Barnsley Safeguarding Children Partnership

Child Safeguarding Practice Review (CSPR) – Child V

1.0 Introduction

1.1 During August 2019 a one year old child, who will be referred to in this report as Child V, was subjected to a sustained assault by her father which was captured on CCTV which had been installed by the child's paternal grandparents. The father was arrested, charged and later convicted of assaulting his daughter and sentenced to a term of imprisonment. Fortunately, Child V's injuries were much less serious than might have been anticipated in an assault of the severity recorded.

1.2 Child V had been subject to support under a child protection plan since injuries, which were presumed to be non-accidental, had been observed on her body when she was less than a month old. The child and her family had been stepped down to support as a child in need less than three months prior to the assault by her father referred to above.

1.3 Barnsley Safeguarding Children Partnership decided to conduct a local child safeguarding practice review (CSPR). David Mellor was appointed as the independent reviewer. He is a retired police chief officer who has eight years' experience as an independent reviewer/author of serious case reviews – which CSPRs have replaced - and other statutory reviews. He has no connection to services in Barnsley. A description of the process by which the review was conducted is set out in Appendix A.

2.0 Terms of Reference

2.1 The period on which the review has focussed is from the point at which agencies became aware of mother's pregnancy with Child V (early 2018) until 16th August 2019 when the serious assault on the child was reported.

2.2 The key lines of enquiry addressed by the review are as follows:

- Whether mother and father could have benefitted from the offer of Early Help?

- How effective was the action taken to safeguard Child V when she was taken to the hospital accident and emergency department on 27th August 2018 with bruising over her left eye?

- How effective was the action taken to safeguard Child V when scratching and bruising above her left eye was noted by a health visitor on 5th September 2018?

- Was the local procedure for 'injuries to non-mobile infants or children' followed on each occasion?

- How comprehensive was the assessment of Child V and her family when safeguarding concerns arose in September 2018? How well understood was parenting capacity and family functioning?

- How effective was the Child Protection Plan for Child V?

- When it was decided to step Child V down from the Child Protection Plan to support as a Child in Need on 29th May 2019, was this decision fully informed by all concerns of which partner agencies had become aware?

- How effective was the support provided to Child V and her family after she had been stepped down to Child in Need?

- Were there any opportunities for practitioners to have become aware of the fracture to Child V's left ulna which she sustained between two weeks and three months prior to the 16th August 2019 serious assault?

- How appropriate were agency responses to indications of maternal mental health concerns and how were any risks to Child V arising from maternal mental health issues addressed?

- How effective was the response of agencies to the incident of domestic abuse involving the parents which was reported on 13th March 2019? Was the potential impact of domestic abuse on Child V fully considered?

- Was professional practice sufficiently child-focussed?

3.0 Glossary

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

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

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

A **Family Group Conference** is a process in which families can meet together, to find solutions to problems that they and their children are facing, within a professionally supportive framework. The Family Group Conference process involves all family members, friends and other adults who the family feel can contribute to making plans for the children.

Health visiting levels of service. The health visiting service provide four levels of service as follows (1):

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

A **Legal Gateway** meeting is an opportunity to discuss a case fully, and to consult with colleagues to ensure that children are the subject of active case management and effective child protection planning and that appropriate legal action is taken when required to promote and safeguard the welfare of the child.

Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

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

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

Section 47 Enquiry is required when children's social care have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child.

A **Strategy Discussion** must be held whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. The purpose of the Strategy Discussion is to decide whether a Section 47 Enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry.

Synopsis

4.1 On 15th January 2018 mother, accompanied by father, attended a booking appointment with the community midwife. They were both 17 years of age at the time. Mother was documented to be epileptic, to have mental health issues ('depression, overdose and self-harm') and noted to present with low mood during the appointment, to have misused substances previously, to be a smoker and to be living with her mother and her younger siblings in an over-crowded environment. Mother was referred to a specialist teenage pregnancy midwife, to the maternity stop smoking service and a mental health midwife. Mother's alcohol intake prior to pregnancy was documented as 4-5 units per day which was said to have ceased since she became pregnant. (No further assessment of mother's alcohol intake was undertaken during pregnancy).

4.2 Early Help was mentioned to mother and father and it was intended that this would be further discussed with the specialist teenage pregnancy midwife to whom mother had been referred. It is not documented whether such a discussion took place, whether or not Early Help was offered or, if offered, whether it was declined. Mother was documented to have declined a referral to the 'mental health team'. Mother and father would also have been eligible to access the Having a Baby programme to support them to prepare for the birth but there is no record of them being offered or attending that programme.

4.3 Mother initially stopped smoking but was unable to sustain this.

4.4 On 12th March 2018 mother was seen in Hospital 1 Emergency Department (ED) after a seizure at home. After an antenatal check she was discharged home. She was referred to neurology as this was her second seizure since 2017.

4.5 On 11th April 2018 mother, accompanied by father, attended a community midwife appointment. She said she continued to see Child and Adolescent Mental Health Services (CAMHS) although by this time, she had actually been discharged by CAMHS.

4.6 On 15th April 2018 mother again attended Hospital 1 ED with pain to her legs and thighs, radiating to her back. After review, she was discharged home.

4.7 During May 2018 mother and father moved into Address 3, a property which had been purchased by Child V's paternal grandparents for mother, father and Child V to live in.

4.8 On 6th May 2018 mother again attended Hospital 1 ED. On this occasion she was experiencing reduced movements due to pyelonephritis (inflamed kidney). She was admitted to the Hospital Birth Centre. She was discharged home after four days.

4.9 On 12th May 2018 (two days after previous discharge) mother attended Hospital 1 with right sided abdominal pain (This was her fourth unscheduled hospital attendance since her maternity booking appointment). On this occasion and at her later obstetric review (23rd May 2018) mother's mental health needs were not documented.

4.10 At around 1am on 29th May 2018 mother attended Hospital 1 reporting reduced foetal movements. An obstetric review documented normal maternal observations and she was discharged. Mother, this time accompanied by father, again attended Hospital 1 reporting reduced foetal movements shortly after midnight on 16th June 2018. Foetal movements were seen and felt by staff.

4.11 On 29th June 2018 mother attended Hospital 1 Triage with pain in her legs, lower abdomen and vagina. Whether or not she was accompanied and by whom, was unrecorded. The domestic violence question was not asked.

4.12 On 18th July 2018 the specialised midwife conducted a mental health review of mother who reported to be 'feeling well'.

4.13 At 3.45am on 22nd July 2018 mother attended the Hospital 1 Birth Centre Triage reporting reduced foetal movements after a 'fall down stairs at home' between 2.30 and 3am. Whether she was accompanied and by whom was not recorded and the domestic violence question was not asked.

4.14 Shortly after midnight on 31st July 2018 mother attended Hospital 1 Triage with excessive foetal movements and an unspecified discharge. An obstetric review took place. Whether she was accompanied and by whom was unrecorded, and the domestic violence question was not asked.

4.15 At 1.20am on 6th August 2018 mother attended Hospital 1 reporting reduced foetal movements after being involved in a 'road traffic incident', in respect of which no further details were recorded. Mother was reviewed and discharged. Whether she was accompanied and, if so, by whom was unrecorded, and the domestic violence question was not asked. Mental health issues were not identified as a risk factor. No further details of the 'road traffic incident' have been shared with this review.

4.16 At 1.20am on 8th August 2018 mother attended Hospital 1 Triage with visual disturbances and reduced foetal movements. Foetal movements were seen by staff.

When assessed, mother was noted to look tired. Whether she was accompanied and, if so, by whom was unrecorded, and the domestic violence question was not asked. Mental health issues were not identified as a risk factor.

4.17 Child V was born in mid-August 2018 in Hospital 1. Mother and child were discharged the following day to paternal grandparents' address although Address 3 was recorded as mother's home address. The new born and infant physical examination (NIPE) documented no marks on the child's body.

4.18 The community midwife completed the first home visit two days after Child V's birth and no marks on the child's body were documented. She was unable to obtain a reply on a planned visit three days later.

4.19 On 19th August 2018 the community midwife was able to make a home visit and no marks were documented on Child V's body.

4.20 On 24th August 2018 the community midwife saw mother at a family centre. Child V had been put on 'hungrier baby' formula milk. The midwife discussed smaller feeds more often, including waking the baby in the night.

4.21 On 27th August 2018 Child V was taken to Hospital 1 ED by her parents. The practitioner who saw the parents and child during triage noted 'query bruising around left eye darker, reddish purple skin'. Mother and father left with Child V at 11.25pm 'due to long waiting times' before the child could be further examined. They had been waiting for just over an hour. 'No concerns with parent's behaviour' was documented and the safeguarding question on the relevant ED form was answered in the negative. The following was also recorded 'Approached by parents, due to waiting time and having the health visitor visit at 8.00am tomorrow, they did not want to wait that long and were to get the health visitor to check her eye in the morning'. There is no indication that the injury was discussed with a doctor, or communicated to the Hospital 1 safeguarding team, or a referral made to children's social care. A 'communication form' was sent to the health visitor but not received by that service until 29th August 2019. (The communication form is a paper form completed by ED staff when they wish to share information regarding a child's attendance in ED with the health visiting service or where the child requires follow up in the community by the latter service. The form is collected by the health visiting service and scanned onto their information system. This is not a timely process and so there is an expectation that in more urgent cases the information contained in the communication form would be communicated by telephone. This did not happen in this case).

4.22 The health visitor new birth visit took place the following day (28th August 2018) at Address 3. There was a delay in completing the health visitor new birth visit which took place two days later than the mandated 10-14 days after birth. Mother advised the health visitor that Child V had been taken to Hospital ED the previous evening after she had noticed bruising to Child V's inner eye, that the child had been seen by triage but that they had left after being told that 'she could be waiting for five hours'. The health visitor did not document what she observed, later advising an internal management review that she did not perceive the mark to be a bruise, and advised mother to register Child V with a GP and take her to see the GP that day. Child V was not taken to see the GP for three days and the health visitor did not verify whether the GP visit took place.

4.23 The next day (29th August 2018) Child V was examined by a community midwife at a family centre. No concerns were documented. Mother said that she had taken the advice given by the community midwife in respect of feeding (Paragraph 4.20). The child was seen by a specialist midwife a day later who documented no concerns and recorded that mother and child were staying with 'grandmother' for a few days for support.

4.24 On 31st August 2018 Child V was taken to the GP by maternal grandmother. The reason for the visit to the GP was not recorded. Child V was examined and no concerns were documented. A 'strong' history of epilepsy in the family was noted. (At the initial strategy meeting subsequently held on 6th September 2018 it was documented that the GP had not been concerned about Child V during this 31st August 2018 visit).

4.25 On 5th September 2018 the specialist midwife – the same specialist midwife who had seen Child V on 29th August 2018 - made a planned home visit and documented that the child's eyes became swollen and bruised during the early hours of the previous day and two marks had appeared on her abdomen. Mother told the specialist midwife that she had tried to obtain a GP appointment, but none had been available. The specialist midwife telephoned the GP and requested an urgent appointment. It was arranged that the GP would contact mother that afternoon with an appointment time.

4.26 Child V was taken to see the GP at 3.20pm the same day by mother and maternal grandmother. The GP documented a small bruise on the child's left eye over the upper eye lid on the left side. Two linear marks on the child's left abdominal wall were also noted. The GP also documented that mother was unable to say how the bruising had occurred. The GP concluded that the injuries were 'most likely' non-accidental.

4.27 The GP practice made a referral to children's social care and the screening team spoke to mother who said she had no idea of the cause of the bruising, stating that 'it looks like she had a bang', although it was noted that the child's cot, moses basket and pushchair were all soft in padding. Mother said she first noticed the bruise on Child V's left eye on 28th August 2018, after father had got up to attend to her when she woke. Father then woke mother up to show her the bruise to Child V's eye. Mother went on to say that she took Child V to Hospital ED on 28th August 2018 where she said she had been advised to register Child V at the local GP Practice. (It is assumed that mother was referring to the 27th August 2018 visit to Hospital ED (Paragraph 4.21)). Maternal Grandmother confirmed that Child V had been taken to the GP on 31st August 2018, adding that the GP was 'not worried about the mark to Child V's eye'.

4.28 Child V was taken to Hospital 1 where a full child protection medical took place at 8.30pm the same evening which disclosed a non-blanching (does not fade when pressed) mark on the left side of the forehead near the supra orbital ridge (eye bone above the eye), another mark on the upper eyelid, and a further mark on the right medial part of the eye below the eyelid. Additionally, two marks were noted under the left arm and two further marks on the abdomen. A sub conjectural haemorrhage was also noted in the left eye. The initial skeletal survey disclosed no acute or healing bony injury.

4.29 The paediatrician concluded that whilst marks and bruises on the face and a sub conjunctival bleed can be caused by forceps (forceps had been required to deliver Child V) they are usually apparent at birth, but these were not noted by practitioners at the time or subsequently. There was no history of vigorous coughing and vomiting. No explanation had been given for two linear bruises on the left armpit and the left side of abdomen. The parents had raised concerns that Child V's arms and legs twitched during sleep and provided a video recording which the paediatrician felt looked like benign myoclonus (spasmodic jerky contraction of the muscles). Child V remained in hospital overnight as part of safety planning. Her parents were not allowed unsupervised contact.

4.30 The following day (6th September 2018) a strategy meeting took place at which the marks on Child V's body were described as 'unexplained', although it was noted that the outcome of the child protection medical suggested that the injuries were 'non-accidental'. It was stated that further medical investigations were being undertaken. Family members were said to have given varying accounts of seeing marks and then not seeing marks. Reference was made to mother's presenting behaviour and some concern regarding her being anxious about her parenting which had resulted in Child V being cared for by various family members. Concerns had also been raised by paternal grandmother about father's volatility and anger issues.

Checks had been made of both parents and nothing was known about father whilst mother's family had been known to services.

4.31 It was agreed that the threshold for risk of significant harm was met in this case and that the current joint police/children's social care Section 47 investigation should continue with the case to be presented at an Initial Child Protection Conference (ICPC) and further legal advice sought. Child V would be placed in the care of her paternal grandparents following discharge from hospital under Section 20 of the Children Act. A viability assessment was undertaken in respect of the paternal grandparents which was positive. (Maternal grandmother was not considered as a carer due to what was documented as a 'fractured relationship' with mother).

4.32 No concerns were noted in respect of mother and father's observed behaviour and interaction with Child V. Nor were concerns noted in respect of the parent's relationship or issues pertaining to mental health (it is assumed that mother's mental health history must have been overlooked at this time), alcohol or substance use. Although they were a young couple, they were surrounded by a large extended family who were considered to be supportive practically, emotionally and financially.

4.33 On 7th September 2018 the police arrested the parents who were interviewed under caution. The police established that the injuries to Child V took place whilst the parents were caring for her. However, the parents made no admissions of guilt during the interviews. The police ultimately concluded that extensive medical examinations could not 'state the injuries were intentional'. They documented the injuries to Child V to be 'unexplained' rather than non-accidental. It is understood that no crime was recorded.

4.34 On 10th September 2018 the paternal grandparents contacted children's social care to report that on three separate occasions Child V had cried for prolonged periods which had resulted in the bruise/mark becoming visible once again – assumed to be in and around the left eye. Images of the bruise/mark were shown by the paternal grandparents and the plan appeared to be to compare them with images obtained during the child protection medical. Contact was made with the hospital by email for this purpose but no response from the hospital was recorded.

4.35 On 13th September 2018 the case was presented at a Legal Gateway panel. It was agreed that subject to any new or additionally concerning information coming from the further medical tests, the threshold had not been met for the issue of care proceedings, but that Child V should be made subject to a child protection plan (CPP). Although the marks on Child V could be said not to be serious they were considered to be extremely concerning due to the age of the child. The question of whether the injuries to Child V's could have been caused by epilepsy seizures was to

be explored as the females in mother's family suffered from epilepsy. It was decided to discharge Child V from Section 20 of the Children Act once the final test results were known, and if there were no further concerns, the ICPC was to be arranged and it would be agreed for the parents to live with the paternal grandparents in order to be supported.

4.36 A second strategy meeting took place on 17th September 2018 at which practitioners were in agreement with a recommendation to proceed to an ICPC for consideration of child protection planning in respect of Child V in view of the ongoing concerns around the unexplained bruising to this pre-mobile baby. Child V was to remain at the paternal grandparent's home. Section 20 was to be discharged and mother and father were said to have moved into the paternal grandparents address to share Child V's care. A repeat skeletal scan of Child V was to take place in two weeks and if nothing of concern was disclosed by this, Child V would then return to her parent's primary care.

4.37 On 20th September 2018 Hospital 1 confirmed Child V's repeat skeletal scan was normal with no injuries shown. The following day, Section 20 ceased and Child V was returned to the care of mother and father who were said to have moved in with the paternal grandparents on the same date. However, in their contribution to this review mother, maternal grandmother and the paternal grandparents stated that mother, father and Child V did not move in with paternal grandparents and continued to reside in address 3 where they cared for Child V alone.

4.38 On 25th September 2018 Child V was taken to Hospital 1 and seen on the Child Assessment Unit by a paediatric doctor. Eye swabs were taken for chlamydia – which can arise from a serious eye infection in a new born child. The eye swabs proved negative. The hospital records documented that a child protection medical had recently taken place. In the absence of notification that a CPP was in place, no information about this hospital attendance was shared with children's social care.

4.39 On 27th September 2018 mother made a housing application to Berneslai Homes – which is Barnsley Metropolitan Borough Council's (BMBC) social housing company which manages 18,500 homes on their behalf - in respect of herself and Child V. There was no mention of father. In their contribution to this review, mother and the maternal and paternal grandparents have stated that mother, father and Child V moved out of Address 3 on 5th November 2018 and so it is possible that this housing application was made in anticipation of the departure from Address 3.

4.40 On 28th September 2018 the health visitor carried out the 6-8 week home visit at 'grandmother's' house (the first name of the grandmother was recorded but since

both grandmothers have the same first name it is unclear at which address the visit took place). No concerns were documented.

4.41 On the same date the Section 47 enquiry concluded. The enquiry report noted that extended tests such as skeletal, CT, Ophthalmology review and extended blood tests for clotting had all been 'clear', disclosing no underlying organic reason for the marks on Child V nor providing further evidence to conclusively indicate a non-accidental injury. A manager from children's social care decided that as the injuries to Child V remained unexplained but considered likely to be non-accidental due to her being a non-mobile baby, it was therefore appropriate to progress to child protection planning for further assessment and work with the family.

4.42 On 2nd October 2018 an ICPC decided that Child V would be made subject to child protection planning under the category of physical harm. Although the conference was quorate, the police did not attend, sending a report. The grandparents were invited but did not attend. Because the child protection plan had been put in place, the health visitor service began supporting the family at 'Universal Partnership Plus' level which provides ongoing support from the health visiting team and bringing together a range of local services, to help families who have complex additional needs.

4.43 On 15th October 2018 a core group meeting took place but there is no record of the information shared at that meeting as no minutes were taken. A child protection visit took place on the same date and no immediate concerns were noted. Child V was seen to be fit, well and alert with emotional warmth displayed by mother. It is assumed that the core group meeting and child protection visit coincided with each other and took place at paternal grandparents' address.

4.44 On 26th October 2018 father contacted the police to report receiving a text message from a friend of mother's cousin's in which the person threatened to set father's house on fire. Another message stated, 'you shouldn't beat your missus'. The matter was investigated by the police and filed 'evidential difficulties'.

4.45 On 2nd November 2018 the social worker made a child protection visit to the 'grandparents' home. Child V presented as clean and content during the visit. Her parents were observed to interact and respond to Child V appropriately who was observed to smile, babble and make noises when interacted with. Mother said that an incident had been reported to the police after her cousin 'had started rumours' that father had assaulted mother. Mother was spoken to quietly alone when father was out of the room and did not disclose any current or previous domestic abuse. Mother added that her cousin had 'caused lots of trouble for other family members

in the past'. Father said that the texts also included threats to burn down their house.

4.46 In her contribution to the review, mother said that on 5th November 2018 she, father and Child V moved out of Address 3 and she and Child V moved in with maternal grandmother. Agency records indicate that when she, father and Child V moved out of Address 3, they initially moved to paternal grandparents' address until mother and father's relationship temporarily ended on 4th December 2018.

4.47 On 12th November 2018 the social worker made a referral for a family group conference, the focus of which was unclear, other than improving the relationship between maternal grandmother and father.

4.48 On 19th November 2018 a core group meeting and a child protection visit took place at paternal grandparents' address. No concerns were noted although Child V was being weaned. The parents were advised to stop solids and seek advice from the health visitor in view of the child being only 13 weeks old. The health visitor later discouraged weaning until the child was six months old.

4.49 On 5th December 2018 mother rang the social worker to say that she and father had split up the previous night due to constant arguing. Mother added that she had stayed at paternal grandparents' address the previous night but had collected her belongings together and intended to move to maternal grandmother's address with Child V that day.

4.50 On 10th December 2018 a core group meeting took place at maternal grandmother's address at which mother's separation from father and tensions which existed within the wider family were discussed including conflict between mother and paternal grandfather who had said mother was lazy. The core group meeting coincided with a child protection visit at which no concerns were noted. Child V was described as clean and happy, well presented and responsive to mother and maternal grandmother.

4.51 On 12th December 2018 a Review Child Protection Report was completed which, given that it was early in the child protection plan and Child V was of a very young age and completely dependent on her parents to meet her care needs, recommended that a further period of child protection planning was necessary in order to evidence the parents' ability to continue to safeguard and meet the care needs of Child V and complete the child protection plan actions. The recommendation was endorsed by the social worker's team manager.

4.52 The review child protection case conference took place on 17th December 2018 at which it was confirmed that Child V would remain subject to child protection planning. Actions included:

- mother to use strategies to remember to take her epilepsy medication.
- mother to be referred to Family Intervention Service for support towards independence, housing, routines and safety (Berneslai Homes Family Intervention Service have no record of any referral being received)
- funding to be sourced for alarmed wrist watch to Central Call System in preparation for independence (mother's epilepsy)
- referral to the Family Group Conference
- any disagreement within the families to be totally away from Child V.
- police to provide information relating to threatening and abusive messages to father on 26th October 2018 (Paragraph 4.44).

The grandparents were invited but did not attend.

4.53 Mother and Child V's move to maternal grandmother's address necessitated the transfer of their case to the health visitor North East team on 28th December 2018.

4.54 On 30th December 2018 the police were called by mother who was at a friend's address when father attempted to attend. He was told to leave but refused. The police attended and spoke to both parties and assessed the risk as standard. Mother and father went to separate addresses to prevent further issues. Child V was not present.

4.55 On 7th January 2019 the duty social worker made a child protection visit and no concerns were noted. Child V, who was seen with mother and maternal grandmother, was teething, not sleeping and was unsettled. The following day a health visitor from the North East team made a 'movement in' visit and no concerns were documented.

4.56 On 16th January 2019 children's social care received a police referral in respect of the incident on 30th December 2018 (Paragraph 4.54). Child V had not been present. A visit to the family was to be arranged. (Mother had not disclosed the incident to the duty social worker during the 7th January 2019 visit).

4.57 A core group meeting was held on 17th January 2019, but no notes of the meeting were taken. The children's social care chronology states that this was the responsibility of the duty social worker, who was also chairing the meeting. Paternal grandmother requested a home visit from the social worker to discuss the issues raised at the core group which was arranged for 25th January. In her contribution to this review paternal grandmother said that father asked her to attend the core group

meeting on 17th January 2019 in order to support him. Father had told paternal grandmother that mother had been physically abusing him and had 'blacked his eye'. At the core group meeting, paternal grandmother said she raised the issue, saying that she wanted it to be known that mother had been hitting father. Paternal grandmother said that, at that point, father 'backed down' and said that he and mother had only been play fighting.

4.58 On 18th January 2019 Child V was seen by the GP and referred for paediatric advice in respect of possible lactose intolerance.

4.59 On 21st January 2019 mother was admitted to Hospital 1 after taking an overdose of amitriptyline and dihydrocodeine. The hospital ED documented that mother had taken an intentional overdose as a result of stress arising from the death of a friend in a road traffic collision and also having an argument with her boyfriend. She was referred to the hospital based mental health liaison service who carried out an assessment which identified (unspecified) risks. Mother described a deterioration in her mental health since the birth of Child V, she presented as quite flat in mood and it was difficult to gather information from her. The plan was for the perinatal mental health team to be contacted the following day to discuss a referral to that service. Mother was discharged from hospital and encouraged to return to ED if she experienced further thoughts of self-harm. SWYFPT records state that Children's Services EDT was contacted as Child V had been present in the house when mother took the overdose. SWYPFT records state that the EDT advised them that mother had been visited by a social worker the day before she took an overdose and that the social worker would visit again when mother was discharged. Children's Services state that there is no record of contact with the EDT by SWYPFT. Their records indicate that they found out about mother's overdose only when the family group conference practitioner made a pre-arranged visit to mother – see next Paragraph. Hospital 1 has not shared any information about mother's admission with this review.

4.60 On 22nd January 2019 the perinatal mental health team were contacted and they arranged an appointment for a perinatal assessment on 6th February 2019. On the same date the family group conference practitioner visited mother to discuss the process. Mother felt that the family group conference process could be helpful but said she was worried about what father's family would say.

4.61 On 24th January 2019 the social worker made a child protection visit and discussed the recent overdose with mother who reported being upset by paternal grandmother's comments at the core group about her parenting and that she (mother) was abusive to father. Mother advised that Child V had been upstairs in bed at the time of her overdose, which took place downstairs. Mother was found by

maternal grandmother who called an ambulance. Mother said she felt low in mood and was encouraged to engage with mental health support. Mother said she still had feelings for father but said she would not resume her relationship with him unless he received support with his anger. It was agreed that the social worker would speak with father about this, however the social worker advised that he needed to seek support if he was willing to engage with it. A discussion took place over disclosures made by mother following the last core group meeting that father had physically assaulted her, pulled her hair and dragged her in the car which had not been reported to police.

4.62 Throughout the visit Child V was in a bouncy chair in front of the TV and mother did not interact with her. The social worker talked to mother about stimulation, floor time, play time and interaction with Child V and also discussed possible baby groups for Child V which mother said she was interested in. It was agreed that the social worker would look at groups at local children's centres. The social worker would also inform the health visitor about mother's overdose.

4.63 The following day the social worker discussed the case in supervision. It was documented that the CPP was progressing with 'no concerns' regarding Child V. The plan would continue to address issues relating to the parent's relationship and concerns relating to mother's health including her mental health which would help to support her in caring for Child V independently.

4.64 On 25th January 2019 the social worker made a child protection visit to Child V who was in the care of her father and paternal grandparents at that time. Father said that he and mother were trying to make their relationship work and confirmed that mother would like father to address his anger, which father accepted he struggled to manage. The paternal grandparents said that this had been an issue since father was around six years old and that a referral had been made to CAMHS but his parents had been offered and completed a Webster Stratton parenting course. Father was asked about mother's disclosure that he had hit her and pulled her hair. Father said the incident had taken place whilst he was setting off in the car with mother as a passenger. He said that she kept trying to get out of the car so he had grabbed her and accidentally pulled her hair, adding that he pulled mother back into the car by her shoulder and she hit her hand on the dash board which led to a bruise on her finger. Father said that mother had also hit him. The grandparents said that mother had told lots of lies to different people about what had happened and about her relationship with father. Child V was in her walker throughout the visit, babbling loudly, laughing and interacting with father and her paternal grandparents.

4.65 On 29th January 2019 children's social care advised the health visitor of mother's overdose and the health visitor followed up with a home visit on 4th February.

4.66 On 6th February 2019 the perinatal mental health team conducted an initial assessment of mother and assessed her risk of intentional completed suicide in the near future to be low, her risk of impulsive self-harm as low to moderate and there was a risk of deterioration in mother's mental health without intervention. It was identified that mother needed to develop coping strategies, build her self-confidence and manage her anxiety. She agreed to seek help immediately if suicidal thoughts recurred. A moderate risk of carer stress in respect of maternal grandmother was identified as she was also managing the diagnosed needs of mother's younger siblings and there was overcrowding in the family home. Maternal grandmother was advised to contact SENDIASS (special educational needs, disability information and advice service) regarding issues in school and BMBC housing department to arrange a meeting regarding overcrowding. A further appointment with the perinatal mental health team was to be arranged for mother.

4.67 A core group meeting took place on 7th February 2019 at which father asked about an anger management referral which the social worker was to follow up on. A child protection home visit took place at the same time as the core group meeting during which no concerns were noted. Also on the same date the case was audited by the Head of Service as a follow up from the earlier Legal Gateway meeting (Paragraph 4.35) which identified that the CPP was safeguarding and supporting the child.

4.68 On 14th February 2019 the perinatal mental health team made a home visit. Self-care was discussed with mother including enjoyable activities and future plans. The perinatal team were to liaise with the social worker and the health visitor.

4.69 On 27th February 2019 the case was allocated to a new social worker as a result of the extended sickness absence of the previous social worker.

4.70 On 28th February 2019 the perinatal mental health team made a further home visit and completed a perinatal mental health care plan and crisis plan and referred mother to improved access to psychological therapies (IAPT). Mother reported an improvement in her mood but disclosed issues around low confidence, a lack of assertiveness, and ongoing difficulties in coping with stressful situations, describing feeling unable to cope with multiple stressors. She said she had resumed her relationship with father but felt she could not tell maternal grandmother who would not let her see him.

4.71 On 1st March 2019 the new social worker made a child protection visit. Mother reported that she and father had resumed their relationship. Domestic violence was discussed with mother who said that she was willing to work with domestic violence services. Mother was observed to attend to Child V although there was some lack of warmth.

4.72 A core group meeting took place on 5th March 2019. There were no concerns about the child. Mother was waiting for an IAPT appointment. There was a discussion with father about a referral to 'Inspire to Change' – a programme designed to help participants find ways to manage and control their abusive behaviour - to which father agreed. Apologies were received from mental health services.

4.73 On 6th March 2019 Child V was taken to Hospital 2 – which is situated in the neighbouring Wakefield Council area - due to increased vomiting. No safeguarding concerns were identified or communicated from the hospital.

4.74 On 9th March 2019 the police were called after father visited maternal grandmother's address to see Child V and mother declined to take the child outside to see him because she felt that the weather was too cold. Father began to shout at mother as a result. The police assessed the risk as standard and filed the incident as a non-crime verbal domestic incident.

4.75 On 11th March 2019 the social worker discussed the case in supervision during which mother's concerns about father's anger issues - which were said to have previously been perceived to be historical – were considered. Father had reported he was willing to engage with work in this area and the social worker was to refer him to 'Respectful Relationships' and to refer mother to independent domestic abuse services (IDAS). (Respectful Relationships is a course which may be offered as part of the previously mentioned 'Inspire to Change' programme).

4.76 Also on 11th March 2019 father contacted the police to report what was recorded as a domestic assault by mother. Father reported that he and mother had split up on Saturday (9th March 2019) and that mother had denied him access to Child V. Father disclosed that mother had historically assaulted him by hitting and kicking. Father declined to engage with any police investigation

4.77 On 12th March 2019 mother phoned the social worker to request an urgent visit. She said that father had 'slammed the brakes' on the car causing her knees to hit the dashboard. She also said that he had been texting her to demand that she came out of the house with Child V and making threats to her and her family. Mother said that she had contacted the police. The social worker visited mother the

same day and she disclosed that the domestic violence in her relationship with father was more significant than she had initially indicated. She said that he hit her when they were living together with paternal grandparents. She said he pulled her hair and dragged her into the car and threatened to drive her to the moors and leave her there. She also said he pulled her hair, dragged her into the car and drove with her legs hanging out. Mother said that this occurred prior to her recent overdose. Mother showed photographs of fingertip bruising on her shoulder which had been taken during her hospital admission following the overdose. Mother agreed to a referral to IDAS. She said that the police 'had offered to put an injunction in place' which she had agreed to. No other information has been shared with this review to suggest that an injunction had been considered. Obtaining an injunction was not a police responsibility.

4.78 On the same date the social worker contacted Berneslai Homes to support a housing application from mother due to overcrowding issues in maternal grandmother's home.

4.79 On 13th March 2019 children's social care received the DASH risk assessment from the police which appeared to relate to the 9th March, as opposed to the 11th March, contact. Risk had been assessed as standard and mother had answered the question in relation to father ever hurting the child in the negative.

4.80 The following day the social worker received a text from mother to say that she and father had resumed their relationship.

4.81 On 19th March 2019 the social worker made a child protection visit. Father and mother had resumed their relationship and mother and Child V were living with him at paternal grandparents' address as maternal grandmother would not speak to mother because she had resumed her relationship with father. Father said he would address his anger issues. Father and mother were said to have agreed a referral to Inspire to Change to look at their relationship. Child V was seen and noted to be smiling with lots of eye contact and was clean and well dressed. A discussion took place about the importance of Child V being safeguarded and not left alone with her parents to help reduce conflict.

4.82 On 22nd March 2019 a family group conference took place which was attended by Child V's parents, paternal grandparents, maternal grandmother and wider family members. The family plan which emerged from the meeting included father's referral to Inspire to Change, that Child V would not be exposed to any arguments and that the wider family would be engaged in ensuring that Child V was safeguarded.

4.83 A child protection visit also took place on the same date at which no concerns were noted in respect of Child V. Mother expressed concern about her rising anxiety.

4.84 On 23rd March 2019 mother was seen by IAPT and disclosed that since the perinatal mental health team assessment, her diet had become more restricted and she had been experiencing increasing symptoms of anxiety and agoraphobia. She also disclosed 'ongoing threats from her ex-partner'. IAPT referred her to the core CMHT as there had been a change in her presentation since her referral from perinatal to IAPT.

4.85 A further child protection visit took place on 25th March 2019 at which relationships and the 'cycle of violence' were discussed with mother who said she was awaiting contact from IDAS.

4.86 On 26th March 2019 a core group meeting took place at which it was documented that father had been 'referred to mental health services by college'. Children's social care understood this entry in the core group minutes to refer to paternal grandfather speaking to father's college tutor about support for his son. In their contribution to this review, the paternal grandparents said that father was referred to a counsellor by the college he attended on one day a week as part of his apprenticeship. They said that father not infrequently came into conflict with his college tutor who would sometimes send him out of class. When this happened, father would go and see the counsellor. If he couldn't locate the counsellor, father would just return home for the rest of the day. Child V's 6th March 2019 attendance at Hospital 2 (Paragraph 4.73) was shared with the core group by the health visitor. Child V was seen at the core group meeting.

4.87 On the same date the social worker followed up mother's referral to IDAS who stated that they had contacted her on 15th March 2019, and she had told them she had never heard of the service and did not know why they would be contacting her. The social worker asked IDAS to recontact mother.

4.88 On 3rd April 2019 the social worker followed up on father's referral to Inspire to Change who confirmed that father had been offered, and accepted, an initial appointment on 16th April 2019.

4.89 On 8th April 2019 a child protection visit took place. The social worker was concerned about the extent to which Child V was moving between family addresses as mother was splitting their time between maternal and paternal grandparents' homes.

4.90 On 16th April 2019 father attended the initial Inspire to Change appointment and was assessed as suitable for the ten week Respectful Relationships programme. The following day Inspire to Change completed a victim/partner which was sent to IDAS. The referral identified father as the perpetrator and mother as the victim of domestic violence which was documented to include 'grabbing hair, punching on the arm and pushing and shoving'. Father was said to be 'very much minimising' the physical harm but admitted that he had a 'temper' which scared mother. He was said to be motivated to address this issue. The risk level was documented to be 'medium'.

4.91 On 18th April 2019 a core group meeting took place at which mother's self-reported mental health was documented as 'poor'. Mother rejected the suggestion that she had declined one to one support from IDAS. A child protection visit took place on the same date and there were no concerns.

4.92 On 21st April 2019 Child V was again taken to Hospital 2 ED with an upper respiratory tract infection. No safeguarding concerns were identified or communicated from the hospital.

4.93 On 23rd April 2019 the social worker discussed the case in supervision. It was documented that the initial concern was the physical injury to Child V however the cause of this was 'inconclusive'. Since that time mother had disclosed that father had been verbally and physically abusive to her. The parents remained in a relationship and there was said to have been no further domestic violence reported. Child V was in the care of her mother, who moved between maternal grandmothers and paternal grandparents - where father lived. The next Review CPC was to take place on 29th May 2019. The recommendation to the CPC was to be determined by mother's mental health and engagement with services. Safety provided by the extended family was to be considered within the recommendations. The team manager directed that mental health were to be invited to core groups.

4.94 On 25th April 2019 the social worker was advised by Inspire to Change that father had not attended a session arranged for that day. The purpose of the session was to complete some preliminary work in advance of the first Respectful Relationships session. The social worker rang father who said he has been busy at work and had forgotten about the appointment. The social worker arranged to see father on 2nd May 2019.

4.95 The following day children's social care received a letter from IAPT to advise that they had referred mother for input from a core CMHT practitioner for her symptoms of agoraphobia which was not treatable by IAPT. She would also receive support regarding restriction of diet in an attempt to lose weight following the birth

of Child V. It was reported that mother still felt at risk from her partner as his anger outbursts could be unpredictable.

4.96 The social worker met father on 2nd May 2019 to discuss his relationship with mother and his issue with anger management. No further details were documented. On the same day father attended the Inspire to Change session which had been re-arranged from 25th April 2019. He said that his relationship with mother was currently 'good'. During the session he and his keyworker discussed the issues which triggered his anger and how to manage these.

4.97 On 8th May 2019 the health visitor saw Child V for her 8-12 month assessment. She was being cared for by her maternal grandmother as mother was away on holiday. Delayed development in gross and fine motor skills was noted and so the health visitor planned to review the child in three months. Activity sheets were provided. Gross motor skills are larger movements with arms, legs, feet or the entire body such as crawling. Fine motor skills are smaller actions such as picking things up between finger and thumb. On the same date the health visitor emailed the social worker to provide further detail on Child V's attendances at Hospital 2 on 6th March and 21st April 2019. The health visitor said she would follow up the second attendance with the GP as maternal grandmother had told her that Child V had been prescribed a course of antibiotics and an inhaler as and when required but this was not recorded in the Hospital ED notes.

4.98 On 13th May 2019 a child protection visit took place at which Child V was seen crawling very well. Mother was said to be keen to show the child crawling following concerns from the health visitor that her development was delayed in gross and fine motor skills. Mother reported that she was binge eating and making herself sick afterwards.

4.99 A core group meeting took place on 15th May 2019 at which mother reported continuing struggles with her mental health, not eating, feeling anxious when leaving home and struggling to take her epilepsy medication. Father had a forthcoming Inspire to Change appointment. Mental health services were unrepresented at the core group meeting but the social worker contacted the service in an effort to expedite mother's appointment with the core practitioner which was arranged for 3rd June 2019.

4.100 On 16th May 2019 father attended his first Respectful Relationships session having been unavailable for the first session on 9th May. He subsequently attended sessions during the remainder of May, June (missing one session that month) and July 2019. His arrest on 16th August 2019 prevented him from fully completing the course.

4.101 On 24th May 2019 the social worker completed the review child protection report which stated that whilst there were worries in respect of mother's mental health and father and mother's relationship, and Child V being exposed to arguments, it was thought that there were protective factors in place such as being able to rely on family support, and parent's engagement with services. Therefore, it was recommended that Child V should no longer be subject to child protection planning and that the family be supported through a child in need plan. The team manager agreed with this recommendation as there had been no evidence of significant harm to Child V during the review period. Father was said to be engaging with the respectful relationships course. Throughout the Child Protection process Child V had presented as a happy, well cared for and content child.

4.102 On 28th May 2019 a child protection visit took place at which the Review Child Protection report was shared with the parents who agreed to work with a child in need plan.

4.103 At the review conference meeting on 29th May 2019 it was the unanimous decision of the practitioners present that Child V should be de-planned. Apologies had been received from the police and mental health services. Whilst it was accepted that there continued to be concerns about mother's mental health, there had been no concerns about the care afforded Child V. Father was said to be engaging with Inspire to Change. The child in need plan was to include the following:

- Mother and father to register Child V with a dentist.
- Social Care to look at any possible support for an epilepsy alarm for mother.
- Father to continue to engage with Inspire to Change.
- Mother to engage with 'health' and Inspire to Change.
- Social Care to support with housing.

4.104 On 3rd June 2019 mother did not attend the CMHT core practitioner appointment. A further appointment was to be offered.

4.105 On 6th June 2019 father's Inspire to Change key worker emailed the social worker to pass on a concern about father's behaviour. The keyworker wrote that father's engagement with the sessions was 'fine' but when he attended sessions, mother accompanied him and waited in the vehicle in which they had travelled to the evening session. The key worker said that father had been asked about this and replied that mother wanted to accompany him. The keyworker went on to write in the email that 'bearing in mind the concerns about (his) controlling behaviour, it might be that he is making her come with him because he has to do the group'. The

keyworker concluded the email by writing that this might be an issue the social worker wanted to speak to father about. There is no record of this email or any action in response to the email in the children's social care chronology.
4.106 On 14th June 2019 the police were called to an argument between mother and father. Mother said she had become anxious during the argument and texted a friend to contact the police on her behalf. Mother disclosed to the police that she suffered from anxiety and panic attacks from a previous relationship. The incident was assessed as a standard risk and filed.

4.107 On 17th June 2019 a person reported that father had threatened to smash his face in with a hammer during a phone call. The incident was categorised to be neither familial nor domestic related and the case was filed by the police under 'evidential difficulties'.

4.108 On 24th June 2019 the CMHT practitioner visited mother at home where she was feeding Child V. She said she currently spent most days in the house or at her maternal grandmother's house when her partner was at 'college/work'. She said she had low self-esteem and did not like her 'body image' since having her daughter. Due to being anxious and not accessing the community she had been unable to attend parenting classes and mother and baby groups. She said that Child V's christening was taking place in August and she was become increasingly anxious about it. Mother said that she would like to be able to 'talk to someone' about her mental health who was not a member of her family or a friend. She said she would like to be able to access the community with her daughter and increase her confidence. Graded exposure work and the Recovery Skills Training Course (RSTC) were discussed with mother. She described fleeting thoughts of harming herself but confirmed that these were 'just thoughts' and cited her daughter and partner as strong 'protective' factors.

4.109 On 25th June 2019 children's social care received a referral from the police in respect of the verbal dispute between mother and father on 14th June 2019. Child V was present in the home but did not witness the verbal argument.

4.110 On 2nd July 2019 the first child in need meeting took place. Mother was said to be accessing mental health support and now taking anti-depressants. Father was said to be engaging with his course but had missed one appointment (on 27th June 2019). Father said he was enjoying the course, had learned a lot from it and could see other's points of view. The recent verbal argument was addressed. Mother said she was being 'paranoid' about the past, but became scared when father raised his voice. Mother and father were living with paternal grandparents as mother was said to have fallen out with maternal grandmother over the christening arrangements for Child V. Mental health services did not appear to have been invited to the first child

in need meeting, the date of the meeting having been set at an earlier meeting at which mental health services were unrepresented.

4.111 On 3rd July 2019 the social worker discussed the case in supervision. The recent dispute between mother and father was discussed. Mother's emotional health remained a concern. Whilst she did not present as having significant mental health problems, her mood peaks and troughs could intensify arguments with father. Mother's mental health worker was to be invited to the child in need meeting to ensure mother was getting the support she needed. Paternal grandmother was also to be invited.

4.112 A child in need visit planned for the same day did not take place as no-one answered the door. The social worker phoned mother and received no reply. She phoned father who said that mother would be in bed.

4.113 A planned child in need visit by a duty social worker did not take place on 15th July 2019 as no-one answered the door.

4.114 A child in need visit was completed by a duty social worker on 17th July 2019 and no concerns were noted. Child V was clean and well presented. Mother was said to be eating well and engaging with her mental health worker and taking her antidepressant medication.

4.115 On 22nd July 2019 mother was seen at home by the CMHT practitioner. Father was also present on arrival. Mother said she had been spending most of her time at home or going to maternal grandmothers when taken by father. She said she had been experiencing 'mood swings' adding that she could often cry for no reason and become upset but struggled to identify any particular triggers. She questioned the benefit of the antidepressants. She denied any current suicidal ideation and had no plans or intent. She reported that she may have 'thoughts' of harming herself, adding that these were just thoughts and cited her daughter as a strong 'protective factor'.

4.116 The health visitor was unable to obtain a reply to planned home visits on 24th and 25th July 2019. When she visited again on 1st August 2019, the health visitor was told by maternal grandmother that mother was living between addresses and that she was unable to contact her. A successful home visit was made on 2nd August 2019 when Child V's development was assessed to be age appropriate.

4.117 On 5th August 2019 the CMHT practitioner visited mother at home. Father was present during the visit. She said her medication was making her 'tired all the time' and that she could sleep for 12 hours and still be able to nap during the day.

However, she felt that the medication was having a positive effect on her mood and also reported that she had caught a bus to maternal grandmother's address recently which she would not have had the confidence to do before. She said that Child V's birthday and christening were taking place the following week and she was looking forward to this. She said she remained conscious about her weight and body image. She has been referred to a dietitian but if this did not help her to lose weight she would explore the option of a gastric band.

4.118 On 7th August 2019 the social worker discussed the case in supervision. It was agreed that it was necessary to ensure that mother was engaging with mental health services and father was engaging with 'domestic violence' services. Further reference was made to the need to invite paternal grandmother to the child in need meeting.

4.119 On 8th August 2019 Child V was seen by a consultant paediatrician following the earlier GP referral to assess lactose intolerance. The child was discharged as her symptoms were said to be 'resolving'.

4.120 On 12th August 2019 the social worker rang the CMHT to check on mother's progress and was advised that there were no concerns around risk and possible discharge plans were to be discussed with mother at the next appointment.

4.121 The social worker made a child in need visit on 13th August 2019 and no concerns were noted. Child V was happy and content throughout the visit and moving normally. The child in need meeting also took place on this date. No details have been provided other than a reference to a 'growth review' being requested.

4.122 On 15th August 2019 the health visitor received no reply to a planned home visit. She contacted mother by telephone who agreed to attend clinic for a weight review in September.

4.123 On 16th August 2019 Child V's paternal aunt took the child to Hospital 1 ED after noticing that she had some bruising to the side of her face. She explained to staff that covert cameras had recently been fitted by the paternal grandparents. When the recording from those cameras was viewed it showed that Child V had been the subject of a very violent assault by father who was the only other person in the room at the time. The cameras had been fitted two days prior to the assault as the paternal grandparents were concerned that Child V was being neglected when they were out of the house as they often returned to find her in soiled nappies and left in her cot. They had also experienced an incident of some money going missing.

4.124 The further medical examinations of Child V revealed that she had a healing fracture to the left ulna (bone in the forearm) believed to have been sustained between two weeks and three months prior to the incident reported on 16th August 2019. There was bruising to her left arm, bruising to the palm of one of her hands, a three centimetre by two centimetre bruise over her left eye and some haemorrhaging of her eye.

5.0 Contribution of family members

5.1 Mother and maternal grandmother met the independent reviewer together, although mother was spoken to alone for part of the conversation to enable her to have a private discussion about more sensitive issues.

5.2 The paternal grandparents also met the independent reviewer together and were joined by their daughter (paternal aunt) for part of the conversation.

5.3 At the time the conversations took place both families were understandably preoccupied with the ongoing care proceedings in respect of Child V which may have influenced some of the comments they made to the independent reviewer.

5.4 The recollection of key events by family members is presented as a single narrative. To aid clarity the contribution of the paternal grandparents is shown in italics.

5.5 At the time she became pregnant with Child V, mother said that she was attending College, adding that father wasn't working at the time. She recalled that she had quite a difficult pregnancy.

5.6 Mother said that the paternal grandparents purchased a property (address 3) for mother, father and Child V to stay in which she said was 'lovely'. Mother added that she and father moved into this address in May 2018 in order to 'get it ready' for the child's birth.

5.7 Mother confirmed that forceps were used during Child V's birth. She said that she took Child V to a doctor's appointment when the child was around 10 days old. (This may have been the 31st August 2018 GP appointment (Paragraph 4.27)).

5.8 Turning to the incident on 5th September 2018 when marks were observed in and around Child V's left eye, under her left arm and on her abdomen, mother said that 'everyone put it down to the forceps' used in Child V's delivery. She added that she understood that the marks had initially been investigated as a non-accidental injury because of the young age of Child V but eventually it had been concluded that the use of forceps was the cause. She said that if the marks were believed to be non-accidental, she questioned why had the child been returned to the care of herself and father?

5.9 Mother confirmed that Child V was allowed to stay with the paternal grandparents for around two weeks after being discharged from hospital following the 5th September 2018 incident. She said that the child was then returned to the care of mother and father who continued to live at Address 3.

5.10 *The paternal grandparents also confirmed that Child V was discharged from hospital into their care. They said that they believed this was because they had not had contact with the child in the days prior to the marks being seen on 5th September 2018 and because children's social care deemed them capable of looking after her.*

5.11 *During this period of two weeks or so, the paternal grandparents said that they managed contact between Child V and her parents, including mother's breastfeeding of the child. Around five days after the child was discharged from hospital, the paternal grandparents said that 'the bruising reappeared in the same place' when Child V began 'screaming' for her milk. The paternal grandparents added that at the time Child V had been discharged into their care from hospital, the marks observed on 5th September 2018 were no longer visible but the marks seen in and around her left eye appeared to return when the child cried to be fed. They said that they contacted the social worker and arrangements were made for Child V to be taken back into hospital. They said that the child was taken away and examined but they didn't hear anything more about it. They added that the marks were no longer visible by later that same day (Paragraph 4.35 refers to this incident).*

5.12 *The paternal grandparents said that they were told by children's social care that they could return Child V to the care of mother and father and they recollected that this took place during the first week in October 2018 (This actually took place on 21st September 2018). They also said that mother and father then began caring for Child V in the house that they (paternal grandparents) had purchased for them (Address 3).*

5.13 *The paternal grandparents said that they were never told whether the marks observed on Child V's body on 5th September 2018 were accidental or non-accidental. They say they assumed they must be non-accidental because of the decision to return Child V to the care of her parents in September 2018.*

5.14 Mother said that she thought that the child protection plan was 'just a procedure' for 'keeping an eye on things' as Child V had been under a certain age at the time the marks were observed on 5th September 2018.

5.15 The paternal grandparents said that at the beginning of November 2018 mother, father and Child V moved in with them, adding that their daughter (paternal aunt) moved out of the family house into address 3 to facilitate this.

5.16 Mother said that she didn't settle in Address 3 because she wanted to live nearer to her mother and Address 3 was closer to the paternal grandparents' address. After Child V was returned to the care of herself and father, father would regularly drive her and the child to maternal grandmother's address before going off to work with his father, so she was not actually spending much time at address 3. She said she tried to make things work at address 3 but said she was struggling. Mother said that she had anticipated more support from the paternal grandparents whilst she and father were living at address 3 with Child V but claimed that this had not materialised despite paternal grandmother cutting her working hours.

5.17 Mother said that she, father and Child V moved out of Address 3 on 5th November 2018 and she and Child V moved in with maternal grandmother. Mother added that she had never actually lived at the paternal grandparents' address. She said that she would take Child V to see the paternal grandparents, who also looked after Child V on some weekends. (Agency records indicate that mother and Child V were living with the paternal grandparents at times).

5.18 The paternal grandparents said that after a short period staying with them, mother and Child V moved back to maternal grandmother's address because mother and father were frequently arguing and falling out. They said that the couple would periodically split up and then 'make up' a few days later.

5.19 Shortly after moving out of address 3, mother said that she and father split up, adding that they remained friends and were civil with each other.

5.20 The paternal grandparents said that they had very little contact with children's social care after Child V was returned to the care of her parents in September 2018. They said that the service never approached them to ask how things were with Child V. They said that they were not invited to core group meetings and that if they had been invited, they could have attended as both of their jobs were flexible. The paternal grandparents said that they were unaware that Child V had been stepped down to support as a child in need until advised of this by this independent reviewer. (It is not documented whether the paternal grandparents were consulted as part of the process of compiling the review child protection report (Paragraph 4.102)). The paternal grandparents felt that children's social care had relied too heavily on information provided by mother and father who they felt were immature and were not always truthful.

5.21 *Paternal grandmother said that father asked her to attend the core group meeting on 17th January 2019 in order to support him (Paragraph 4.57). Father had told paternal grandmother that mother had been physically abusing him and had 'blacked his eye'. At the core group meeting, paternal grandmother said she raised the issue, saying that she wanted it to be known that mother had been hitting father. Paternal grandmother said that, at that point, father 'backed down' and said that he and mother had only been play fighting.*

5.22 *The paternal grandparents also recalled the family group conference although they said that they understood the purpose of the meeting was to ensure that if mother and father 'fell out', they (paternal grandparents) would be able to have access to Child V. The purpose of the family group conference was much wider than the paternal grandparents recalled and the concerns in respect of Child V would have been summarised and a discussion of the role the wider family could play in safeguarding Child V would have taken place.*

5.23 *They said they had been unaware that the police had been called to their address in respect of domestic abuse incidents until after the 16th August 2019 incident. They said that they were also unaware of difficulties practitioners experienced in gaining access to their address, although paternal grandfather was aware of practitioners ringing father, who worked with him, to enquire about the whereabouts of mother and Child V. The paternal grandparents said that they were both at work all day and so were not always aware of events which had taken place whilst they were out.*

5.24 *However, they became concerned that mother was neglecting Child V and began returning home at random times during the working day and found mother in bed and Child V with a nappy which needed changing. These concerns and an incident in which money went missing convinced them to install CCTV cameras in the house. Less than 48 hours after their installation, the incident in which father subjected Child V to a sustained assault was captured by the cameras. The paternal grandparents were away at the time but were able to access the recording of the incident remotely.*

5.25 Mother's recollection of the assault captured on CCTV was that father told her that Child V had 'head butted him deliberately' so he had put her back in her cot, adding that the child was at an age when she could be told off and that she couldn't be allowed to 'get away with it'. Mother checked Child V at this point and saw what she described as a 'black eye'.

5.26 *The paternal aunt, who was also in the house at the time, took Child V to hospital. In her contribution to this review, paternal aunt said that when she took*

Child V to hospital on 16th August 2019 (Paragraph 4.123), she says that she asked staff in the Hospital ED to contact the police and says that she was told that the police would not be contacted until the following morning so she decided to report the matter to the police that evening. BHNFT records indicate that both the paternal aunt and nursing staff contacted the police on the evening of 16th August 2019.

5.27 *The paternal grandparents said that they told children's social care about father's anger management issues at the time that the marks observed on Child V were investigated in September 2018. They said that he had struggled to control his temper all of his life and they recalled two referrals to CAMHS during his childhood which they say were rejected by that service.*

5.28 Mother said she was concerned about father's anger issues which she understood he had had difficulty in managing for many years. She felt that the paternal grandparents tended to play down concerns about father's anger management which she felt may have prevented him getting the help he needed. However, mother acknowledged that the paternal grandparents were not aware of all of the incidents in which he had lost control of himself.

5.29 *The paternal grandparents didn't feel that the Respectful Relationships course did father any good. Although they said he didn't really speak about the course, they say that he did tell them that it wasn't really about anger management. They went on to say that the course didn't prevent his anger worsening. They said he became so angry with paternal grandfather that he left his apprenticeship with him and he and mother 'banned' them from attending the christening of Child V.*

5.30 Mother felt that father's attendance on the Respectful Relationships course had been of benefit to him. She said he seemed to become a totally different person, adding that it was like 'waking up in a new relationship'. Maternal grandmother concurred with her daughter, saying that she noticed a difference in him.

5.31 Mother confirmed that there had been arguments over the christening but portrayed these as primarily arguments between herself and paternal grandfather.

5.32 *The paternal grandparents also said that father had been referred to a counsellor by the college he attended on one day a week as part of his apprenticeship. They said that father not infrequently came into conflict with his college tutor who would sometimes send him out of class. When this happened, father would go and see the counsellor. If he couldn't locate the counsellor, father would just return home for the rest of the day.*

5.33 Paternal grandmother said that she had become so concerned about father's ability to manage his anger that, with his agreement, she arranged an appointment for him to see his GP which was scheduled to take place on 19th August 2019, three days after his assault on Child V came to light. The GP appointment had been arranged prior to the assault on Child V.

5.34 Mother was asked whether there was any domestic violence and abuse in her relationship with father. She said that there were three main incidents. She said that the first incident took place when Child V was a couple of weeks old. The child had had a restless night and so mother had taken her out of her Moses basket and put her in the bed she shared with father. However, the child was still unable to settle, and she said that father was getting more and more annoyed. So mother removed the baby from the bed and sat in a swivel chair in the bedroom with the child wrapped in her dressing gown. She said that father pulled her off the swivel chair. Mother said she was able to protect the child, but her elbow was injured in the incident which she said 'really, really hurt'. She said that father may not have realised that mother was holding the baby at the time he pulled her off the chair. Mother said he then snatched the baby from her and took her into his car, telling mother to get in the car also and then drove them onto the moors and threatened to leave her there, making her get out of the car for a time. She said that she cried all the way there and all the way back. She said she had been scared and in pain (This disclosure is similar in several respects to an incident mother recounted to the social worker in March 2019 (Paragraph 4.77)).

5.35 In their contribution to this review, the paternal grandparents said that they did not believe the incident described by mother in the above paragraph ever happened.

5.36 The second incident mother shared with the review took place when she and father were leaving a friend's house. Child V was not present. She said she carried her shoes and handbag out to the car and sat in the front passenger seat with her feet out of the stationary car whilst she put her shoes on. She said that father pulled her towards him, hurting her hand and she quickly shut the car door as he drove off. When they arrived at paternal grandparents' house, she said that ice was put on her injured hand and paternal grandfather drove her to her mother's address. She said that this incident took place shortly after they had moved out of address 3 and that she and father split up after this. This incident was not reported to any agency until January 2019 when mother disclosed it to the social worker (Paragraph 4.61). Father later largely confirmed mother's account (Paragraph 4.64).

5.37 *In their contribution to this review, the paternal grandparents confirmed that this incident took place although they said that mother 'tried to jump out' of the car and that father grabbed her in order to pull her back in.*

5.38 The third incident mother disclosed to this review was when she asked her friend to contact the police as a precaution after father raised his voice to her which she said had panicked her (Paragraph 4.105).

6.0 Analysis

In this part of the report each key line of enquiry will be addressed in turn.

The offer of Early Help

6.1 When mother, accompanied by father, attended the booking appointment in respect of her pregnancy with Child V, the community midwife documented a number of concerns (Paragraph 4.1) She and father were young parents. Father was due to turn eighteen in two weeks whilst mother was two months away from that milestone. Mother was documented to be epileptic, to have mental health issues ('depression, overdose and self-harm') and noted to present with low mood during the appointment, to have misused substances previously, to be a smoker and to be living with her mother and her siblings in an over-crowded environment.

6.2 It would have been appropriate to offer mother and father Early Help in these circumstances. Early Help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years (2). Early Help was discussed with mother and father at the booking appointment by the community midwife and it was intended that this issue would be further discussed by the specialist teenage pregnancy midwife to whom mother was referred. When the specialist teenage pregnancy midwife subsequently met mother and father, whether Early Help was discussed, offered or declined was not documented and the subject does not appear to have subsequently been returned to despite mother's unusually large number of unscheduled attendances at hospital during the course of her pregnancy.

6.3 Irrespective of whether mother and father declined the offer of Early Help, which was support which would have required their consent, the specialist teenage midwife could have completed an Early Help Assessment (EHA) to better inform the care and support provided to the family. The Barnsley Assessment Framework states that an EHA should be commenced when a child appears to have an additional need that cannot be met by a single agency (3). Completion of the EHA would have enabled a thorough exploration of issues such as family functioning and relationships in the home, home stability, physical, emotional and mental health needs, domestic abuse, antenatal care and readiness for the baby's arrival – including encouragement to attend the Having a Baby programme - substance misuse, social

isolation, access to services, formal and informal support from wider family networks, employment, training and finance and housing conditions.

6.4 A more thorough exploration of issues may have prompted contact with CAMHS whom mother said continued to support her with her mental health. (Mother had been referred to CAMHS in August 2016 following the first of two overdoses. Her final contact with CAMHS was in May 2017 which was seven months before her January 2018 booking appointment with the community midwife). A more thorough exploration of issues may also have prompted consideration of a referral to children's social care for a pre-birth assessment, although it seems unlikely that that agency would have considered a pre-birth assessment to be necessary given the support mother was receiving from the specialist teenage pregnancy midwife and the support being provided by the paternal grandparents.

6.5 However, the Barnsley Assessment Framework makes clear that the EHA process is a consensual process (4) and does not encourage practitioners to complete an EHA, or complete it as far as possible, when consent is refused or withdrawn.

6.6 An area of antenatal support that mother did not benefit from was the nationally mandated visit by a health visitor at 28 weeks or later in the pregnancy (5). This is the first time the health visitor meets with the parents to discuss any concerns or issues they may have about becoming parents and is particularly important for first time parents – as in this case. During this visit the health visitor would be expected to explain the health visiting service and complete the initial holistic family health needs assessment. The assessment includes: emotional support, transition to parenthood, attachment, identify families who need additional support, infant development, feeding, and the Healthy Start programme (https://www.healthystart.nhs.uk/). The antenatal visits also help the health visitor identify the appropriate level of health visitor support a family requires.

6.7 The reason mother and father did not receive this antenatal visit was because an incorrect estimated date of delivery (4th October 2018) was sent to, or incorrectly recorded by the health visiting service. It is understood that this may not be a problem exclusive to this case. The health visiting service realised that mother's estimated date of delivery may have been incorrectly recorded a few days prior to the birth of Child V when an entry in mother's notes made by the epilepsy service indicated that delivery was imminent. Efforts to contact the specialist teenage pregnancy midwife prior to the birth proved unsuccessful.

The effectiveness of action to safeguard Child V when she was taken to Hospital 1 emergency department on 27th August 2018 with marks on her eye

6.7 Neither the practitioner who saw Child V in Hospital 1 ED during the late evening of 27th August 2018 (Paragraph 4.21), nor the health visitor who saw the child the following morning (Paragraph 4.22) followed the Barnsley Safeguarding Children Board *Protocol for the management of actual or suspected bruising in non-mobile infants* which had been issued in March of that year (6), hereinafter referred to as the non-mobile protocol. The non-mobile protocol states that 'bruising in babies who are not rolling, or crawling is unusual. National and local serious case reviews have identified the need for heightened concern about any bruising in a baby who is not independently mobile. It is important that any suspected bruising is fully assessed, even if the parents feel they are able to provide a reason for it'. In cases in which the infant the infant does not appear seriously ill or injured – as in Child V's case - practitioners are expected to record what is seen, using a body map or line drawing if appropriate and record any explanation or comments by the parent/carer word for word. The protocol goes on to state that a referral must be made to children's social care without delay and they would arrange further multi-agency assessment, the first part of which would be a paediatric assessment. The protocol advises practitioners to use their own professional judgement to determine if they need to stay with the child in order to maintain the child's safety.

6.8 The practitioner who saw Child V in Hospital 1 ED documented '?bruising around left eye darker, reddish purple skin' but did not go on to describe the location, appearance, size, or colour in more detail which may have helped in the management of the case. On the ED form the practitioner wrote 'no concerns with parents behaviour' which indicates that the practitioner gave some thought to whether the mark noted could have been non-accidental. There is no record of the practitioner discussing the case with a doctor and no contact was made with children's social care. The question on the ED form which asks whether there are any safeguarding concerns was answered in the negative but no rationale for this response was provided. When the parents decided to leave ED after waiting for just over an hour, advice should have been sought from a doctor. The ED practitioner may have taken some comfort from being told by the parents that a health visitor was scheduled to visit the family the following day, although the time the ED practitioner documented for the visit (8am) was outside standard working hours and therefore could have been queried. The only communication the ED practitioner made with any other agency was with the health visitor service via a standard 'communication form' which was not received by the health visitor service until 29th August 2018, which was the day after the health visitor appointment. Care of the

child was still under midwifery but details of the child's visit to ED were not shared with that service.

6.9 The ED practitioner would have been working in a busy, pressurised environment in which communication with colleagues can be difficult at the time she saw Child V. It is not unusual for parents who bring children into Hospital 1 ED to be unwilling to wait to be seen. It is not known what explanation was provided by the parents for the mark observed by the ED practitioner, but it seems likely that they may have linked the marks to the forceps used in Child V's delivery. The ED practitioner would not have had routine access to maternity records as the majority of these are in paper form and stored elsewhere. However, BNHFT has confirmed that there are processes in place for ED staff to request maternity records.
If the ED practitioner came to the conclusion that the mark was not a bruise this should have been documented and advice sought from a doctor. The ED practitioner has since offered the explanation that she believed that the child had been seen by a doctor in ED, although there is no documentation to support this. The Barnsley Hospital NHS Foundation Trust (BHNFT) *Safeguarding Children Guidelines* stress the importance of taking a bruise or injury in non-mobile children very seriously, adding that the child should be seen by at least an ED middle grade or consultant. The BHNFT Guidelines, which were written in April 2012 and reviewed in February 2015 do not include any reference or link to the subsequent Barnsley Safeguarding Children Board non-mobile protocol.

6.10 When the health visitor saw Child V during the new birth visit the following day, she did not document the mark on the child. During the visit mother told her that Child V had been taken to Hospital 1 ED the previous evening after she had noticed bruising to Child V's inner eye, that the child had been seen by triage but that she had left after being told that 'she could be waiting for five hours'. The health visitor advised mother to take Child V to see her GP but did not verify whether the child had been taken and what the outcome was.

6.11 The health visitor was subsequently interviewed as part of an internal review and had some difficulty in recalling the visit in any detail. She was not the named health visitor for Child V and had been asked to fit in this visit because the named health visitor was on leave. She recalled that the visit was the fifth visit in a busy day. She said she observed the mark to be a red mark in the corner of Child V's eye with slight 'shadowing' which could have been interpreted as bruising although she felt that it could have been trauma from the child's birth or an infection such as conjunctivitis. However, the health visitor recalled checking the midwifery notes and child health records for Child V and found no reference to trauma at birth. She said that she forgot to check whether the child had been taken to see the GP due to workload pressures.

6.12 Both practitioners (Hospital ED practitioner and health visitor) who did not follow the non-mobile protocol, or adequately document their reasons for not doing so, were coping with quite challenging work situations at that time. When under pressure, it is not unusual for practitioners to complete tasks less fully, or to 'cut corners' or for the quality of work to diminish. Nor is it unusual for practitioners and their managers to prioritise tasks depending on their importance. However, following the non-mobile protocol is a critical element in the whole system for safeguarding children and it is therefore concerning that practitioners, when managing tasks whilst under pressure, do not appear to have prioritised following this protocol.

The effectiveness of action taken to safeguard Child V when marks to her eye and body were observed by practitioners on 5th September 2018.

6.13 It is unclear whether the 'query bruising around left eye' observed by the ED practitioner on 27th August 2018 (Paragraph 4.21) could have been linked to whatever trauma caused the 'small bruise on the child's left eye' observed by the GP nine days later on 5th September 2018 (Paragraph 4.27). It seems unlikely given the length of the intervening period and the fact that Child V was seen by several practitioners during that intervening period - including the same specialist midwife who noted the marks on the child's eye and body on 5th September 2018 – and none of those practitioners noted any concerns.

6.14 Although the specialist midwife response to the marks observed on Child V on 5th September 2018 ultimately safeguarded the child, she did not follow the non-mobile protocol in that she did not refer the case to children's social care without delay. The author of the BHNFT chronology also observed that the specialist midwife did not inform the hospital safeguarding team. However, the aforementioned BHNFT guidelines are focussed primarily on the action to be taken when a non-mobile child presents at hospital rather than when seen in the community.

6.15 A GP appointment was promptly arranged by the specialist midwife and the GP who examined Child V followed the non-mobile protocol and referred the child to children's social care without delay. A full child protection medical took place on the same evening followed by a strategy meeting the next day and a joint police/children's social care Section 47 investigation commenced during which further medical investigations took place to rule out any underlying organic reason for the marks observed on Child V. The case was promptly presented to a Legal Gateway Panel and by 2nd October 2018 the initial child protection conference had taken place at which Child V was made subject to child protection planning under the category of physical harm. The initial child protection conference could have taken place earlier had it been triggered by the first strategy meeting on 6th

September 2018 rather than the second strategy meeting which was held on 17th September. However, it was not until the second strategy meeting that most of the health investigations had been completed and there is no indication that any delay in holding the initial child protection conference adversely affected Child V.

6.16 The criminal investigation was quickly concluded. Both parents were arrested and interviewed under caution by the police on 8th September 2018 and later released on bail. The case was filed on 21st September 2018. As stated in Paragraph 4.33 the police established that the injuries to Child V took place whilst the parents were caring for her. However, the parents made no admissions of guilt during the interviews. The police ultimately concluded that extensive medical examinations could not 'state the injuries were intentional'. They documented the injuries to Child V to be 'unexplained' rather than non-accidental. It is understood that no crime was recorded. South Yorkshire Police has advised this review that they do not routinely record non-accidental injuries to children as crimes when such injuries are considered to be 'unexplained', as in this case. They add that the fact that an injured child is non-mobile 'must be considered when making (such) decisions'. In deciding whether to record the incident as a crime, the police appeared to be looking for positive proof that the injuries had been inflicted intentionally rather than taking the view that in the absence of any credible alternative explanation for marks on the body of a non-mobile child who was less than a month old, a crime was indicated.

6.17 There is no indication that the response to the 5th September 2018 incident included consideration of the possibility that this may have been the second non-accidental injury to Child V in her short life if the mark observed on her left eye by different practitioners on 27th and 28th August 2018 was a separate and distinct event as it seems likely to have been.

6.18 Additionally, the paternal grandparents' concern that the mark Child V's left eye became visible again when she cried excessively (Paragraph 4.34) was not fully investigated.

The comprehensiveness of the assessment of Child V and her family and how well understood were parenting capacity and family functioning?

6.19 As it was not possible for Child V to be returned to the care of her parents until the investigation had been concluded and the medical position was clearer, the viability of the child being cared for by members of the extended family was rapidly explored. A viability assessment undertaken in respect of the paternal grandparents was positive. Paternal grandmother was a nurse, the paternal family were not known to children's social care or the police and the paternal grandparents demonstrated commitment to work with services for the benefit of Child V.

6.20 Child V had been admitted to Hospital 1 on Wednesday 5th September 2018 and when she was discharged on Friday 7th September 2018, she was discharged into the care of her paternal grandparents. It was stipulated that the parents were not to have contact with the child over the forthcoming weekend.

6.21 At the second strategy meeting held on Monday 17th September 2018 it was agreed that the parents could move in with the paternal grandparents to share the care of Child V. On Thursday 20th September 2018 it was decided that Child V could return to the care of her parents the following day and Section 20 of the Children Act was discharged at that point. It was clear that the expectation of children's social care was that the parents would continue to live with the paternal grandparents to be supported to care for Child V (Paragraph 4.35).

6.22 However, children's social may not appear have been aware that the paternal grandparents had purchased a property for the parents and Child V to rent from them (Address 3). In their contribution to this review, the paternal grandparents said that once Child V was returned to the care of mother and father, they (the parents) and Child V lived in address 3 until they left the address in early November 2018. If this is correct, and address 3 was recorded as the parent's address by both maternity and health visiting services, Child V was in the sole care of mother and father in address 3 for over a month. Mother, father and Child V do not appear to have moved back to the paternal grandparents' address until they left address 3 around 5th November 2018, a move facilitated by paternal aunt moving out of paternal grandparents address and into address 3.

6.23 The author of the children's social care chronology observes that whilst the Section 47 assessment in respect of the presenting issue (the injuries to Child V) was detailed and of good quality, the assessment of the wider family and social and environmental factors was left blank although these issues were addressed in the body of the report. At the time the positive viability assessment of the paternal grandparents took place it was noted that further assessment would be required. However, the viability assessment was not further developed because care proceedings were not instigated and so it was not necessary to further assess the paternal grandparents as primary carers for Child V. Additionally the placement plan relating to the discharge of Child V into the care of the paternal grandparents and the transition plan for the return of Child V to the care of her parents both lacked detail. The lack of detail in the transition plan may have been as a result of the assumption that the paternal grandparents would continue to be heavily involved in the care of the child.

6.24 In their contribution to this review, both the paternal grandparents and mother separately said they assumed that the return of Child V to the care of the parents on 21st September 2018 indicated that the marks observed on the child on 5th September 2018 had been found to be non-accidental. Clearly this was not the case and seems highly unlikely to have been communicated to the paternal grandparents or parents by any practitioner. However, the lack of precision in the placement and transition plans may have left some room for the parents and paternal grandparents to misinterpret events or possibly create a narrative with which they felt more comfortable.

How effectively did the Child Protection Plan safeguard Child V?

6.25 The initial child protection plan conference took place on 2nd October 2018 and the decision to step down to child in need support was taken almost eight months later at a review child protection conference on 29th May 2019. Nine core group meetings and a further review child protection conference took place during the eight month period. The meetings were generally attended by the social worker (with a duty social worker deputising on a small minority of occasions), the health visitor and the parents. An epilepsy nurse attended quite frequently. Maternal and paternal grandmother attended two meetings and one meeting each respectively. The police do not appear to have attended any core group meetings and sent apologies to the two review child protection conferences. Mental health services did not attend any core group meetings although they began to be invited only after mother's overdose of prescribed medication on 21st January 2019.

6.26 Given the importance of the role of the paternal grandparents in supporting mother and father to parent Child V, their absence from all but one core group meeting is unfortunate. Having said that, their absence from core groups may have been an accurate reflection of their role in supporting father and mother with the parenting of Child V, which appeared to diminish over time and the ill feeling which appeared to develop between the paternal grandparents and mother, which may have been a factor in mother dividing her time between maternal grandmother's and paternal grandparents' addresses. Children's social care have advised this review that whilst there was a lack of written invitations to grandparents to attend core group meetings there may have been informal invitations through telephone contact and child protection visits. The service also points out that the grandparents and members of the wider family were represented at the Family Group Conference at which concerns in respect of Child V would have been shared with attendees. In her contribution to this review mother said that she and Child V never lived with the paternal grandparents although this is not confirmed by agency records of visits to Child V. At the practitioner learning event arranged to inform this CSPR, attendees suggested that the times at which core group meetings are held should be more

flexible in order to facilitate the attendance of family members with work commitments. However, in their contribution to this review, the paternal grandparents both said that their work commitments were sufficiently flexible for them to be able to attend meetings during the working day.

6.27 The absence of mental health practitioners from core group meetings will be dealt with later in the report. The police do not appear to have been invited to core group meetings but having been invited to the initial child protection conference and the two review child protection conferences, including the conference at which it was decided to step down Child V's case, they sent apologies to all three meetings. Given the reason for the child protection plan was suspected physical abuse of a non-mobile child and given their involvement in most of the domestic abuse incidents involving the parents, it would have been preferable for the police to have prioritised attendance at the two review child protection conferences. The lack of police involvement may have prevented the timely sharing of information held by the police in respect of an incident in which a threat was made to set father's house on fire (Paragraphs 4.43). The children's social care chronology questions whether the review child protection conferences were actually quorate in the absence of police representation.

6.28 Two core group meetings were not minuted, and attendance at one core group meeting was not recorded. One set of core group minutes included a narrative of the discussion which took place at that meeting alongside the attendees and actions from a much later meeting. Children's social care have advised this review that it is the responsibility of the key social worker to ensure that core group meetings are minuted and distributed. However, their chronology was far from clear on this point, indicating that minute taking is a joint agency responsibility and that core group members are responsible for keeping their own record of the *outcomes* of the meetings but at another point in the chronology noting that the social worker was responsible for both chairing and minuting the core group meetings, a combination of tasks that many people find quite difficult. Without sufficiently detailed and accurate minutes and actions, completed and circulated promptly, both the ability to progress child protection plans and review progress achieved is compromised.

6.29 Child protection visits tended to coincide with core group meetings in the early months of the child protection plan, but eleven child protection visits took place on dates outside of core group meetings. There was a change of social worker five months into the child protection plan which was necessitated by the extended sickness absence of the previous social worker. There was also a change in health visiting team three months into the child protection plan when it became clear that mother and Child V were largely residing with paternal grandmother in a different area of Barnsley.

6.30 This was quite a dynamic case to manage, with issues arising during the period in which Child V was being supported under a child protection plan which had the potential to present a risk to the child. Concerns that mother may be the victim of domestic abuse from father arose early on and persisted for several months. Father later disclosed that mother physically abused him although he was unspecific about the circumstances in which this took place. A pattern developed of mother and father's relationship ending then resuming. Mother and Child V moved from paternal grandparents' address to live primarily with maternal grandmother, who had been found to have a 'fractured' relationship with mother at the time of the viability assessments and in a house in which concerns had been expressed about overcrowding. Additionally, maternal grandmother was parenting mother's younger siblings who had complex needs which may have limited the extent to which she could support mother and Child V. It gradually became clear that father's anger management issues were current and not wholly historic. Mother took an overdose of prescribed medication and disclosed mental health issues which risked isolating Child V. Indications began to emerge that the parents were not always engaging openly with services including taking Child V to Hospital 2 on two occasions, mother's denial that IDAS had offered her support etc. Delayed development in Child V's gross and fine motor skills were noted.

6.31 Children's social care and the health visiting service responded promptly and effectively to most of these issues, maintaining a strong focus on the welfare of Child V throughout. Mental health services provided mother with largely effective support although clarifying the issues on which she needed support took some time and resulted in some delay in her being connected to the most appropriate team. A family group conference took place which sought to involve the wider family in safeguarding Child V and it is significant that it was one of the attendees at that event, paternal aunt, took Child V to hospital on 16th august 2019 after the child had been assaulted by father. The social worker followed up on issues such as mother's overdose and emerging concerns about father's anger assiduously and liaised effectively with other services such as mental health services, IDAS and Inspire to Change.

6.32 However, reflecting on the case, particularly the gradual emergence of issues of concern over the course of the child protection plan, emphasises the need for as thorough an assessment as possible at the outset. The prior concerns about mother's mental health appear to have been overlooked in the assessment carried out by children's social care, father's anger management issues came to be regarded as historic, the existence of Address 3 appeared to be overlooked and the assumption that the paternal grandparents were a vital protective factor who were in a position to step in and safeguard Child V should the need arise ought to have

been questioned given the fact that mother and Child V began spending an increasing amount of time living with maternal grandmother from early December 2018 and the paternal grandparents only attended one core group meeting. It may have been useful to explore why the engagement of the paternal grandparents, who were initially seen as pivotal to safeguarding Child V, diminished over time.

6.33 The social worker was able to regularly discuss the case in supervision, a process which clearly added value at times, including direction on the need to engage mental health services and paternal grandparents in the core group process for example. However, the author of the children's social care chronology commented that the record of supervision did not always reflect the level of concern which began to emerge about the conflict in the relationship between mother and father.

The effectiveness of the response to father's anger management issues

6.34 Concerns were first raised about father's 'volatility' and difficulties in controlling his anger at an early stage in the investigation of the marks observed on Child V on 5th September 2018 (Paragraph 4.30). However, children's social care appear to have perceived these concerns to be historic rather than continuing (Paragraph 4.75) until January 2019 when mother disclosed a physical assault by father to the social worker following a core group meeting, later adding that she wasn't prepared to resume her relationship with him until he received support with his anger (Paragraph 4.61).

6.35 When spoken to by the social worker, father accepted that he struggled to manage his anger, and largely confirmed the details of the disclosure of physical assault made by mother (Paragraph 4.64). During the same meeting, the paternal grandparents disclosed that father's anger management issues had been present since his early childhood. With father's agreement, the social worker subsequently referred father to the Inspire to Change programme. However, he failed to attend a preliminary session on 25th April 2019 (Paragraph 4.94). He subsequently began to engage with the ten week Respectful Relationships course offered as part of the Inspire to Change programme. Father missed the first evening Respectful Relationships session on 9th May 2019 as he was on holiday and attended his first session on 16th May. His Inspire to Change keyworker prepared a report for the 29th May 2019 review child protection conference on 21st May 2019 and sent apologies. At the time the Inspire to Change report was completed father had missed the preliminary session, which had been re-arranged, had missed the first of ten Respectful Relationships sessions because he was on holiday and had attended only the second Respectful Relationships session.

6.36 The Inspire to Change programme is provided by South Yorkshire Community Rehabilitation Company (CRC) who prepared a report describing father's engagement with the Respectful Relationships course. During the initial interview father acknowledged that he 'got wound up quickly' and had sought help from his GP but felt he had 'nowhere to go'. At this initial appointment he said that he wanted to learn how to manage anger better. He was assessed as suitable for the ten week Respectful Relationships course. He did not attend a further meeting to complete work in preparation for the start of the Respectful Relationships course, saying he had forgotten about it. This meeting was re-arranged for 2nd May 2019. At this meeting he said that his relationship with mother was 'good' and when asked what he was doing to achieve this improved state of affairs, he replied that when he began to feel 'wound up', he had started to take time out. He said that one of the main triggers to his anger was when mother said things about him under her breath. He later linked this to bullying he had experienced at school when other pupils would say things about him including sometimes whispering about him. Father went on to say that he eventually hit one of the pupils who was bullying him and 'they didn't bother him again'.

6.37 Father attended eight of the ten scheduled evening Respectful Relationships sessions. He was observed to be quiet during these sessions but apparently focussed on the content. He began to engage more fully in the later sessions when he acknowledged the impact of his non-verbal communication, recognising that his tendency to clench his fist during disagreements could be seen as intimidating. He was said to have put a great deal of effort into the skill of active listening and into seeing things from another's perspective. The final Respectful Relationships session took place on 18th July 2019 and he was invited to an exit interview scheduled for 17th September 2019 which he did not attend as by this time, he had been arrested for the assault on Child V.

6.38 Father's Inspire to Change keyworker expressed concern that mother accompanied father to the Respectful Relationships sessions and waited for him outside in his vehicle (Paragraph 4.106). When asked about this, father said that mother wished to accompany him. The keyworker was concerned that this could be evidence of controlling behaviour on father's part and alerted the social worker by email.

6.39 Mother felt that engaging with the programme had been of significant benefit to father (Paragraph 5.30) whilst paternal grandparents felt that the course did not do him any good, adding that in their view it wasn't really about anger management (Paragraph 5.29). Father told the first child in need meeting on 2nd July 2019 that he was enjoying the course, had learned a lot and could see other's points of view (Paragraph 4.108). What is clear is that father continued to struggle with his anger

whilst engaging with the programme. On 14th June 2019 mother texted a friend to call the police during an argument in which he raised his voice to her (Paragraphs 4.105 and 5.38) and three days later a person contacted the police to report that father had threatened to 'smash his face in with a hammer' during a phone call (Paragraph 4.106). The police shared the details of the first incident with children's social care but not the second.

6.40 Paternal grandparents have shared with this review that father's anger was becoming more problematic despite his involvement in the Inspire to Change programme, describing not infrequent conflicts with his college tutor, that shortly before his assault on Child V, he had fallen out with paternal grandfather and left his employment but had agreed to paternal grandmother arranging a GP appointment to seek further help with his self-control. This information was not known to children's social care or any other agency at the time.

6.41 Given his assault on Child V and the sustained severity of that attack, father's anger management issues have assumed greater prominence than they may have been afforded prior to the 16th August 2019 assault on Child V. Once children's social care understood that father's anger was a current, rather than a historical issue, they took appropriate action to refer him for support and monitored his attendance and engagement with the programme to which he had been referred. However, father's anger appeared to be viewed primarily in the context of his relationship with mother and the need to safeguard her from domestic violence and abuse and prevent Child V being affected by the domestic violence and abuse in her parent's relationship. Indeed, Inspire to Change is a programme for men and women who have been abusive, controlling or violent towards *their partner*. There is little indication that father's anger was seen as a direct risk towards Child V.

Appropriateness of agency responses to maternal mental health concerns and the extent to which any consequent risks to Child V were addressed?

6.42 Mother's mental health was a periodic, although usually fairly low level concern throughout the period covered by this review. Prior mental health issues were documented by the community midwife at the booking appointment where she presented with low mood (Paragraph 4.1).

6.43 Although she was generally documented to be mentally well during the pregnancy with Child V, the substantial number of unscheduled attendances at hospital during this period could have prompted enquiry about whether she was experiencing anxiety. There was a lack of consistent documenting of her mental health needs by maternity services during several of these hospital attendances.

6.44 Mother was admitted to hospital in January 2019 after taking an overdose of prescribed antidepressant and pain relief medication. When assessed by hospital mental health services, she described a deterioration in her mental health since the birth of Child V, although the core group meeting four days previously at which it had been alleged that she had physically abused father (Paragraph 4.57) may have precipitated the overdose. She subsequently disclosed that father had assaulted her shortly before she took the overdose and showed the social worker photographs of fingertip bruising on her shoulder which she said had been taken during her hospital admission following the overdose. Mother had previously taken overdoses of medication on two occasions during 2016.

6.45 In early February 2019 the perinatal mental health team assessed mother's risk of intentional completed suicide in the near future to be low, her risk of impulsive self-harm as low to moderate and there was a risk of deterioration in mother's mental health without intervention (Paragraph 4.66). She was subsequently referred to IAPT who then re-referred her to core mental health services as there had been a change in her presentation - agoraphobia – which was not treatable by IAPT (Paragraph 4.84).

6.46 After a fairly long interval – 4th April to 24th June 2019 – although mother did not attend a CMHT appointment arranged for 3rd June 2019, mother was seen by a CMHT practitioner who documented that mother was experiencing low self-esteem, low confidence and anxiety which was preventing her accessing community support for herself and Child V. She described fleeting thoughts of harming herself. Child V was documented to be a strong 'protective factor' on this occasion and another by the CMHT practitioner (Paragraphs 4.108 and 4.115). Previous serious case reviews have found that whenever practitioners perceive children as 'protective factors' in respect of paternal mental health, the unintended outcome is invariably to increase risks for the children who in this case was a ten-month-old child (7).

6.47 When it was decided that Child V should be stepped down to support as a child in need, continued concerns about mother's mental health were acknowledged, but it was stated that there had been no concerns about the care afforded to Child V (Paragraph 4.103). However, there had been limited joint working between children's social care and mental health services to assess the potential impact of mother's mental health needs on her parenting of Child V. After the social worker's manager had directed that mental health services were to be invited to core group meetings (Paragraph 4.94), mental health services were unrepresented at the next core group meeting (Paragraph 4.100) invited to, but did not attend the review child protection conference (Paragraph 4.103), did not appear to be invited to the first child in need meeting (Paragraph 4.108) and it is not known whether they attended the second child in need meeting (Paragraph 4.121) as no details of the meeting

have been shared with this review. However, the social worker contacted the CMHT prior to the second child in need meeting and established that the service were considering discharging mother from mental health services (Paragraph 4.120). The social worker had also contacted mental health services on an earlier occasion in an attempt to expedite an appointment for mother. Additionally, IAPT wrote to children's social care to update them on the treatment being provided to mother (Paragraph 4.96). During the period when mother's case was first transferred from the perinatal team to IAPT and then onto core CMHT, lack of continuity of mental health worker may have impeded communication between SWYPFT and children's social care for a time.

6.48 Had joint working between children's social care and mental health services been more substantial it may have enabled a more complete understanding of the potential impact of mother's mental health on her parenting capacity. Whilst it is important to note that most parents or carers who experience mental ill health will not abuse or neglect their children, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured paternal mental health problems (8). Additionally, the risks to children are greater when paternal mental health problems exist alongside domestic abuse, paternal substance misuse, unemployment, financial hardship, poor housing, discrimination and a lack of social support (9). Together, these problems can make it very hard for parents to provide their children with safe and loving care (10). In mother's case domestic violence and abuse was present in her relationship with father and there was overcrowding in maternal grandmother's home, where mother and Child V appeared to spend the majority of their time.

6.49 Turning to the potential impact of mother's mental health needs on her parenting of Child V, the primary issue appeared to be a degree of social isolation and lack of stimulation for Child V, because mother's anxiety and lack of self-confidence prevented her from taking the child to mother and baby groups in the community. Additionally, although mother was often noted to demonstrate emotional warmth towards Child V, in the period which followed her overdose she was noted to be less emotionally available to her child during visits by practitioners (Paragraphs 4.62 and 4.71).

6.50 Additionally the mental health practitioner did not enquire how Child V's needs were being met when mother disclosed that she was sleeping for twelve hours because her medication was making her 'tired all the time' (Paragraph 4.119).

Effectiveness of the response of agencies to disclosures of domestic violence and abuse in the relationship between father and mother? Extent

to which the potential impact of domestic abuse on Child V was fully considered?

6.51 The police attended three domestic incidents between mother and father (Paragraphs 4.54, 4.74 and 4.105) and all were assessed as 'standard' risk. Child V had been present during the latter two incidents but did not witness either incident. Additionally, father had reported what the police documented as historical assaults by mother by hitting and kicking but declined to assist any investigation (Paragraph 4.76).

6.52 Mother shared her concerns about father's anger in late January 2019. At that time she also disclosed to the social worker an incident in which father had pulled her hair and dragged her into the car he was driving. Father later accepted that he struggled to address his anger and paternal grandparents confirmed that this had been an issue for him since the age of six. Father also largely confirmed the above domestic violence disclosure mother made to the social worker. Mother later made a further disclosure to the social worker of what may have been domestic abuse when father was said to have 'slammed the brakes' on the car causing her knees to hit the dashboard. At this time mother also disclosed that father had hit her whilst they were staying with the paternal grandparents and threatened to drive her onto the moors and leave her there. This latter disclosure is similar in some respects to the disclosure of domestic abuse mother made to the independent reviewer (Paragraph 5.34).

6.53 In Barnsley there is no policy of automatically referring a case to MARAC after three non-high risk domestic abuse incidents in a twelve month period as is the case in some areas of the country. South Yorkshire Police has advised this review that they deal with around 37,000 repeat domestic abuse incidents each year. If three non-high risk incidents in a twelve month period were to automatically generate a MARAC referral, they take the view that this would be unmanageable.

6.54 In this case three incidents of domestic abuse were reported to the police by mother over a period of six months which were all assessed as standard risk. During the same period father appears to have reported an incident or incidents of domestic abuse by mother to the police which were considered to be historic. During the same period mother disclosed three incidents of domestic abuse by father to the social worker, although the dates on which these incidents occurred are not completely clear. None of the disclosures of domestic abuse mother shared with the social worker were reported to the police and no DASH risk assessments were conducted. This prevented these incidents being considered alongside the other domestic abuse incidents involving father and mother which had been reported to the police and may have prevented the consideration of a MARAC referral. Whilst

South Yorkshire Police are clear that there is no automatic referral to MARAC on exclusively numeric grounds, a referral to MARAC could have been considered on the grounds of professional judgement.

6.55 At the practitioner learning event arranged to inform this review, the view was expressed that it was not necessary for the social worker to conduct DASH risk assessments when mother disclosed domestic violence and abuse to her because this would be considered alongside all other information relevant to the child protection process. Whilst it is clear that mother's disclosures of domestic violence and abuse were considered as part of child protection planning, the absence of DASH risk assessments limited the opportunity to consider a MARAC referral as stated in the preceding paragraph.

6.56 Father's Inspire to Change keyworker raised concerns with the social worker that father was exhibiting controlling behaviour towards mother as she accompanied him to the Respectful Relationships evening sessions and waited for him outside in his vehicle. The keyworker questioned whether father might be making her accompany him because he 'had to' attend the course. It is not known what action the social worker took in response to the keyworker's concerns.

6.57 Additionally there appeared to be a lack of professional curiosity when mother attended Hospital 1 on 22nd July 2018 having 'fallen down the stairs at home' (Paragraph 4.13). It seems likely that mother, who was over eight months pregnant at that time, was living with father at address 3 at that time. Whether mother was accompanied and by whom was not recorded and the domestic abuse question was not asked.

6.58 Documentation of the domestic abuse question being asked was not completed on a number of occasions when mother attended hospital. Whilst it is BHNFT policy only to ask the question at least once in private, good practice would be to ask on a number of occasions.

6.59 It is not known whether the possibility that father's anger management issues and mother's disclosures of domestic abuse by father prompted consideration of whether father was capable of physically abusing Child V. CAADA (co-ordinated action against domestic abuse) research indicated found a major overlap between domestic abuse and direct harm to children (11), finding that 'the perpetrator of domestic abuse was very often the perpetrator of direct harm to the child'.

When it was decided to step Child V down from the Child Protection Plan to support as a Child in Need on 29th May 2019, was this decision fully informed by all concerns of which partner agencies had become aware?

6.60 The child protection plan was first reviewed in December 2018 (Paragraphs 4.51 and 4.52). Given that the plan was at an early stage and Child V was of a very young age and completely dependent on her parents to meet her care needs it was recommended that a further period of child protection planning was necessary in order to evidence the parents' ability to continue to safeguard and meet the care needs of Child V and for the actions in the child protection plan to be completed. Progress was acknowledged as was the fact that Child V had experienced no further injuries.

6.61 It was entirely appropriate to continue with the child protection plan. In addition to the injuries to Child V noted on 5th September 2018 - assumed to be non-accidental – which had precipitated the child protection plan - by the time of the first review child protection plan conference there had been a threat to set father's house on fire, the first indication that mother may be the victim of domestic abuse by father, mother and father had separated 'due to constant arguing', mother and Child V had moved to maternal grandmother's address where there had been concerns about overcrowding and where paternal grandmother had caring responsibilities for mother's younger siblings who had complex needs. The updated child protection plan envisaged mother being supported to attain independent living and a referral to the Family Intervention Service was to be made to assist her in this regard. The paternal grandparents were invited to the first review child protection conference but did not attend.

6.62 The second review child protection conference took place on 29th May 2019 at which a unanimous decision was taken to de-plan Child V and support her as a child in need (Paragraph 4.103). Although the decision was unanimous the meeting was attended only by the chair, the social worker, the health visitor, the epilepsy nurse and mother and father. Apologies were received from the police and mental health services.

6.63 Whilst there are limitations on the usefulness – and fairness - of 'second guessing' decisions taken by practitioners in good faith based on the information available to them at the time they made their decision, it is appropriate to review the information which was known to partner agencies at the time the decision to step down Child V was made and the extent to which the actions in the child protection plan had been accomplished.

6.64 The key consideration was that Child V was not known to have suffered any further physical harm, although as previously stated the injuries observed on Child V on 5th September 2018 appear to have been treated as the only incident in which the child sustained non-accidental injuries even though prior marks had been noted

on the non-mobile child which *may* also have been non-accidental. However, by April 2019 the cause of the injuries to Child V was documented to be '*inconclusive'* (Paragraph 4.94) which was unhelpful. Whilst it was true to say that the injuries to Child V had not been *conclusively* proved to be non-accidental, unexplained bruising in a non-mobile child is highly suggestive of non-accidental injury unless proven otherwise**.**

6.65 Additionally Child V had been regularly observed by a range of practitioners at both her paternal grandparents' address and maternal grandmother's address and always presented as a happy, well cared for and content child. Although she was well cared for, social isolation could have been considered to be a developing concern. There were also concerns over the frequency with which she was being moved between her grandparents' addresses and delayed development in gross and fine motor skills had been noted by the health visitor.

6.66 Other issues of concern arose or developed further during the five months in between the December 2018 and the May 2019 review child protection conference which are summarised below:

- Mother and father were young parents whose personal relationship had come under strain. Mother and father split up in early December 2018, had resumed their relationship by late February 2019, split up again in early March but resumed their relationship within a few days.

- Mother and Child V divided their time between paternal grandparents' and maternal grandmother's addresses from 5th December 2018. On 6th February 2019 the perinatal mental health team identified a moderate risk of carer stress for maternal grandmother as she was managing the complex needs of mother's younger siblings and there was overcrowding in her home. Her capacity to support mother in parenting Child V may have been affected by the other demands on her time.

- Although there was a well-attended family group conference, conflict between mother and the paternal grandparents continued.

- Mother took an overdose of prescribed medication on 21st January 2019. The trigger appeared to be paternal grandmother's criticism of her parenting of Child V and her disclosure that mother had physically abused father which were made at the core group meeting on 17th January 2019. Child V was present in the house at the time mother took the overdose. During her subsequent engagement with mental health services, mother disclosed low confidence, lack of assertiveness, ongoing difficulties in coping with stressful

situations, symptoms of anxiety and agoraphobia when leaving home and struggling to take her epilepsy medication.

- Largely as a result of her mental health issues, mother was unable to make progress towards independence, which had been a key objective of the child protection plan agreed at the December 2018 review child protection plan.

- Although mother had expressed an interest in taking Child V to baby groups in late January 2019, she had not had the confidence to do so by the time of the May 2019 review child protection conference.

- Mother's concerns about father's anger emerged in late January 2019. At that time she also disclosed to the social worker an incident in which father had pulled her hair and dragged her into the car he was driving. Father later accepted that he struggled to address his anger and paternal grandparents confirmed that this had been an issue for him since the age of six. Father also largely confirmed the above domestic violence disclosure mother made to the social worker. Mother later made a further disclosure to the social worker of what may have been domestic abuse when father was said to have 'slammed the brakes' on the car causing her knees to hit the dashboard. At this time mother also disclosed that father had hit her whilst they were staying with the paternal grandparents and threatened to drive her onto the moors and leave her there.

- The police attended two domestic incidents between mother and father (Paragraphs 4.54, 4.74) and both were assessed as 'standard' risk. Child V had been present during one of the incidents. Additionally father had reported historical assaults by mother by hitting and kicking but declined to assist any investigation (Paragraph 4.76).

- During April 2019 mother disclosed ongoing threats from father, describing him as her 'ex-partner' to IAPT who wrote to children's social care on 26th April 2019 to advise them that mother felt at risk from father as his anger outbursts could be unpredictable.

- Father agreed to a referral to the 'Inspire to Change' programme. It was also learned that he had been referred for support with his mental health by the college he attended one day a week. He forgot to attend an Inspire to Change appointment on 25th April 2019 but by the time of the May 2019 review child protection conference was said to be engaging with the programme's Respectful Relationships course and self-reported positive effects on his life. However, father had attended only one of the ten

Respectful Relationships sessions by the time his keyworker prepared a report for the review child protection conference on 29th May 2019.

- Child V was twice taken to Hospital 2 – which is situated in the neighbouring Wakefield Council area – and is further away from Hospital 1 where mother received her antenatal care, where Child V was born and had previously been cared for (6th March and 21st April 2019).

- Mother did not engage with domestic abuse services (IDAS).

6.67 The review child protection report concluded that Child V was no longer at risk of significant harm. Mother was engaging with mental health services and there was said to be no evidence that her anxiety, which appeared to be low level given it was not thought mother required medication, had impacted on the care of Child V (mother was in fact taking antidepressants, prescribed by her GP, which she said were contributing to her sleeping for twelve hours at a time). The domestic abuse between the parents was also considered to be low level. Mother's concerns about father's anger was being addressed through his engagement in the respectful relationships course. There was said to be no evidence to suggest that domestic abuse had escalated as mother's disclosures of physical violence were said to pre-date the most recent DASH risk assessment conducted by the police on 9th March 2019.

6.68 It was said that Child V had never been present during paternal disputes and therefore would not be impacted by the behaviour. This was incorrect as Child V had been present during one of the incidents reported to the police (Paragraph 4.74) and it is unclear if it had been established whether or not the child had been present during the two or three incidents which mother had disclosed to the social worker. In her contribution to this review mother said that she was holding Child V when assaulted by father (Paragraph 5.34), although this does not appear to have previously been shared with any practitioner. Additionally, it is unwise to assume that domestic abuse in a relationship is limited only to the incidents disclosed.

6.69 The possibility that father's anger management issues and mother's disclosures of domestic abuse by father prompted consideration of whether father was capable of physically abusing Child V when the social worker discussed the case with her team manager in supervision in March 2019 but does not appear to have been revisited thereafter.

6.70 The paternal grandparents continued to be seen as protective factors. Paternal grandmother was described as a paediatric nurse whose professional background would enable her to recognise if Child V was at risk of harm or her needs were not

being met. The paternal grandparents were said to be aware of concerns in respect of the parents but, on the basis of their contribution to this review, this may not have been an entirely correct assumption. The positive viability assessment of paternal grandparents was referred to, but this had been conducted nearly nine months earlier and their absence from the child protection plan process since that time could have raised questions, although they had participated in the family group conference. Children's social care have advised this review that the paternal grandparents were not seen as a significant protective factor in the decision to step down to child in need support. Maternal grandmother was said to be providing practical support to mother and was considered to be able to step in to care for Child V if the parents were unable. This was a challengeable assumption. The parents were said to be engaging with services although the two recent presentations of Child V at Hospital V challenged this view.

6.71 The review child protection conference concluded that the ongoing concerns could be met through a child in need plan. Given the range of concerns set out in Paragraph 6.64 and the potential impact on Child V of domestic violence and abuse in father and mother's relationship, father's long term anger management issues which he had only recently begun to address and mother's mental health issues, it could be argued that a further period of child protection planning would have been beneficial. For child in need support, paternal engagement would be vital. Whilst the parents had engaged in the child protection process, there were some indications to the contrary.

Effectiveness of support provided to Child V and her family after she was stepped down to support as a Child in Need?

6.72 The social worker continued to work diligently to safeguard Child V after the child began to be supported as a child in need and her manager maintained oversight of the case. Two child in need meetings were held.

6.73 However there was a discernible change in paternal engagement with two no-access child in need visits and four no-access health visitor home visits during this period. It is unclear whether the parents were deliberately seeking to avoid Child V coming into contact with practitioners during this period but their decision to present Child V at Hospital 2 ED on two occasions in March and April 2019 after routinely taking her to the geographically closer Hospital 1 could have merited further enquiry. Additionally, the child continued to be unobserved in community settings as mother was unable to take her to mother and baby groups because of her anxiety.

6.74 Children's social care were notified of a further domestic incident involving mother and father (Paragraph 4.105) although the police did not consider it

necessary to notify children's social care of an incident in which father made threats to a person who was not a member of his family (Paragraph 4.106). Children's social care were made aware of what may have been father's controlling behaviour of mother who accompanied him to Respectful Relationships sessions and then waited for him in his vehicle (Paragraph 4.106). Children's social care were not made aware of the concerns about father's anger management which led paternal grandmother to arrange a GP appointment in an effort to seek help for him (Paragraph 5.33).

Were there any opportunities for practitioners to become aware of the fracture to Child V's left ulna which she sustained between two weeks and three months prior to the serious assault reported on 16th August 2019?

6.75 It is difficult to answer this question given the substantial period during which the injury could have been sustained (between two weeks and three months prior to the serious assault on Child V).

6.76 Examining the period from mid-May 2019 – which is the earliest point at which the injury could have been sustained – until the assault on Child V was reported on 16th August 2019, Child V was observed by practitioners on at least seven occasions. She was seen three times by the social worker - during one child protection and two child in need home visits, once by the health visitor, once by the CMHT practitioner and once by a consultant paediatrician. No concerns about Child V were noted by any of these practitioners. However, as stated earlier, there were two no-access child in need visits and four no-access health visitor home visits during this period. Additionally, the child was not being observed in community settings as mother was unable to take her to mother and baby groups because of her anxiety.

6.77 The health visitor had noted delayed development in gross and fine motor skills on 8th May 2019 (Paragraph 4.98) which raises the question of whether pain from the fractured ulna could have adversely affected Child V's crawling. However, the date on which the health visitor observed Child V is just outside the three month window when it is estimated the fracture took place and the child was seen to be crawling 'very well' when seen during a child protection visit a few days later (Paragraph 4.99). Whilst there are several potential factors in delayed development of gross and fine motor skills such as home environment and parenting capacity, there is no indication that physical abuse was considered as a factor despite the child being on a child protection plan for physical abuse.

Child V's lived experience. Extent to which professional practice was sufficiently child-focussed?

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

6.79 Child V was invariably noted by practitioners to present as happy and contented, with generally positive interaction from mother and father although in the period following mother's overdose, a lack of interaction by mother was noted (Paragraph 4.62) as was a lack of warmth (Paragraph 4.71). The effect of the antidepressants mother was prescribed appeared to increase the amount of sleep she required which may have affected the attention Child V received.

6.80 Child V appears to have lived in three addresses during her first year of life, address 3, paternal grandparents address for a period and then living between paternal grandparents and maternal grandmother's address. This may have been unsettling. Maternal grandmother's address was described by several practitioners as overcrowded and the social worker supported mother's application for social housing for herself and Child V.

6.81 There was clearly tension in the relationship between Child V's parents which led to break ups, arguments and violence. Child V was present during two of the three domestic violence and abuse incidents reported to the police although she did not witness either incident. It is not known whether Child V was present during the two or three incidents of domestic violence and abuse mother disclosed to the social worker but in her contribution to this review mother elaborated on one of these disclosures and said that she was holding Child V when father assaulted her (Paragraph 5.34). There were also tensions between Child V's mother and her paternal grandparents and between father and her maternal grandmother. The relationship between mother and maternal grandmother was described as 'fractured' in a viability assessment.

6.82 Child V was subjected to a sustained assault by her father which must have been very frightening and distressing. Her left ulna had been broken in an undocumented incident between two weeks and three months prior to the assault by father which must have been painful for the child and caused her pain when moving her arm. She sustained injuries which were assumed to be non-accidental on one, or possibly two occasions during the first month of her life. She encountered a substantial amount of violence in her young life which appears likely to have affected the child's sense of being in a secure, loving environment.

6.83 Although she saw family members frequently, Child V was isolated from contact with children outside the extended family as a result of mother's anxiety which prevented her accessing community groups.

6.84 Concerns that Child V was being neglected, by being left in dirty nappies for example, led the paternal grandparents to install CCTV in their home address.

Multi-agency communication and information sharing

6.85 Child V's presentation at Hospital 1 on 25th September 2018 (Paragraph 4.38) did not generate any contact with children's social care. The hospital noted that a child protection medical had recently taken place but this hospital attendance took place prior to the child protection plan commencing which suggests that hospital attendances during the period in which a Section 47 enquiry is being conducted may be missed.

6.86 Child V was taken to Hospital 2 on two occasions and on neither occasion was a safeguarding concern identified and communicated by the hospital (Paragraphs 4.73 and 4.93). The attendances were shared with the health visitor who then shared them with the social worker. There is therefore a concern that there could be a delay in being notified of out of area hospital attendances in respect of children subject to child protection plans.

6.87 The police did not share the details of father's threat to a non-family member with children's social care (Paragraphs 4.106). Given the concerns about father's anger management it would have been beneficial for this information to be shared but there did not appear to be a formal mechanism for doing so.

6.88 Berneslai Homes state that they have no record of any referral to the Family Intervention Service following the review child protection meeting on 17th December 2018 (Paragraph 4.52).

6.89 Children's social care have advised this review that they were not notified of mother's overdose either by the hospital or the hospital based mental health liaison team. The information provided by BHFT does not indicate whether any safeguarding children issues were explored with mother but the SWYPFT chronology states that the Children's Services EDT was informed. It has not been possible to resolve this inconsistency and so there remains a concern an overdose by the parents of a child on a child protection plan may not have been promptly notified to children's social care.

Continuity of practitioner involvement

6.90 In the postnatal period mother and Child V were seen by four different community midwives in a relatively short period. The health visitor new birth visit was not carried out by mother's allocated health visitor. Duty social workers conducted several child protection visits. Child V's case was transferred to a different health visitor team when she and mother moved to maternal grandmother's address and the case was allocated to a new social worker in the original social worker's sickness absence.

Good practice

- Mother's epilepsy and the impact of this on her parenting capacity through experiencing seizures or not taking her medication was carefully monitored through the child protection plan and an epilepsy nurse attended the majority of core group meetings.

- The child protection medical documented the marks on and around Child V's left eye and on her body very clearly.

- The health visiting service promptly undertook an internal review after the non-mobile policy was not followed by the health visitor (Paragraph 4.22).

- The family group conference was attended by members of Child V's wider family, including paternal aunt who subsequently took Child V to hospital after the child had been assaulted by father.

- Inspire to Change notified children's social care of father's non-attendance at the first group session on the same day. They also notified children's social care of possible controlling behaviour by father towards mother.

- IAPT shared mother's concerns about father's outbursts of anger with children's social care.

- There was much solid and proactive practice by the social worker to whom Child V's case was allocated in February 2019.

- The social worker liaised with mental health services in an effort to expedite appointments for mother.

7.0 Findings and Recommendations

Early Help

7.1 Mother and father would have benefitted from Early Help but whether or not they were offered Early Help was not recorded. They received valuable specialist support from the teenage midwife and the Smoke Stop midwife, but the offer of Early Help might have assisted in organising the support provided and improving information sharing and liaison with other agencies. Additionally, the support offered would have been underpinned by an Early Help Assessment which could have enabled practitioners working with the family to have a more sophisticated understanding of their needs.

7.2 The review has been advised by BHNFT that community midwives have received awareness training in respect of Early Help and an internal pathway to streamline the process is under development. Additionally, all practitioners are required to notify the Hospital 1 safeguarding team of all offers of Early Help.

7.3 At the learning event arranged to inform this review, practitioners expressed the view that whether or not Early Help was offered, and if offered and declined, completion of the Early Help Assessment would have been beneficial. This view appears to have much to commend it but is not currently explicitly reflected in the Barnsley Assessment Framework.

7.4 It is therefore recommended that Barnsley Safeguarding Children Partnership seek assurance that the changes introduced by BHNFT have had the desired effect and that community and specialist midwifery understand and apply the threshold for the offer of Early Help and record that offer and whether or not it is accepted or declined. The Safeguarding Partnership may also wish to consider promoting the wider use of the EHA as an assessment tool to understand need and inform service provision, irrespective of whether Early Help is offered or accepted.

Recommendation 1

That Barnsley Safeguarding Children Partnership seeks assurance from Barnsley Hospital NHS Foundation Trust that midwifery services understand and apply the threshold for the Early Help offer and record that offer and whether or not it is accepted or declined.

Recommendation 2

That Barnsley Safeguarding Children Partnership considers promoting the wider use of the Early Help Assessment as an assessment tool to understand need and inform service provision, irrespective of whether Early Help is offered or accepted.

Antenatal visits by Health Visitors

7.5 Mother and father did not receive the nationally mandated antenatal visit by a health visitor. Given their vulnerabilities, this was a significant omission. The reason for this omission was that mother's estimated date of delivery had been incorrectly notified to the health visitor service. It is understood that this issue was also identified by an earlier Serious Case Review (Child T).

7.6 Barnsley 0-19 Public Health Nursing Service has shared an internal action plan with this review which is designed to address the problem. The action plan includes reviewing antenatal communication pathways in order to improve information sharing. It is recommended that the Safeguarding Partnership seeks assurance that the 0-19 Public Health Nursing Team has a sufficiently robust system to ensure the timely arrangement of the antenatal visit by a health visitor.

Recommendation 3

That Barnsley Safeguarding Children Partnership seeks assurance that the Barnsley Hospital NHS Foundation Trust Midwifery Service and the Barnsley 0-19 Public Health Nursing Team have an agreed robust system of communication in place to provide confirmation of pregnancy in a timely manner so that health visitors can undertake the required antenatal visits.

'Non-Mobile' Protocol

7.7 The Barnsley Safeguarding Children Board *Protocol for the management of actual or suspected bruising in non-mobile infants* was not followed by practitioners from three different disciplines (ED practitioner, health visitor and community midwife) after observing marks on Child V when less than a month old. This suggests that at that time – the summer of 2018 – professional awareness of the non-mobile protocol and the need for heightened concern about any bruising in a baby who is not independently mobile was insufficiently embedded within the safeguarding children workforce.

7.8 The ED practitioner and the health visitor were both under workload pressures at the time they did not follow the non-mobile protocol. It seems unlikely that the type of workload pressures experienced by these two practitioners will diminish in the near future.

7.9 The BHNFT *Safeguarding Children guidelines* contain no reference or link to the Barnsley Safeguarding Children Board non-mobile protocol, although the former was written before the latter. Additionally the BHNFT guidelines are primarily focussed on action to be taken when a child is brought to hospital and may therefore need to be developed to provide appropriate guidance to BHNFT practitioners who work in the community such as the community midwife who did not follow the non-mobile protocol in response to the marks she observed on Child V on 5th September 2018, although the action she took helped to safeguard the child.

7.10 It is therefore recommended that the Safeguarding Partnership seeks assurance that all relevant practitioners receive the necessary training and/or briefings to ensure they are fully aware of the non-mobile protocol, the principles which underpin it and understand the action they need to take in order to follow the protocol. The Safeguarding Partnership may also wish to seek assurance that working practices are put in place to support practitioners to follow the non-mobile protocol when they are under workload pressures or operating in a challenging environment such as a hospital ED. Additionally, the dissemination of learning from this case will provide the Safeguarding Partnership with a further opportunity to emphasise the importance of following the non-mobile protocol.

Recommendation 4

That Barnsley Safeguarding Children Partnership seeks assurance that all relevant practitioners receive the necessary training and/or briefings to ensure they are fully aware of the non-mobile protocol, the principles which underpin it and understand the action that they need to take to follow the protocol.

Recommendation 5

That Barnsley Safeguarding Children Partnership seeks assurance that working practices are put in place to support practitioners to follow the non-mobile protocol when they are under workload pressures or operating in a challenging environment such as a hospital ED.

Recommendation 6

That Barnsley Safeguarding Children Partnership disseminates the learning from this review and takes that opportunity to further emphasise the importance of following the non-mobile protocol. Dissemination of learning will also provide the opportunity to consider links between domestic abuse and child abuse (See Paragraph 7.22).

Child Protection Planning in respect of Child V

7.11 It was the clear expectation of children's social care that once Child V was returned to the care of mother and father on 21st September 2018, they would be living with the paternal grandparents who would thereby be well placed to support mother and father in caring for the child and would be in a position to step in to ensure the child's needs were met and that the child was safeguarded.

7.12 Children's social care's expectations do not appear to have been met. The paternal grandparents had purchased a property for father, mother and Child V (address 3) which they appear to have occupied until early November 2018. Both mother and the paternal grandparents have advised this review that mother, father and Child V lived in address 3 from the point at which Child V was returned to them (21st September 2018) until they moved out of address 3 to stay with paternal grandparents (around 5th November 2018).

7.13 This situation appears to have arisen in part because the placement plan – under which Child V was placed with paternal grandparents under Section 20 – and the transition plan – which covered the transfer of care for Child V from the paternal grandparents to mother and father – lacked detail. Mother's mental health history may also have been omitted and it appears that the impression was gained that father's anger management issues were historic rather than current. Gaps in the assessment may have contributed to children's social care finding themselves responding to issues as they cropped up rather than being in a stronger position to anticipate them.

7.14 The paternal grandparents were regarded as pivotal to the child protection plan, and there was an assumption that they were supporting mother and father in caring for Child V and that they would step in to safeguard Child V should this become necessary. This assumption remained unchallenged even after mother and Child V largely moved to live with maternal grandmother, tensions developed in the relationship between mother and paternal grandparents and despite the paternal grandparent's lack of involvement in child protection planning.

7.15 Once they had conducted the criminal investigation into the injuries sustained by Child V in September 2018, the police involvement in child protection planning for Child V was negligible. The police should have attended the review child protection conferences at which key decisions were taken in respect of a non-mobile child who had sustained injuries which were presumed to be non-accidental.

7.16 Not all core group meetings were adequately minuted in terms of information shared and outcomes agreed.

7.17 Child V was stepped down to support as a child in need prematurely because the assumption that the paternal grandparents were in a position to ensure the child was safeguarded was not revisited (although their CCTV system ultimately revealed the assault on Child V by father), concerns about domestic violence and abuse by father had not been fully risk assessed, father had only recently begun the Inspire to Change programme to address his anger management in relationships and the possibility that a domestic abuser could also be a child abuser did not appear to have received sufficient attention.

7.18 It is therefore recommended that the Safeguarding Partnership seeks assurance in respect of the following child protection planning issues:

- That placement and transition plans are completed fully,
- that assumptions which are critical to the safeguarding of a child - such as the role of the paternal grandparents as a protective factor in this case – are reviewed in the light of information which challenges those assumptions,
- that police involvement in child protection planning is sufficient and
- that the outcomes of core group meetings are documented sufficiently.

7.19 It is also recommended that child protection plans are not stepped down to support as a child in need prematurely.

Recommendation 7

That Barnsley Safeguarding Children Partnership seeks assurance in respect of the following child protection planning issues:

- *that placement and transition plans are completed fully,*
- *that assumptions which are critical to the safeguarding of a child - such as the role of the paternal grandparents as a protective factor in this case – are reviewed in the light of information which challenges those assumptions,*
- *that police involvement in child protection planning is sufficient and*
- *that the outcomes of core group meetings are documented sufficiently.*

Recommendation 8

That Barnsley Safeguarding Children Partnership seeks assurance child protection plans are not stepped down to support as a child in need prematurely.

Domestic Violence and Abuse

7.20 Mother made disclosures of what appeared to amount to three separate domestic violence and abuse incidents to the social worker who recorded this information and ensured that it was considered as part of child protection planning.

7.21 Each disclosure should have been subject to a DASH risk assessment in order to understand the risk to mother and Child V. Had DASH risk assessments been carried out, there would have been a more complete understanding of domestic abuse incidents and a referral to MARAC could have been considered on the grounds of professional judgement, given the apparent escalation in abuse over a relatively short period of time and father's anger management issues. However, children's social care's position appears to be that social workers should not complete DASH risk assessments. If this is to remain the position then children's social care need to share with the police any new disclosures of domestic abuse made to social workers so that the police can conduct DASH risk assessments.

7.22 Consideration of the risk of physical abuse of Child V by father given father's anger management issues and mother's disclosures of domestic abuse by father did not appear to be prominent in this case. Dissemination of learning from this review could highlight research evidence relating to the potential overlap between domestic abuse and direct harm to children (12). See Recommendation 6 above.

7.23 It is recommended that the Safeguarding Partnership share this report with Barnsley Safer Barnsley Partnership, so that the latter partnership can consider whether to support practitioners from a range of disciplines, including children's social care, to complete DASH risk assessments when disclosures of domestic violence and abuse are made to them.

Recommendation 9

That the Barnsley Safeguarding Children Partnership share this report with the Safer Barnsley Partnership, so that the latter partnership can consider whether to support practitioners from a range of disciplines, including children's social care, to complete DASH risk assessments when disclosures of domestic violence and abuse are made to them.

Impact of maternal mental health on Child V

7.24 There was an absence of joint working between mental health services and children's social care to gain an understanding of how concern's about mother's mental health in the wake of her overdose of prescription medication may affect the care she was able to provide for Child V. This could have been discussed had mental health services attended those core group meetings to which they were invited or sent reports.

7.25 It is therefore recommended that the Safeguarding Partnership seeks assurance that mental health services and children's social care collaborate effectively when maternal mental health issues are relevant to child protection and/or child in need planning.

Recommendation 10

That Barnsley Safeguarding Children Partnership seeks assurance from Barnsley Children's Services and South West Yorkshire Partnership NHS Trust that mental health services and children's social care collaborate effectively when maternal mental health issues are relevant to child protection and/or child in need planning.

7.26 When mother was admitted to Hospital 1 following an intentional overdose Child V was present in the house. Child V was being supported on a child protection plan at that time. There is no indication that Hospital 1 considered or made a safeguarding referral as a result of mother's overdose. SWYPFT, as provider of the hospital mental health service to which mother was referred during her hospital admission state that they contacted the Children's Services EDT but children's social care has advised this review that they have no record of this contact.

7.27 It has not been possible to reconcile the differences in the records of SWYPFT and children's social care but it is clear that Hospital 1 did not make a safeguarding referral. It is therefore recommended that the Safeguarding Partnership seek assurance from BHNFT that they have systems in place to ensure that any safeguarding children implications of hospital attendances by parents as a result of self-harm are fully explored and referrals made where appropriate.

Recommendation 11

That Barnsley Safeguarding Children Partnership seeks assurance from Barnsley Hospital NHS Foundation Trust that they have systems in place to ensure that any safeguarding children implications of hospital attendances by parents as a result of self-harm are fully explored and referrals made where appropriate.

Single Agency Learning

7.28 There is much single agency learning arising from this case, some of which has been referred to in this report. It is recommended that Barnsley Safeguarding Children Partnership request the agencies involved in this review to reflect on the contents of this report and share their single agency learning and any consequent action plans with the Safeguarding Partnership.

References

(1) Retrieved from https://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/

(2) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

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(4) Retrieved from https://www.barnsley.gov.uk/media/3081/early-help-assessment-frequentley-asked-questions-docx.pdf (FAQ number 8)

(5) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464880/Universal_health_visitor_reviews_toolkit.pdf

(6) Barnsley Safeguarding Children Board *Protocol for the management of actual or suspected bruising in non-mobile infants* - March 2018.

(7) Retrieved from https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=F01AF3CF-F58F-42AD-B89A-96A4A692DF77&searchterm=maternal%20mental%20health&Fields=%40&Media=%23&Bool=AND&SearchPrecision=20&SortOrder=Y1&Offset=10&Direction=%2E&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

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

(9) ibid

(10) ibid

(11) Retrieved from https://safelives.org.uk/sites/default/files/resources/Final%20policy%20report%20In%20plain%20sight%20-%20effective%20help%20for%20children%20exposed%20to%20domestic%20abuse.pdf

(12) ibid

Appendix A

Process by which the CSPR was conducted

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

Agency reports including chronologies which described and analysed relevant contacts with Child V and her family were completed by the following agencies:

- Barnsley Children's Services
- Barnsley Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust
- Barnsley Public Health Nursing Service
- Berneslai Homes
- South West Yorkshire Partnership NHS Foundation Trust
- South Yorkshire Police

The independent reviewer analysed the chronologies and identified issues to explore with practitioners and managers at learning events facilitated by the lead reviewer.

Child V's mother, maternal grandmother and paternal grandparents contributed to the review and were later provided with an opportunity to comment on the report prior to publication. Both families expressed their support for the findings and recommendations.

The independent reviewer then developed a draft report to reflect the agency reports and the contributions of practitioners and managers who had attended the learning event. The report was further developed into a final version and presented to Barnsley Safeguarding Children Partnership.