the extent to which practice issues identified in the case are generalisable issues. We endeavour to reflect this in the way the findings are written up.

4. Contributors to the review

4.1 The SCR Review Panel is made up of the following members:-

Designated Nurse Safeguarding Children	Fareham and Gosport Clinical Commissioning Group representing the five Clinical Commissioning Groups
HSCB member	District Council representative
Service head (Housing)	East Hampshire and Havant
Detective Chief Inspector	Hampshire Constabulary Crime Standards Department
District manager	Hampshire Children's Services
Designated doctor safeguarding children	Fareham and Gosport Clinical Commissioning Group representing the five Clinical Commissioning Groups
Local Authority Designated Officer	Hampshire County Council
Administrator	Hampshire Safeguarding Children Board

4.2 The frontline professionals consisted of:-

Community Midwifery team leader	Portsmouth Hospital Trust
Teenage Pregnancy Midwife	Portsmouth Hospital Trust
Midwifery support worker	Portsmouth Hospital Trust
Post natal coordinating midwife	Portsmouth Hospital Trust
Health Visitor 1	Southern Health NHS Foundation Trust

Health Visitor 2	Southern Health NHS Foundation Trust
GP1	GP Surgery
GP2	GP Surgery
Accommodation Officer 1	Housing options Borough Council Housing Department.
Obstetric Consultant 1	Portsmouth Hospital Trust
Obstetric Consultant 1	Portsmouth Hospital Trust

4.3 Conversations have also taken place with the Named Nurse Safeguarding Children. Southern Health NHS Foundation Trust for advice on health visiting services.

5. The scope of this Serious Case Review

5.1 Systems reviews consider how safeguarding systems within a local authority area operate and the purpose of the review is to test out how safe and effective they are. Therefore when considering where to start the review we do not go back many years because systems will have changed. This does not mean that family history is overlooked but what is relevant is whether the professionals working with the family during the period under review knows about the family history.

5.2 In this case it was agreed that we would start the review from 17.10.12, which was the date Ms M had her first booking appointment with the midwife for antenatal care.

5.3 Documents read by the overview author include:-

Southern Health Foundation Trust Serious Case Review Referral (SCRC) Response Form

Southern Health Foundation Trust narrative summary

GP SCRC Referral Response Form

Hampshire Constabulary SCRC Referral Response Form

Hampshire Constabulary SCR Agency Report

Fareham Borough Council Housing Needs Assessment Form

Fareham Borough Council Housing Waiting List Application Form

District Council Agency Report

Portsmouth Hospitals NHS Trust Maternity Outpatients booking Referral Form

Portsmouth Hospitals NHS Trust SCR Agency Report

HSCB Child I Serious Case Review

HSCB Child V Serious Case Review

HSCB Child X Serious Case Review

6. Summary of significant events

17.10.12	Ms M booking appointment for antenatal care. Ms M declined the care of the teenage pregnancy midwife
19.12.12	Family history of blood clotting and heart disorder noted. Ms M referred for Consultant clinic review
24.12.12	Ms M prescribed Fluoxetine for “low mood”
3.4.13	Ms M attended antenatal review, advised midwife she had recently split from partner but had supportive family
End of April 2013	Child L born in hospital and discharged home later that day with routine advice / follow-up plans
10.5.13	Planned antenatal contact at maternal grandmother’s home by HV1. On arrival HV1 discovered Child L had been born the previous day. Child L and mother of Child L seen.

23.5.13	During home visit by HV1 Child L's mother's partner present but no name recorded. Child L's father reported to have no contact. Maternal history of depression noted.
27.6.13	HV1 planned visit to maternal grandmother's home to complete mood assessment for mother of Child L and review Child L. Child L's maternal grandmother seen by HV1 and reports Child L, Child L's mother and her partner have gone to live with paternal step grandfather. Maternal grandmother reports concern about this as worried about Child L's mother's low mood and her partner's 'controlling behaviour' HV1 then visits Child L's mother who reports she has been living with her partner and his family for 4 weeks. Reports low mood, Mother of Child L reports no concerns in relationship with partner and that he is supportive and helps with care of Child L. Edinburgh Post Natal Depression Scale completed and Ms M scored 25 out of 30. HV1 escalated to Universal Plus Offer (See **Finding Three** for description).
27.6.13	Telephone call from HV1 to mother of Child L about GP appointment, no reply
27.6.13	Telephone call from HV1 to GP Surgery 1 to inform of concerns about mother of Child L's mental health and requesting duty GP contact her. Informed of HV1's difficulty in contacting Child L's mother by telephone.
27.6.13	Text message sent to Child L's mother by HV1 as unable to leave a voice message, requesting mother contacts either HV1 or GP
27.6.13	Telephone call from HV1 to mother of Child L about GP appointment, no reply.
30.6.13	HV1 planned contact to check 'emotional and physical wellbeing' – no answer
1.7.13	HV1 planned contact to check 'emotional and physical wellbeing' – no answer

2.7.13	HV1 telephones GP Surgery 1 requesting surgery inform HV1 when contact has been made with Child L's mother. HV1 informed GP Surgery 1 she was due to see Child L on 4.7.13.
2.7.13	Telephone call from HV1 to Child L's mother who reports she is still feeling low in mood and wants to access her GP surgery. HV1 advised Child L's mother to make direct contact with GP Surgery 1.
4.7.13	Telephone call from Child L's mother to HV team cancelling visit due to a family emergency
16.7.13	Ms M seen at GP Surgery 1 for six-week check, Mr F present. Ms M considered to be suffering from post-natal depression and re-prescribed Fluoexitine. Ms M had concerns about bonding with Child L.
19.7.13	HV1 informed Child L now registered at GP Surgery 2.
22.7.13	HV1 transferred the case to HV2. Shared concerns about Child L's mother's mental health and need for support visit discussed as part of transfer of care.
25.7.13	HV2 attempted to contact Ms M to arrange transfer in visit and to review Child L' mother's mood. Unable to contact on mobile telephone so message left on answerphone on landline.
6.8.13	Home visit by HV2. Mr F not present. Ms M reports improvement in her mood since commencing medication. Edinburgh Post Natal Depression Scale completed. Ms M scored 12. Ms M reported good support from her partner and his family but no contact with her own mother at this time. Ms M reports she finds this difficult at times.
15.8.13	HV2 attended planned home visit for Listening Visit. No reply. HV2 left note for Ms M make contact to re arrange visit
16.8.13	HV2 left telephone message for Ms M with the team's contact details, prior to annual leave
5.9.13	HV2 received telephone call from Ms M to arrange listening visit for

	23/9/14. Ms M informed HV2 she was pregnant.
18.9.13	'Booking' review for antenatal care in second pregnancy. Consultant Obstetrician referral for risks as per previous pregnancy
23.9.13	HV2 undertook home visit to Ms M. Ms M ten weeks pregnant, pregnancy unplanned. Ms M reported to be pleased about pregnancy and waiting housing by council. Ms M has stopped anti-depressant medication since pregnancy confirmed. Reports low mood and reduced confidence since medication stopped. Planning to see GP. Warm interaction noted between all adults present to Child L and good eye contact and handling of Child L by mother.
8.10.13	Planned home visit by HV2. Child L seen with Ms M and Mr F. Ms M continues to report low mood, reports had attended GP surgery but told she had no appointment. Ms M and Mr F reported to be moving to bed and breakfast accommodation with Child L on 17.10.13. Initially communication observed between Ms M and Mr F was 'warm and supportive' but during visit minor disagreement observed. Ms M reporting Mr F making accusations about whether he is the father of the unborn baby. When Mr F left the room Ms M reported this was not a regular occurrence but disagreements had increased since couple found out about current pregnancy. HV2 escalated to Orange Alert (See **Finding Three** for description).
21.10.13	Ms M informed HV2 the family had moved to Bed and Breakfast accommodation. They moved on 17.10.13
8.11.13	Planned HV2 visit at Ms P, paternal step-grandmother's home. Ms M, Mr F and Child L not there. HV2 is told by Ms M on the telephone that she has to obtain permission from the landlord of the Bed and Breakfast accommodation for HV2 to visit. During the telephone call Ms M reports to HV2 that she has booked with midwife but has not accessed her GP re anti-depressant medication but she reports as feeling well since moving into the Bed and Breakfast.

11.11.13	Telephone contact from HV2 to Ms M. Discussion about housing situation. Living in bed and breakfast accommodation which Ms M reported as being stressful. Ms M reports she has not yet asked landlord for permission for HV2 to visit at current accommodation.
24.12.13	Planned antenatal review with teenage pregnancy midwife.
31.12.13	HV2 attempted to contact Ms M on mobile phone, no facility to leave a message.
2.1.14	HV2 attempted to contact Ms M on mobile phone, no facility to leave a message. Ms M then telephoned HV2 and informed her family had moved to temporary accommodation on 18.11.13. Ms M reported she will change her GP Surgery because they have moved, she is seeing her midwife regularly and she is well. HV2 makes plan to transfer case to the health visiting team attached to the new surgery.
January, 2014	Child L died.

7. Appraisal of professional practice

7.1 It is particularly important when appraising professional practice to avoid hindsight bias. When we look backwards the world appears linear, which it is not. When reading a chronology, with the benefit of knowing the outcome, events and conversations take on a significance, which it would not be realistic to expect frontline professionals to have seen at the time. This appraisal of practice is written with that in mind.

7.2 Within the findings there is assessment of practice. This section covers assessment of practice that has not contributed to a finding. It is important to learn from good practice, as well as concerning practice and therefore both are highlighted in this review.

7.3 It is an example of good practice that there is a regular meeting within one of the GP surgeries involved in this case to consider families given cause for concern. This meeting is attended

by the community matron, the district nursing team, school nursing team, health visiting team and the GP practice manager. The GP practice is not clear why the community midwifery service is not invited to these meetings but recognises the value of their attendance. These meetings are thought to take place in most but not all GP practices across the five Clinical Commissioning Groups in Hampshire. In some areas health visitors and midwives meet regularly, which again is good practice but again this is not across all of Hampshire.

7.4 It is commendable that there are examples of professionals going beyond their job remit in this case. HV1 went to see Ms M, even though she had moved out of her area, because she was concerned about her low mood and what the mother was saying. The teenage pregnancy midwife, who was only in that role for one day a week, carried on communicating with the teenagers, even when in her other roles because of continuity for the teenager. Although these examples are commendable systems are unreliable if they rely on individual, exceptional workers.

7.5 It is good practice that if the mother is a teenager the midwifery service will always visit on day three, following the birth, with experienced mothers they will receive a telephone call and be offered a visit, unless there are obvious concerns.

7.6 The midwifery professionals in this case clearly demonstrated how persistent they are when working with new babies. They gave examples of how flexible they can be in where they see the baby, how they keep going back if the family is not there for a planned visit and how they keep telephoning, until they get to see the mother and baby. All these are examples of good practice.

7.7 Many of the health professionals tried extremely hard to make contact with and to see Ms M but this was made difficult at times by Ms M missing appointments, not returning telephone calls and not having a mobile. Ms M and Mr F also told the professionals different things about their mobile situation. The teenage pregnancy midwife was told that Ms M's was broken

and she had to contact Ms M through Mr F's mobile. There were also problems with mobiles on which one could not leave messages. In addition to this the family moved four times during the year under review and on no occasion told the health professionals they were moving, or gave them an address and this made it much harder for health professionals to keep track of them. Their change of location also meant the health professionals kept changing because there were three different GP Surgeries and therefore different health visitors and community midwives.

7.8 Ms M was asked about domestic abuse but that was in front of Ms P, which should not have happened. Ms M's family was well known to the midwifery service because Ms M was one of many sisters. Ms M was known to be close to her family and consideration should have been given as to why she moved out of the home and went to stay with Mr F's family, particularly as Ms M's mother expressed concerns about this, as well as Mr F's controlling behaviour and Ms M's low mood. Also, Ms M had told the teenage pregnancy midwife that they had moved out because Mr F had had an argument with her mother and it had become too tense. In addition to this Ms M told HV2 she had no contact with her mother and she found that difficult. This was during the time she was living with Ms P and should have been explored. Some of the health professionals also knew that Ms M had been in an abusive relationship previously and this too should have raised their concerns. The situation with the mobiles should have been explored too. Some perpetrators of domestic abuse control their partners through isolation and their use of mobiles. In September, 2015 the Government introduced a new domestic abuse offence for coercive and controlling behaviour because it is recognised as a form of abuse in itself. Although there is no evidence there was domestic abuse in the relationship between Mr F and Ms M, these issues should have been explored.

7.9 All health professionals work to the National Institute for Clinical Excellence guidelines and in addition health visitors work to the Healthy Child Programme[3]. The guidelines do not set out that health visitors have to see where the baby/child is sleeping but they do have to talk about safe-sleeping, as do midwives. When HV2 was told by Ms P that Mr F, Ms M and Child L were

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

effectively living within one room, Mr F's bedroom, the review panel would have expected her to have asked to see the bedroom because that was the child's living environment.

7.10 The review panel would have expected each of the housing professionals involved to have considered the fact that this couple were living with one child and then became pregnant with another during the time they were homeless. As explored in **Finding One** homelessness adds significantly to risk factors for vulnerable families and safeguarding should have been considered.

8. Themes and analysis

8.1 Following the reading and critical analysis of the reports submitted and the conversations with the frontline professionals the following themes have been identified and agreed by the SCR review panel. These themes have been discussed in great detail and practice has been analysed, in order to maximise our understanding of how agencies work individually and together in Hampshire and to consider how we can best improve our practice.

Finding One In Hampshire there are indicators that there may be limited consideration and understanding by some professionals cross-agency of the potential risk factors when a family becomes homeless. This limited consideration and understanding increases the chance that children in these circumstances will be left vulnerable.
Finding Two The importance of the role that housing plays in safeguarding children may be underestimated by some professionals cross agency in Hampshire.
Finding Three The current alert system used within the health visiting service in Hampshire is complex and confusing and may lead to children about whom there are safeguarding concerns being overlooked.

Finding Four

Unless a child has complex health needs there is no formal system in place across health services nationally, or in Hampshire, to co-ordinate the work of the different health service providers. This fragmented way of working will result in an unsafe system where levels of risk to vulnerable children are missed.

8.2 Finding One

8.3 In Hampshire there are indicators that there may be limited consideration and understanding by some professionals cross-agency of the potential risk factors when a family becomes homeless. This limited consideration and understanding increases the chance that children in these circumstances will be left vulnerable.

8.4 There is a considerable amount of research in the field of homelessness and the evidence clearly shows us that "Temporary accommodation is typically not secure, suitable or affordable for homeless people. Most is provided at high rents, creating poverty traps for people and relying on housing benefit to meet the cost. For families, living in temporary accommodation means constant insecurity and disruption through placements outside their local area and enforced moves for administrative reasons, such as leases with private landlords expiring. Homeless children living in temporary accommodation are some of the most deprived children in this country, missing out on schooling, on play, and opportunities to develop and grow in a healthy living environment."[4]

8.5 Research on the impact on children of homelessness paints an overwhelmingly bleak picture of their current and future status. There is strong evidence that the experience of homelessness inhibits the physical, emotional, cognitive, social, and behavioural development of children. Homelessness is

[4] http://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/living_in_limbo_-_survey_of_homeless_households_living_in_temporary_accommodation

also a significant stress factor for parents and the greater the stress the parent is subjected to, the greater the risk to the child.

8.6 There can be correlation between child maltreatment and inadequate housing and homelessness. Incidents of abuse and neglect are more common in low-income families. Child maltreatment can be linked to stress, and poor families facing housing problems tend to be under more stress than the average family[5].

8.7 The NSPCC has recently produced a report "Housing services: learning from case reviews Summary of risk factors and learning for improved practice around the housing sector[6]". Amongst its learning the report states "Many housing issues are warning signs of child protection concerns".

8.8 The Housing (Homeless Persons) Act 1977 placed a duty on local housing authorities to secure temporary accommodation for unintentionally homeless people in priority need. Authorities' duties towards homeless people are now contained in Part 7 of the 1996 Housing Act (as amended). People with dependent children are considered to be "in priority need". Although the law is clear that you do not have to be without a home to be considered homeless each situation is assessed on a case by case basis.

8.9 The challenge for professionals in Hampshire, and nationally, is that a large percentage of families who become homeless will have dependent children and/or be pregnant and it would not be realistic to refer every single family to children's social care, nor would children's social care accept each and every case. As an example, in the year 2014-2015, across the county, Hampshire has had between 667 -719 children living in statutory homeless households. It would clearly be neither feasible, nor necessary, to refer each of these to children's social care.

8.10 In Hampshire when a family is due to be evicted the housing department and/or housing association does send a notification to children's social care. This notification will be considered and further investigation may occur.

8.11 What happened in this case?

[5] http://www.socialworkers.org/practice/children/2009/sept2009.pdf
[6] http://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/housing/#

8.12 When Ms M became pregnant she was living with her mother and sisters. During the pregnancy her relationship with the person Ms M said was the baby's father, although he denied this, ended and Ms M started a relationship with Mr F. It is not known whether he moved in to live with Ms M and her family. Within two months Ms M and Mr F had moved to live with his mother. They remained there for five months and then moved into B&B accommodation. They were there for 32 nights. They then moved to temporary accommodation.

8.13 As is explored in **Finding Two** the housing department did not consider Child L in terms of safeguarding because in their meetings with the family Child L seemed contented and there was nothing about the behaviour of Ms M or Mr F that led to concerns.

8.14 There was limited recognition, either in their involvement with the family or in the serious case review conversations with the frontline professionals of the impact the homelessness might be having on the family. The teenage pregnancy midwife did say that she asked Ms M if she was under pressure to move but Ms M allegedly said she was not and she knew it was the only way they could get on the housing list and have a home of their own.

8.15 How do we know what happened is an underlying issue and not unique to this case

8.16 We do not have the evidence to extrapolate that this lack of understanding about the risk factors associated with homelessness is true of all professionals in all agencies working across Hampshire however it is extremely unlikely that it is unique to the professionals involved in this case.

Finding One

In Hampshire there are indicators that there may be limited consideration and understanding by some professionals cross-agency of the potential risk factors when a family becomes homeless. This limited consideration and understanding increases the chance that children in these circumstances will be left vulnerable.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system? If professionals have a limited understanding of the impact of homelessness and give limited consideration to it as an issue they will not recognise it a possible risk factor. If professionals are not taking into consideration all potential risk factors when assessing families assessments will be inaccurate and children will be potentially left at risk.
Questions for the Board 1. How will the Board assess whether professionals working across agencies have a sufficient evidence-based understanding of the risk factors associated with homelessness? 2. Is the Board confident professionals are clear at what point a family is considered to be homeless and therefore consider that as a potential risk indicator? 3. Is the Board satisfied that the current threshold chart reflects the potential risk factors that may be associated with homelessness?

8.17 Finding Two

8.18 The importance of the role that housing plays in safeguarding children may be underestimated by some professionals cross agency in Hampshire

8.19 As highlighted in **Finding One** it is recognised that temporary accommodation in B&Bs is inadequate and has unacceptable long-term effects on homeless people. The law says B&B accommodation is not suitable for families with dependent children, including pregnant women. Councils can place families or pregnant women in B&B accommodation if there is no alternative provision available but only for a maximum of six weeks.[7] Some of our most vulnerable families are placed in B&B accommodation.

[7] http://www.legislation.gov.uk/uksi/2003/3326/pdfs/uksi_20033326_en.pdf

8.20 What happened in this case?

8.21 The family was placed in B&B accommodation by the council when Ms M was five weeks pregnant and she had a four month old baby. They remained in B&B accommodation for 32 nights, which is within Government guidance.

8.22 The temporary accommodation co-ordinator in this case has worked for the council for two years but has never received any safeguarding training, although he has had sight of the safeguarding policy. His role is not considered to be "frontline" even though he regularly meets with service-users and also does home visits. On one occasion, while the family was in B&B accommodation, he met with the family who told him they did not have a buggy for Child L, who was under six months old. The review panel would expect anyone working with families to consider safeguarding concerns and in this case the family were homeless, living in temporary accommodation, which automatically increases vulnerability and therefore risk.

8.23 Within the B&B the rule was that guests had to leave for an hour a day, to give the landlord the opportunity to clean the premises. Ms M was pregnant, they had a baby under six months old, it was winter and they had no buggy, very little money and no family living close by. Mr F told the temporary accommodation co-ordinator how hard it was. Those factors should have raised safeguarding concerns.

8.24 How do we know what happened is an underlying issue in Hampshire and not unique to this case?

8.25 Across Hampshire there are 11 district and borough councils, all with their own housing departments and there are 41 housing associations used by the district and borough councils. Each of the housing providers is autonomous. There are only a small number of B&Bs in Hampshire that take families who have to be found temporary accommodation by their local housing team. B&Bs are privately run businesses; they are not a service commissioned by the council. Therefore the council cannot impose conditions on them. There is no requirement for them to have a safeguarding policy, or have any knowledge around risk and vulnerability of their guests. The only requirement of the B&B is that Environmental Health inspects them.

8.26 The relationship between the B&Bs and the council's housing departments is a delicate one because the council needs the accommodation they offer but many B&Bs do not want to take housing referrals from local authorities. As the situation stands currently the council is not in a position to impose conditions but the council has made attempts to work with the B&B landlords. A recent example of this was that children's social care wrote to every single B&B and hotel in Hampshire to invite them to attend training around child sexual exploitation. Over 300 were contacted and not one replied.

8.27 In one district council in Hampshire in the year 2014-2015 there were 16 households who spent any time living in B&B accommodation. Of those, five were expectant couples and 11 of the couples had children. 14 of those households spend an average of two – five weeks in the B&B and two spent considerably longer because they had been evicted for rent arrears and no landlord would take them.

8.28 None of those involved in this serious case review could think of an example when a B&B landlord had telephoned them with concerns about a child. Their experiences are that landlords do telephone housing departments frequently but that is to ask the housing department to move the family out of their property because they are disruptive.

8.29 It is up to each district council to decide whether their staff requires safeguarding training and at what level. Basic safeguarding awareness, sometimes done online, is mandatory for all staff in most of the district councils. More in-depth courses are offered to those considered to have regular contact with service users. In the district council concerned safeguarding training is only offered to those considered to be frontline staff within the housing department, although others not considered to be "frontline" do have regular contact with service-users.

Finding Two

The importance of the role that housing plays in safeguarding children may be underestimated by some professionals cross agency in Hampshire

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Housing departments often work with our most vulnerable families and B&Bs offer temporary accommodation to some of those families. It is essential that all those who have contact with vulnerable families and their children recognise vulnerability and potential risk factors. If this is not happening then it cannot be said that HSCB has in place effective multi-agency systems for safeguarding vulnerable children.

Questions for the Board

1. How will the Board assure itself that those working in housing with vulnerable families have a sufficient level of understanding of vulnerability and risk factors?

2. Whilst recognising that placing vulnerable families in B&B accommodation for up to six weeks is accepted practice nationally, how will the Board assure itself that Housing Services in Hampshire are fulfilling their statutory obligations in terms of safeguarding children when they are placing vulnerable families in privately run B&B accommodation with landlords who may have no knowledge of safeguarding, or risk factors?

8.30 Finding Three

8.31 The current alert system used within the health visiting service in Hampshire is complex and confusing and may lead to children about whom there are safeguarding concerns being overlooked.

8.32 The health visiting service in Hampshire provides the Healthy Child Programme (HCP), Department of Health (2009)[8]. This is a progressive universal, clinical and public health programme for children and families from pre-birth to five years.

8.33 The key aims of the service are:

- That the health visiting service is timely, relevant, accessible and culturally sensitive to all families.

- To reduce health inequalities and improve outcomes in maternal, infant and child health through on-going assessments.

- To promote strong parent- child attachment and positive parenting resulting in improved social and emotional wellbeing.

- To work collaboratively with families and relevant agencies to deliver child centred, evidenced based practice which focus on the promotion of health and well-being, child development and readiness for school.

- To identify families with additional needs and offer an enhanced service so that children are not compromised by poor early experiences.

- To promote healthy lifestyles and support local communities; therefore improving future economic wellbeing.

8.34 The Healthy Child programme is prescribed by the Department of Health and the Department of Health identifies what the universal, universal plus and Partnership plus offer includes. Southern Health Foundation Trust have decided how to identify these cases on their system using a long established colour system that was in place whilst they were still using a paper system. It is not and never has been a triage process.

8.35 Universal offer (No Alert)

8.36 The Universal service will be offered to all families including fathers, partners and carers of children and including carers of looked after children. The Healthy Child Programme is a comprehensive prevention and early

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

intervention public health programme providing an invaluable opportunity to identify families who may be in need of additional support and children who are at risk of poor outcomes. The Universal offer includes:

- *Antenatal visit*

Health Visitors work in partnership with midwives, and aim to visit after the 28th week of pregnancy.

- *New Birth Review*

Around 14 days after birth, the health visitor arranges a face-to-face visit in the home.

- *Maternal mental health*

Home visit at 6-8 weeks to complete maternal mood assessment and provide support

- *Child Health Clinic*

8.37 Within each locality there are child health clinics that families can attend and be able to see a member of the health visiting team. Within the team there are health visitors, community staff nurses and community nursery nurses.

- *One year health review*

- *Two year health review*

<u>8.38 Universal Plus Offer (No Alert but do have care plans)</u>

8.39 Until 2014, there was a yellow Alert to identify this group. This has been replaced with care plans.

8.40 The health visiting team will identify children and families requiring additional support and will deliver short interventions in partnership with the early years workforce. The aim is to ensure that the service takes positive, timely, action and focuses services so that the outcomes of all children including the disadvantaged or at risk children and families are not compromised by poor early experiences and environment. This should reduce problems and service costs in the long and short term.

8.41 Health visitors will combine research-based evidence with professional expertise to ensure families receive the services and early intervention they really need that will make a difference to their lives. Services from the health visiting team may include sleep and behaviour management, promotion of breastfeeding, weaning and healthy eating, speech and language development, support for mothers with postnatal depression.

8.42 The care plan as a minimum is reviewed three monthly. This does not mean that the family or child is seen every three months. The care plan dictates how often the families are seen and what other interventions are offered.

<u>8.43 Universal Partnership Plus Offer (Orange Alert)</u>

8.44 Health visitors and the early year's workforce will identify children and families who require additional services or support from a number of agencies to overcome entrenched problems known to contribute to poor health, social and educational outcomes. Systems are in place to identify and record families receiving

Universal Partnership Plus (orange alert). Health visitors ensure that there are links with specialist services and the common assessment framework process (now Early Help) for families where there are the most complex health or social care needs For example disabled children, children with major health difficulties, or children likely to be "in need" under s.17, Children Act, 1989.

8.45 Health visitors will ensure children with long term conditions and life-limiting illness have access to specialist care and pathways.

8.46 Care plans can be used or there may be a multi-agency plan (Examples, team around the child, CAF and now the "Early Help Hub")

<u>8.47 Red Alerts</u>

8.48 Identify children and their parents who are subject to child protection plans. The alert is put on by the health visitor immediately following the child protection conference and is removed when the child comes off a plan.

8.49 Green Alerts

8.50 Children in Care. All children who are in care will have a green alert on their file.

8.51 When an Orange or Red Alert is used information is recorded on the RIO Electronic Patient Record System by the health visitors.

8.52 The data system in use pulls out monthly reports for the manager and team. The manager or health visitor can also pull out a report any time.

8.53 What happened in this case?

8.54 When Ms M completed the Post Natal Depression Scale[9] with the health visitor, which is a tool used by health professionals, the first time she scored 25 out of 30. HV1, with whom Ms M completed the tool had been a health visitor for 18 months. She says she has not received training in the use of the tool. HV1 had never seen such a high score, the highest she had ever seen previously was 18. A score above 13 is considered to be an indicator of the mother being at risk of post-natal depression. This high score resulted in HV1 changing Child L from Universal to Universal Plus Offer. This should have resulted in a series of four Listening Visits by the health visitor. A further assessment of her emotional health should have been carried out at the end of this intervention and further care needs met as per the Perinatal Mental Health Referral Pathway (See Appendix Two.) No Listening Visits took place prior to Ms M moving out of HV1's area and a health visitor did not see Ms M again until 6.8.13. This was partly due to Ms M cancelling one appointment and being very hard to get hold of by telephone.

8.55 When HV2 became the allocated health visitor she knew that the case was Universal Plus Offer and arranged a Listening Visit, which Ms M did not keep. Subsequently HV2 arranged another Listening Visit for 23.9.13. Following the suggestion of possible domestic abuse during a subsequent visit on 8.10.13 HV2 escalated the case to Universal Partnership Plus Offer (Orange Alert). This should have triggered a response but it did not and there was no formal review of the care plan, or Ms M's mental health.

[9] http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

8.56 The health visitors in this case believe the colour system is being phased out however this is not the case.

8.57 How do we know what happened is an underlying issue and not unique to this case

8.58 It is unlikely that it is only the health visitors involved in this case who are unclear as to whether the colour system is being phased out, or not.

8.59 There are 284,000 children in Hampshire and of those 78,252 0-5 year olds. There are currently 3,280 "Red and Orange Alert" cases in Hampshire.

Finding Three

The current alert system used within the health visiting service in Hampshire is complex and confusing and may lead to children about whom there are safeguarding concerns being overlooked.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

It is not uncommon for agencies to "RAG rate" i.e. red, amber and green cases, in order of priority and urgency. The alert system used within the health visiting service in Hampshire is **not** a "RAG" rating system but there may be confusion because they use the colours red and green in their system and green within a "RAG" rating system means low concerns but in the health visiting service green refers to a child in care.

The system that Southern Health NHS Foundation Trust uses is also confusing because there are three levels of need. The first two, Universal and Universal Plus do not have colours attached to them. The third, Universal Partnership Plus can have an Orange, Red or Green Alert attached to the file. To most people green would mean low concerns but this refers to children in care.

The health visitor team manager carries out clinical supervision with each health visitor and will have oversight of each case. Health visitors also have safeguarding supervision but it is at their discretion which cases they take to

safeguarding supervision. There are too many “Orange Alert” cases for the safeguarding lead to have oversight of every case. In addition to this, if the alert system is not actually triggering the response set out then children identified as potentially vulnerable will remain so and the system is ineffectual.
Questions for the Board 1. How will the Board ascertain to what degree the system is not triggering the responses set out in the Guidance? 2. Would the Board consider it helpful for Southern Health NHS Foundation Trust to review their system?

8.60 Finding Four

8.61 Unless a child has complex health needs there is no formal system in place across health services nationally, or in Hampshire, to co-ordinate the work of the different health service providers. This fragmented way of working will result in an unsafe system where levels of risk to vulnerable children are missed.

8.62 The way the NHS is organised is that everyone should register with a GP/practice who are then the hub for all health information for that individual. So when a number of different specialist health services are involved they are expected to keep the GP informed, this is done by copying the GP into letters and appointments. It is not the role of the GP to be the lead professional, or to coordinate the work of the health visitor, school nurse, or midwife. Each organisation within the NHS, such as Primary Care, Acute Trusts and the Community Trusts, have a different IT Network that may not be accessible to practitioners outside of their organisations.

8.63 What happened in this case?

8.64 It is not the view of any of the review panel that this case met the threshold for a referral to children’s social care however if health professionals

had worked together more closely and had followed up on concerns expressed and issues raised, they may have developed a greater understanding as to the nature of the relationship between Mr F and Ms M and a truer picture of what Child L's life was like. All this information has been put together after Child L's life, as part of the serious case review. The sum of the information given to different health professionals was that Ms M was on anti-depressants from November, 2012 due to her low mood, which she then stopped taking. She split up with the father of Child L during her pregnancy and almost immediately started a relationship with Mr F. The maternal grandmother was worried about Ms M's low mood and Mr F's controlling behaviour in June, 2013, and the fact that Ms M had moved to live with Ms P. Ms M scored exceptionally highly in the Post Natal Depression Scale, the family was homeless, Mr F had expressed a view that he could not be the father of Ms M's second child, Ms P told HV2 that disagreements between Ms M and Mr F had increased since the pregnancy and Ms M described it as being "stressful" living in B&B accommodation.

8.65 In this case there was the GP Surgery, the health visiting service, the maternity service and gynaecology and haematology services in the hospital. That is only four different health services but children with complex health needs may have up to 15 different health professionals involved in their care.

8.66 Ms M completed the Edinburgh Post Natal Depression Scale with HV1 and because the score was so high HV1 contacted the GP Surgery, which was good practice. The EPDS is a screening tool not a diagnostic tool and indicates that a mother may be developing Depression or low mood. A high score indicates that the Health Visitor needs to take further action. The tool is not designed to identify the severity of depression and does not replace professional judgement. HV1's expectation was the duty GP would contact the family but the Surgery was unable to make contact with Ms M. GPs do not have access to health visitor records and the GP who saw Ms M for her six week check, following the birth of Child L had not seen the completed Scale. The GP therefore did not know the high score, or that when the Scale was done again six weeks later, Ms M's score was within the normal range.

8.67 Neither the GP nor the maternity services and gynaecology were able to see the health visiting records because of the different computer systems and

therefore none were aware that there was an "Orange Alert" on the file, nor what it signified.

8.68 How do we know what happened is an underlying issue and not unique to this case

8.69 This is not an issue that is unique to Hampshire. It is a common finding of serious case reviews nationally that this is a frequent concern. There is little coordination of health services, unless a child has complex health needs. It was a recommendation from HSCB's Child I SCR that "The CCG should review and confirm the frequency and effectiveness of health visitor / GP liaison opportunities amongst local Practices". This case has highlighted good practice in this regard but it is clear this is not happening routinely.

8.70 The GPs involved in this serious case review both said they have little contact with midwives. Midwives do not attend the regular meetings held to discuss vulnerable families within their practice.

8.71 The GPs have also stated that if midwives refer to children's social care they may not hear about it.

8.72 Although in some areas there are regular meetings held between health visitors and community midwives, this is not true of all areas in Hampshire.

8.73 There are 150 GP practices in Hampshire. Each has a link health visitor and a link community midwife. The Designated Doctor for Fareham and Gosport CCG reports that there is better liaison between some than others.

8.74 Computer systems across health agencies in Hampshire do not "talk to" each other; therefore health professionals are not able to see each other's involvement with the family, apart from GPs and community midwives. GPs cannot see midwifery records but midwives can request access to the GPs' computer system.

Finding Four

Unless a child has complex health needs there is no formal system in place across health agencies nationally, or in Hampshire, to co-ordinate the work of the different health service providers. This fragmented way of working will

result in an unsafe system where levels of risk to vulnerable children are missed.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

In many cases health professionals are the only professionals involved. In two recent serious case reviews in Hampshire and now this one, that has proven to be the case. That places a great responsibility on health professionals to be accurately assessing levels of risk and makes it vital that health professionals are working very closely together. If this is not happening then children's vulnerability will be missed and the systems in place to safeguard children will not be doing so.

Questions for the Board

1. As this is a national, as well as a local issue, how will the Board address this with the relevant government departments?

2. How will the Board test out how effectively health services are working together?

3. How can the Board be assured that current computer systems across health agencies are being used as effectively as they can be?

Appendix One – Acronyms and glossary of terms used in the report

Acronyms

B&B – Bed and breakfast

CCG – Clinical Commissioning Group

CIN – Children in Need. Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child Protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Hampshire Safeguarding Children Board and Children's Trust Threshold Chart – This is the levels of intervention guide for all professionals

HSCB – Hampshire Safeguarding Children Board

HV – health visitor

Listening Visit - Health visitors follow the Perinatal Mental Health Referral Pathway if a woman is identified with low mood / mild depression at any point. Health Visitors use the Edinburgh Postnatal Depression scale at 6-8 weeks postnatal to help identify women with low mood or depression. Listening visits are defined as non-directive counselling. They are aimed at helping the mother to understand her situation by exploring the possible explanations for the way she is feeling and options and strategies that might support her. It is not giving advice or information. Listening visits should be planned, time limited, focused support provided over four sessions followed by a reassessment.

LADO – Local Authority Designated Officer

LSCB – Local Safeguarding Children Board

MASH - Multi-agency Safeguarding Hub. The Multi-agency Safeguarding Hub became operational in Hampshire on 31.1.15. The MASH team of co-located partners includes children's services, adult services, police and health professionals. There are established links with a number of virtual partners such as probation and housing. The MASH triage all incoming referrals to children's services and share information to ensure children and families receive a responsive, proportionate service that enhances the safeguarding of children in Hampshire.

Working Together to Safeguard Children, 2015[10] - The statutory guidance for inter-agency working to safeguard and promote the welfare of children

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf