Redbridge Safeguarding Children Partnership (RSCP)

# Local Child Safeguarding Practice Review (CSPR)

# Baby ‘A’

October 2022

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## 1) Introduction and Summary of Learning from this Review

1.1. This local Child Safeguarding Practice Review (CSPR) was undertaken to find learning through consideration of practice and systems relating to an infant who sustained a head injury aged 10 weeks old. The infant will be referred to as Baby A[1].

1.2. Baby A is currently subject to childcare legal proceedings and remains within a foster placement. At the time of the review, the Metropolitan Police Service (MPS) are continuing their criminal investigation.

1.3. Baby A was on a Child Protection Plan (CPP) at the time of the incident due to risk of neglect. A Legal Planning Meeting (LPM) had determined that the threshold to initiate care proceedings had been met.

1.4. Baby A's mum[2] at that time was aged 19 and a care leaver.

1.5. Learning was identified in the following areas by considering this case:

- Awareness of a parent's history
- Transitional arrangements between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS)
- Consideration of fathers
- The impact of substance misuse on children and unborn babies
- Timeliness of pre-birth planning
- Avoiding over-optimism and losing focus on the child
- Knowledge of multi-agency safeguarding procedures, joint risk formulation and timely application of statutory processes

## 2) Process

2.1. The London Borough of Redbridge submitted a serious incident notification on 9th February 2022. The Redbridge Safeguarding Partners asked all agencies known to have had an involvement with the family to provide information about their involvement with Baby A and her Mum.

2.2. Following the rapid review process and consultation with the Child Safeguarding Practice Review (CSPR) Panel, the safeguarding partners identified that lessons could be learnt regarding the way that agencies work together.

2.3. A rapid review is undertaken to ascertain whether a local CSPR is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made along with the national CSPR Panel.

2.4. The local CSPR was conducted in accordance with the requirements set out in:

- The Children Act 2004[3] (as amended by the Children and Social Work Act 2017[4])

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[1] The name Baby A was chosen by the Partnership to provide anonymity for the child and family. The family support this choice.
[2] Baby A's Mother would prefer to be referred to as "Mum" within this report.
[3] http://www.legislation.gov.uk/ukpga/2004/31/contents
[4] www.legislation.gov.uk/ukpga/2017/16/contents/enacted

- Working Together 2018[5]
- Local multi-agency children's safeguarding policies and procedures

2.5. An independent lead reviewer[6] was commissioned to work with a panel of local safeguarding professionals from the key agencies. The lead reviewer facilitated a practitioner event[7], analysed agency information and reports, spoke to Baby A's Mother and produced this report. The lead reviewer and the panel collaborated on identifying the learning and writing recommendations from this CSPR.

2.6. The Redbridge SCP provided the reviewer with a plethora of information including its most up to date health profile to provide insight into the geographical area. Additionally progress against various initiatives, pathways and integrated ways of working were provided throughout the review process.

2.7. The reviewer also engaged with Baby A's mother who was supported by her Personal Advisor (PA) beforehand on the purpose of the review. Mum was very keen to contribute to the process and the conversations with her proved to be insightful and helpful for the learning. The learning identified from this engagement is included in the report where relevant. The identity of Baby A's Father became known subsequently to the incident taking place and he has not contributed to this review.

## 3) The child being considered

3.1. Baby A was born on 23rd November 2021 and at the end of the review is aged 10 months. Baby A is the first child to her biological Mother, both of whom are from a white British heritage. She was made subject to a CPP under the category of neglect aged 9 days. A LPM was held on 18th January 2022 due to escalating concerns. On the 27th January 2022 a welfare visit was undertaken at the home and her Mum answered the door in a distressed state, reporting that Baby A had a lump to her head, she was subsequently found to have suffered a head injury, sustaining a skull fracture. It was reported by Mother that Baby A was with a friend in another room when the injury occurred, the case is still under active criminal investigation.

3.2. Baby A remains under an Interim care Order within a Foster placement. Updates on Baby A's progress were provided throughout the review process. Baby A is now 10 months old. She is slightly smaller than average for her age and is generally meeting developmental milestones. She is now very responsive and is a happy baby. Baby A was reviewed by her Paediatric Consultant on 9th February and was discharged with no follow-up required.

3.3. Baby A currently has supervised contact with her Mum four times a week. Mum informed the reviewer of multiple experiences where Baby A has had the opportunity to enjoy such as days out to the zoo and the aquarium.

3.4. The Rapid Review found that there were a number of complex issues relating to Mum, who was/is a care leaver with a number a vulnerabilities. These include a history of childhood abuse and trauma, abandonment, child sexual exploitation, substance misuse and significant and ongoing mental health issues. This is an important context to consider learning from this incident.

[5] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[6] The Lead Reviewer is Anna Berry and is Independent of all agencies

[7] Via virtual meeting technology due to the impact of Covid-19

## 4) About Mum

4.1. Mum had a history of very difficult childhood experiences and complex needs from an early age. She is the sixth of seven children and her family have been known to children's social care services since 1997 with safeguarding concerns including physical abuse. Her parents separated in 2004 and she went to live with her Father at this time.

4.2. There was limited contact with services after this date until 2016 when concerns were raised by school about threats of physical violence from Father, issues around eating, and a child and family assessment was completed and closed with no further action. From consideration of the information, this incident was the first of many significant issues. Mum raised further concerns about her Father and refused to live with him. She subsequently moved in with one of her siblings in a different geographical area before presenting as homeless in 2018.

4.3. At this time Mum disclosed to School that she was involved in a network of gangs who were sexually exploiting people and involved in criminal activity. School raised significant concerns that Mum was being sexually exploited.

4.4. Exploration of options with family members was exhausted and Mum was accommodated under S20 of the Children Act. The risks escalated significantly from this point onwards. There was a deterioration in her mental health, she was struggling to regulate her anger, suffering from anxiety and panic attacks, and using cannabis regularly. She was signposted via CAMHS to psychological therapies and drug services but was not able to work with them at this point.

4.5. She was missing regularly from her placement and was staying with an adult female acquaintance who was well known to both Children's Services and Police for criminal and sexual exploitation concerns. It was identified via police that it was not an appropriate place for her to live however a LPM concluded that threshold for proceedings had not been met.

4.6. The adult acquaintance subsequently secured a Child Arrangements Order (CAO)from the High Court thus mum resided with her until this arrangement broke down in March 2019. This was a significantly traumatic period of time for Mum.

4.7. It is noteworthy that the Local Authority formally contested the CAO and took actions to continue to safeguard and support Mum, including strategy discussions and requests for police support to return Mum to her placement on the basis that she was missing from care. However, despite this, the CAO was upheld by the Court, thus effectively ending Mums Looked After Status under S20.

4.8. Mum subsequently engaged with Psychological therapy sessions where she disclosed a significant history of exploitation over the last year. Although outside of the remit of this review, it is not clear whether there was an outcome to criminal investigation that was commenced, and Mum is not aware of whether it progressed. In November 2019 she was assessed in hospital due to a deterioration of her mental health and she became looked after for a second time under S20.

4.9. Whilst it is not within the remit of this review to scrutinise the full history experienced by mum, the level of trauma experienced by her during this 12-month period should not be underestimated and contributed to significant and continuing issues with mental health.

4.10. From November 2019 to March 2020, she engaged with psychological therapy and described herself as 'sad', 'alone' and 'broken'. She described herself as very worried about what would happen when she turned 18 at the end of March 2020, saying that "she

knows she cannot stay in the current accommodation forever, but has finally found somewhere where people have taken care of her, and she feels safe."

4.11. The plan pre 18 years was for Mum to remain in a transition's placement for up to six months beyond her 18th birthday due to the risk around her mental health. Unfortunately, due to increased complexity in behaviour/mental health, the placement gave notice just before her 18th birthday with a rationale that they were not able to meet her needs. This coincided with Mums 18th birthday and the start of the COVID-19 lockdown in March 2020.

4.12. Due to challenges in matching Mum with other young people the only alternative was a sole placement with a high level of support. The support at the time was agreed at 20 hours per week.

4.13. Mum's transition into adult mental health services was challenging due to geographical boundaries, service changes due to COVID-19 and miscommunication between services. This resulted in an almost a one-year gap in mental health services until she presented in crisis in March 2021.

4.14. By the end of March 2021, Mum was staying for much of the time with her sister and brother-in-law because of her isolation and deteriorating mental health. The Mental Health Home treatment Team became involved in April 2021 shortly before she became pregnant with Baby A.

4.15. The period during pregnancy will be explored within the analysis.

## 5) Mums' perspective

5.1. The reviewer spoke to Mum at length to gain insight into her experience. She was extremely candid and cooperative and was able to reflect on a number of aspects of this review. Mum provided a reflection of her life so far and how that impacted on her as she became a Mother.

5.2. She described her childhood and said her Father was violent and alcoholic, she described a very difficult relationship with her own Mother and how she feels that services let her down time and time again when she told them how bad things were. She recognised how long her mental health had been deteriorating and the chain of events that led to her being groomed and exploited and how this still affects her. She has not been able to have closure on the exploitation she suffered.

5.3. She disclosed the identity of Baby A's father early in the conversation, as being her Brother-in Law, she was very clear about this relationship as being meaningful to her and expressed that she thought he would be part of their lives and that he would support her. She described him subsequently as being manipulative in providing an alternative narrative to her sister and others about their relationship.

5.4. She said that she did not realise at the time that he was influencing how she engaged with professionals, he dictated what she should or shouldn't do and he stopped her accessing the help that she needed.

5.5. She went to stay with her sister when her mental health became so bad, she couldn't be on her own and on reflection believes that her brother-in-law took advantage of her vulnerability at this time.

5.6. In particular she deeply regrets declining the Mother and Baby placement prior to Baby A's birth, she was able to say that she knew at the time that it was the right thing and that she needed support, but Baby A's Father put pressure on her to decline this and she

believed that this was because he wanted to be an active part of their lives. She said if she could "turn back the clock" she would have gone to the Mother and baby placement.

5.7. She expressed that she is rarely able to build meaningful relationship with professionals and she feels very let down however recognised that services were trying to help her. In particular she said her personal advisors had been consistent and "very, very good".

5.8. She said that when she turned 18, she felt as if she was "thrown into adulthood", into a flat during the COVID-lockdown and she couldn't cope with the constant silence and she found it difficult to cope with being alone. She was frustrated with mental health services as she didn't know who she was supposed to turn to. She felt so alone during her pregnancy as felt scared of becoming a Mother and she knows that she should have accepted the help that was offered but she felt overwhelmed, she acknowledged that she hadn't worked with services and that she should have.

5.9. In particular she found going home with Baby A to be overwhelming, she said it was "awful" having people she didn't know coming into her home although she knows it was necessary. She felt sad that she had no family that were really supportive.

5.10. She explained that it had been difficult to tell people who Baby A's father was due to the complexity of her relationship with her sister and him. However, it would have been helpful if people knew why she refused some of the help she was offered.

5.11. Mum expressed how much she loves Baby A and how she wants her to have a good future. She feels scared for the future and can't look forward at the moment.

## 6) Summary of timeline crucial to learning

| Episode | Key Points |
|---|---|
| **Early and later history (Mum)** | - Significant childhood trauma, sexual exploitation, mental health issues, cannabis use.<br>- Several child and family assessments throughout this time.<br>- CAMHS input |
| **Care Experience (Mum):** | - 2 episodes of being accommodated under s20 aged 16 and 17 (2018 & 2019)<br>- significant CSE issues in between these episodes<br>- Supported as care leaver from 18 in solo accommodation (2020)<br>- Regular PA sessions offered<br>- COVID-19 |
| **Mental Health** | - Robust offer with regular sessions pre-18<br>- Psychological therapy uptake pre-18<br>- Significant gap post 18 years until adult mental health services were accessed in crisis<br>- Involvement of Home Treatment Team<br>- Involvement of Perinatal Mental Health Team<br>- Signposted to drug services with little uptake |
| **Pregnancy** | - Identity of father unknown<br>- Living arrangements – between own home and sister's home<br>- Deteriorating mental health- episodes of crisis in between declining offers<br>- Ongoing cannabis use |

| | |
|---|---|
| | - Sporadic contact with services (Midwifery, perinatal mental Health, Family Nurse Partnership) due to failed appointments, difficulty contacting Mum<br>- Some services discharged mum due to lack of contact<br>- Early referral to the "Baby and Me" service but drifting assessment period- C&F assessment concluded same month as birth<br>- X2 strategy meeting- decision to initiate S47<br>- Early birth (4 weeks early) |
| **Post Pregnancy** | - Initial Child protection case Conference (ICPCC) held post birth and CP plan commenced<br>- Mother and Baby placement offered and declined<br>- Discharge plan agreed with multiple daytime and night-time visits<br>- Core Group/ CP plan met twice<br>- Deteriorating situation with escalating concerns about mental health, cannabis use, poor uptake of services/ missed calls and appointments<br>- Reports of poor state of property<br>- Baby A was reportedly clean, well dressed and fed during this period<br>- Concerns about safe sleeping noticed<br>- Concerns that Mum did not know how to interact with baby<br>- Legal Planning meeting- threshold for proceedings met<br>- Injury to Baby |

## 7) Positive Practice identified

The following areas of positive practice were identified during the Review:

- Joint visits between agencies facilitated
- Leaving Care Service linked with other agencies throughout
- Good attendance and contributions at multi-agency meetings
- Timely referrals to services e.g. Perinatal mental Health, Family Nurse Partnership
- Meetings arranged within statutory timeframes
- Multiple communications across agencies

## 8) Learning

8.1. The review has identified learning following consideration of the following areas of practice that were identified during the rapid review process, highlighted within the agency reports, discussed at the practitioner event and from speaking to Mum.

| Areas of learning: |
|---|
| Knowing the history - impact of trauma, transition from childhood to adulthood and impact on parenting |
| Role of the Father |
| Childs lived experience |
| Professional challenge/ joint management of risk from pre-birth, application of policies in practice |
| Impact of Covid |

## 9) Knowing the history

9.1. A large number of case reviews completed in recent years have highlighted the importance of considering, understanding and sharing details of a parent's history if it may have an impact on the care of their child. It is known that when children and young people are subjected to difficult experiences, it can have an effect both at the time and when they become parents themselves. Research into Adverse Childhood Experiences (ACEs) states that the more additional ACEs a child experiences and the longer they experience them for, the worse their physical, mental, and social outcomes are likely to be. This includes the possibility that their own children will be known to safeguarding services, and that their longer-term mental health will be adversely impacted. In respect of Baby A's mother, there was good awareness across agencies of her significant mental health history, history of exploitation, usage of cannabis and other more recent and current vulnerabilities.

9.2. One of the practitioners at the Practitioner Event acknowledges that "just because you turn 18 doesn't mean you can function as an adult" and this has been a helpful reference point for the review.

9.3. For some adults who have experienced ACEs, there may be protective factors and individual levels of resilience so negative outcomes should not be assumed. However, they always need to be considered on a case-by-case basis and this case indicates the impact that ACEs and cumulative traumatic events did result in negative outcomes.

9.4. Mum experienced two periods as a looked after child, one when she was sixteen and one when she was seventeen. The Rapid Review found that the Looked After Children (LAC) service had limited opportunities to engage with her and to fully understand the complexity of her life experiences and her needs.

9.5. Mums' history was outlined earlier in this report however in summary she had experienced trauma, rejection, and a lack of positive parenting or attachment throughout her childhood. In between her episodes of care, she lived with an adult who subjected her to sexual exploitation and abuse and rejection, and she has significant mental health needs. It was known to services that she found it difficult to regulate anger or behaviour and self-medicated by smoking cannabis frequently to "numb" her feelings. In order to successfully transition to adulthood she required a comprehensive programme of support, nurturing and engagement with many services for a prolonged period of time.

9.6. It is important to note that most parents or carers who experience mental ill health will not abuse or neglect their children. However, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured parental mental health problems[8]. Additionally, the risks to children are greater when parental mental health problems exist alongside problems such as unemployment, financial hardship, poor housing, discrimination, and a lack of social support. Together, these problems can make it very hard for parents to provide their children with safe and loving care. In this case Mums mental health problems were accompanied by social isolation, recent trauma, cannabis use and family dynamic complexity.

9.7. Analysis of the chronological involvement with services tells a difficult story of challenges with pathways resulting in delays and gaps in services being offered. It is reassuring to

[8] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

see that this was not the result of practitioners not recognising or trying to facilitate the right services- instead barriers and problems with IT systems, misinterpretation of need and policies such as discharge due to "lack of engagement" which are not helpful for an 18-year-old with multiple complexities. The additional finding was that the offer and criteria for CAMHS and adult mental health services are very different and significant work is ongoing in Redbridge to bridge the gap for 18–25-year-olds.

9.8. Prior to pregnancy, the Leaving Care service held sole case responsibility for coordination of services for Mum. There were some changes at that time for the services which was again provided by the Council and seemed to be effectively managed. However, in view of the complex presentation and the sheer amount of coordination required in this case, it is not clear whether the service is equipped to navigate its way through the provision of mental health services and how this changes pre and post 18. This raised the question of whether there could be a different pathway or wider service scope to connect the LAC and leaving care services with Mental Health Services.

9.9. In this case it is evident that services absolutely understood the need for a seamless transition into mental health services and significant efforts were made to try and facilitate this however, despite these efforts it did not happen, and referrals went from pillar to post around various services resulting in Mum not receiving a service until she presented in crisis.

9.10. The review has not found an absence of services that are trauma informed and available- instead that there was an absence of all those who knew Mum best coming together with her at the leaving care stage to agree the most effective service for her needs.

9.11. Those professionals who know Mum spoke warmly of her and described her as up and down in manner but open about her experiences. Her experiences and risk factors were well known. Mum had expressed her fear of isolation in living on her own and this was recognised by professionals, however because her placement broke down, she was moved into her own independent home around her 18th birthday and on the first day of the national COVID-19 lockdown. Mum told the reviewer that this was particularly difficult for her, and she felt isolated, lonely and like she was going 'mad'.

9.12. There is little doubt that many of those working with Mum knew her very well. There was an admirable commitment to ensuring that she was not labelled by her history, but a recognition that she required support to enable her to live independently and subsequently to positively parent Baby A. The degree to which this was pulled together into a coherent multi-agency plan is less clear with evidence that services worked hard with Mum but struggled to get access to her and it felt overwhelming for Mum. Therefore, there were multiple efforts and approaches, but they didn't always align with each other and must have been confusing and difficult to navigate for Mum.

9.13. In particular the connection between the Leaving Care Service and the Baby and Me (and subsequently Community Social Work Team) did not emerge as connected as it could be given that Mum and Baby were part of the same household. Therefore, other professionals such as Mental Health Practitioners or Midwives were sharing concerns and information two ways which may not always connect. A more connected "family" approach may have helped inform subsequent assessments and risk formulations.

9.14. Like Mum in this case, many children in care have experienced severe neglect in their earliest years. Neglect occurs when physical, emotional, or cognitive experiences required for normal development are either inadequate or absent. The impact is severe whether neglect is deliberate or the consequence of problems caregivers face in managing their own and their children's lives. Children struggle to manage later traumatic events if they cannot regulate emotions or acquire reflective skills to make sense of what

has happened to them. These early experiences can have cascading and damaging effects throughout childhood and adolescence and well into adulthood. This can be applied to Mum in terms of her own childhood experiences but then in turn to her ability to apply appropriate parenting methods to her baby.

9.15. It is reflected in Mums Leaving Care pathway plans that she was not ready to be fully independent, however the enormity of being responsible for a baby with the adversity that she faced should not be underestimated and one could consider that she was set up to fail at home with Baby. This will be explored later in the report.

**Learning:**

- There remains a need in the area for professionals to consistently consider and apply the impact of cumulative harm and a parent's own history to the current situation- this should be applied to risk assessment and support packages for the family .
- Pathways for care leavers to ensure good transition of mental health services should be reviewed to ensure seamless transition into the most appropriate service.
- There is a need to ensure connectivity between LAC/ Leaving Care teams and generic Children's Services team facilitate a "family" approach.

## 10) The Father

10.1. Within this section of learning it should be acknowledged that the identity of the Father was only known post incident. However, the review has found some areas of practice where professional curiosity could have been more robustly applied to understand some of the unknown pressures to Mum.

10.2. Learning has been identified nationally about the requirement for meaningful involvement with fathers by professionals working with children within the CSPR of non-accidental injury in children under one. This was published in 2021[9].

10.3. Fathers should always be considered and involved during the pregnancy, at the time of the birth and in the months that follow. Albeit with the benefit of hindsight there is an emerging pattern of control and influence now apparent that has contributed to an understanding of why Mum made certain decisions and appeared reluctant to work with services or professionals in the way that may have helped.

10.4. In this case Mum specifically told the reviewer that the reason she declined her Mother and baby placement was due to the pressure that baby's father put on her to remain at home. She regrets this deeply as she knew that was the right thing at the time for her and baby but was pressurised to decline this and she truly believed that he would step in and support her. This leads to the question of whether her reason for refusing the placement could have been better explored and understood by all agencies.

10.5. There is evidence that the Social Work Team were proactive in discussing this several times with Mum and understood that Mum was fearful that the placement would lead to baby being removed from her care, despite reassurances that the purpose of the placement was to keep them together. The perception was that her sister was the influencing factor and the social work team worked with sister and maternal grandmother to support them in encouraging Mum to accept the placement. Baby A was subsequently born prematurely, and Mum did agree to the package of day and night home visits as an alternative.

[9] National Review of Non-Accidental Injury in under 1s (publishing.service.gov.uk)

10.6. Professionals knew that Mum was having contact with and getting support from her sister and sister's partner. It was expressed at the practitioner event that some professionals suspected that he may have been the father of Baby A but there was little evidence of any challenge about this or his role.

10.7. Scrutiny of the agency information demonstrated that there were several occasions where professionals felt that "brother-in-law" was controlling Mums decision making. There were multiple references to him speaking over mum, not allowing her to voice her opinion and making decisions on her behalf.

10.8. Mum cites her relationship with Baby A's biological father as negatively affecting her mental health and detrimental to her ability to work with services to maximise her parenting abilities.

10.9. It was also documented that due to the involvement of Children's Services with Sister and Brother-in-laws family unit, he was reluctant to allow professionals in the house thus blocking appointments when Mum was visiting or staying with them. It was documented elsewhere that Mum was helping them out financially despite not being in a position to do so.

10.10. However, although this was noted on several occasions, there was still a perception that Sister and Brother-in-Law were protective factors and supporting influences. It is easier with the benefit of hindsight but there was evidence that their influence was having a negative effect on Mums mental health and access to the services being offered.

10.11. Those involved with Mum during her pregnancy did not feel that it would be appropriate to pressurise her to disclose who the father was or might be. This does pose a dilemma to professionals however, who would want to involve a child's father in assessments and plans and key meetings such as child protections conferences. In this case had that line of enquiry been followed, services would have been aware that there was a controlling element to his behaviour. Additionally that the dynamic of his family connection to Mum was adding a very stressful and difficult dimension to Mum's wellbeing.

**Learning:**

- Fathers should not be missed or be an after-thought – at every meeting fathers should be considered as a potential risk or protective factor to a child. All professionals have a responsibility to engage with fathers or question any apparent lack of engagement from other agencies.
- Reasons for refusal to disclose the identity of a Father should be considered in terms of risk assessments and explored further.
- When relying on the support provided by wider family members to reduce any risk to a child, it is important to make checks and assess their suitability for the role.

## 11) Child's lived experience

11.1. When there is a parent who is vulnerable, as Mum was in this case, it can be difficult to vigilantly consider the child's lived experience while providing support and advice to the parent. Mum's own needs could dominate conversations with and between professionals. An awareness of and focus on the risks to the child from the parent's vulnerabilities is essential. In this case there were concerns about the impact on Baby A of maternal mental health and drug use. Along with this there were the added risks of a move to a new flat alone when professionals had documented and shared concerned about her ability to cope.

11.2. Baby A was 10 weeks old when she sustained a head injury. She lived with her mother with an initial package of support including several daytime visits and waking night-time support. A Mother and Baby placement to support mum in view of her complexity and mental health difficulties had been declined. The reasons for declining this placement are known only in hindsight but may have been better explored at the time. In terms of considering this planning through the experience of Baby A, this placement would have provided her with a more stable and predictable start in life and multiagency planning and decision making will be explored in relation to this.

11.3. Analysis of Baby A's first 10 weeks prompted consideration that practitioners may have focused too much on the needs of the mum and her vulnerabilities and not enough on the implications of her vulnerabilities on Baby A.

11.4. It is helpful to reflect on Baby A's experience from the observations shared within agency reports and from Practitioners. It is documented several times that Mum said she didn't think she was "good enough", she was noted to be angry at times and appeared to be under the influence of cannabis on many occasions. Her engagement with professionals reduced at the times that she felt at her worst from a mental health perspective.

11.5. Practitioners described how mum needed a lot of information to care for Baby A such as safe sleeping advice, feeding advice and information about how to interact with and stimulate Baby A such as talking to her.

11.6. Records report that Mum did have a friend visiting on occasion but there is no record of any names or exploration of who that person was. In the early weeks, it is noted that Sister and Brother-in law were present occasionally, and over the Christmas period she did visit them.

11.7. It is observed that Mum was warm towards baby, was seen to cuddle her and stroke her face and that she was receptive and responsive in the main when she was advised about elements of care. Baby was noted to be clean and appropriately dressed throughout the records. Mum did admit that she did not know a lot of things about caring for a baby and she recognises that the Mother and Baby placement would have given her a better start.

11.8. However, there were also occasions when Mum would have angry outbursts and shout near Baby A and on one occasion baby was noted to flinch, this was noted during a video call and had not been observed previously, this did prompt a visit, but it is not evident whether this observation prompted urgent review of baby A's lived experience. Albeit the Legal Planning Meeting did take place in view of the overall deteriorating situation.

11.9. It was also known by agencies that Mum continued to smoke cigarettes and cannabis. Although Mum reported that she did not do this near the baby, there was frequently a strong smell and Mum did often appear to be under the influence of a substance. She had been referred to R3 which is a support service for people affected by drug and/or alcohol services. Mum did not engage with this service and so the issue was never mitigated against. The experience and risk for a baby living in an environment where cigarette smoke and cannabis is present should always be considered.

11.10. There was sufficient concern about neglect that Baby A was subject to a child protection plan aged 9 days. There were multiple people observing Mum and Baby at different times of the day and night and there are mixed reports that varied from day to day. However, as the weeks went by Mums mental health deteriorated, she struggled to regulate her anger and emotions and she was observed to find basic care difficult at times such as providing Baby A with cold milk, not following safe sleeping guidance, and missing crucial

appointments with professionals. This prompted a legal planning meeting and a plan for proceedings, unfortunately in the meantime Baby A sustained a head injury.

11.11. Considering the pre-birth presentation and her first few weeks through the lens of Baby A it is indicated that agencies did not interpret their findings well enough collectively to protect Baby A. A timelier pre-birth assessment is likely to have prompted earlier consideration of risk and legal planning processes.

**Learning:**

- Any change of circumstances or sharing of concerns must consider, first and foremost, the impact on the child. Professionals need to balance supporting a vulnerable parent with clear child focused challenge about the potential for a negative impact on the child.
- Professionals need to be clear about the impact of substance misuse on children and unborn babies, including on the parent/carers ability to protect their child from harm.
- Consideration should always be given to who is in the family home when considering a child's lived experience.

## 12) Professional Challenge/Joint Risk assessment

12.1. There were multiple risk factors well known to professionals in this case. As a result of this, there were also multiple practitioners and services involved in providing support and working with both Mum and Baby A. There were the "adult focused services" that were already involved with Mum from the leaving care team, drug services and mental health services, then there were maternity and perinatal services leading to Children's Services and Universal plus for baby A.

12.2. The reviewer is keen to acknowledge that each service and professional worked incredibly hard to support Mum and baby and the sheer number of telephone calls, contacts, visits, and emails between services is reflected throughout the records and within the practitioner event.

12.3. It can be observed throughout that there was constant consideration of risk, escalating concerns and efforts to address issues as they arose. What is less evident is how the emerging picture over the timeframe of this review informed joint approaches in order to reduce risk, instead strategies and plans were often reactive to a given situation rather than responsive to a cumulative picture of risk factors.

12.4. There were opportunities pre-pregnancy, during pregnancy and post pregnancy to have worked together differently and some of the barriers that prevented a successful approach include insufficient transitional arrangements from child to adult mental health services, delays in decision making as Mum moved backwards and forwards across boundaries and often due to poor engagement, delays in carrying out assessments and interventions.

12.5. In April 2020 Mum aged 18 moved into her own accommodation. She said that she was scared of moving to her own place and she couldn't face being alone. This was very soon after she had suffered an extremely traumatic experience, unfortunately the response to what had happened to her was inconsistent due to geographical council boundaries and thus delayed a meaningful trauma informed therapeutic package of support.

12.6. Compounding this was a difficult transition into adult mental health services for various reasons which are considered earlier in the report, suffice to say she did not receive mental health support for a period of time when she most needed it.

12.7. Mum spent a year yo-yoing between her sister and brother in laws address and her home address and despite efforts of the leaving care team, the GP and the CAMHS service that

she had previously engaged well with, she was not able to access adult mental health services.

12.8. In April 2021 Mum presented in mental health crisis which prompted the Mental Health Home Treatment Team to be involved and she was commenced on medications and seen regularly. However, at this time she informed services that she was pregnant, and this triggered a referral to Perinatal Mental Health Services.

12.9. In July 2021 the Midwifery team made a referral to Children's Services for pre-birth assessment in view of the complex vulnerabilities that Mum presented with. This was allocated to the Baby and Me team who conduct pre-birth assessments for complex cases at an earlier stage than the generic Children's Services team (before 24 weeks). Unfortunately, there were challenges in accessing/ contacting mum and the progress of the pre-birth assessment was delayed.

12.10. Strategy meetings were held on 4th and 9th November with a decision to initiate S47 enquiries which concluded the day before Baby A was born.

12.11. Throughout pregnancy the risk indicators escalated, uptake of appointments dropped, successful telephone calls and visits reduced significantly meaning that Mum was not receiving the mental health oversight and care or drug service support. Services recognised the risks and shared information with each other regularly. However, there were only two occasions pre-birth that agencies came together at strategy meetings to discuss these issues and the decision was for S47 enquiries to be made. These meetings were very close to the birth of Baby A and left little time for proactive planning. When Baby A was born four weeks early, the plan was to proceed to Initial Child Protection Conference (ICPC).

12.12. The plan to have support workers going into the property day and night when Mum and Baby were discharged home was in place of a Mother and Baby placement which would have holistically and therapeutically considered their needs. It is not evident how the daily observations of this team were considered and listened to in order to aid decision making and risk formulation. There are many reports and phone calls to the allocated children's Services Social Worker, but things fluctuated on a daily basis and were only a part of the overall picture.

12.13. The reviewer did not find that there was a perceived difference of opinion between services and practitioners in terms of how they viewed the issues but the professional dialogue between professionals was limited meaning that communications did not always provide context, clarity, or expert knowledge. Put more simply, communications were vast but often relied on messages or emails. The opportunities where professionals came together to collectively consider the presentation as a whole were not as frequent as they could have been.

12.14. Already identified in this review is the finding that there was insufficient professional curiosity about Baby s father's details, questioning of father's role, or of anyone else who may care for Baby A, which may have informed both clinical and safeguarding risk and provided an understanding of why Mum felt unable to engage with services.

12.15. Taking stock of the plethora of concerns which include a very vulnerable and lonely young person accommodated via the leaving care service, the absence of mental health input at times, social isolation, complex family dynamics, mental health crisis, extensive use of cannabis and a new baby that Mum "did not feel good enough" to parent- it can be seen that as the number of services involved increased, Mums engagement and the uptake of them decreased.

12.16. Paradoxically despite escalating risk factors, multiple services being offered and poor engagement it was some time before Legal Planning processes were instigated very shortly before the injury to Baby A occurred. This should be considered in the context of Baby A being a new-born infant and could have been more robustly explored earlier.

12.17. LPM processes was considered mid November 2021 when S47 processes were initiated shortly prior to birth, this was reflected in Children's Services management oversight and subsequently in supervision. It was concluded that threshold had not yet been reached however if there was continuing/escalating pattern of poor engagement then LPM would take place with a view to use Public Law Outline (PLO) to include a plan for a Mother and Baby placement.

12.18. PLO process takes place when a Local Authority is concerned about a child's wellbeing and unless positive steps are taken to address and alleviate those concerns, the Local Authority may consider making an application to the Court. In simple terms, the PLO process is the last opportunity for parents to make improvements to their parenting before care proceedings are issued. This is known as a "pre-proceedings" meeting.

12.19. This raised the question of whether agencies interpreted their findings together with a joint risk assessment well enough to protect the baby. The overall perception from agencies was that the situation continued to deteriorate and there was not improvement seen. The review finds that the pre-birth assessment could have been timelier, albeit recognising that baby was born early. The review also concludes that there were missed opportunities for Legal Planning processes and use of PLO to have been considered more robustly at an earlier stage:

- 4th and 9th November 2021, strategy meetings, S47 initiated.
- 26th November 2021, Discharge Planning meeting – Mum had declined the Mother and baby placement and agreed to night and day home visits in order to cooperate with child protection processes.
- 2nd December 2021, ICPC – LPM was discussed but not initiated.
- 22nd December 2021, Core Group Meeting.
- 10th January 2022, professionals meeting.

12.20. Due to escalating concerns, a LPM was held on 18th January and the threshold to initiate care proceedings was met. Redbridge Children's Services planned to seek an Interim Care Order, with the view of placing Mum and Baby A in a mother and baby foster placement. It was decided that Mum would not be informed about the outcome of the LPM until the application was made to court to reduce the risk of deterioration in mental health and impact on Baby A. It is noted that during this time there were delays in the availability of court hearing slots and although there was deterioration, there was not a precipitated incident that may have added priority.

12.21. Between the 18th January and the day of the incident there were attempts to contact and visit Mum and Baby A on two occasions (22nd and 24th). There was an opportunity for a more robust safety plan to have been initiated during these 9 days to reflect escalating concerns. The process alone of the LPM and subsequent plan for care proceedings did not protect Baby A.

12.22. Regarding the CP Plan, it is important to note that having a plan alone isn't the protective factor and contrary to risks reducing, they did increase throughout pregnancy (pre-plan) and despite the best efforts of services, continued to escalate from thereon. The CP Plan relied heavily on Mum working with the services in place and the evidence demonstrated that she was not able to do so, and this pattern continued quickly after the plan commenced.

12.23. The reviewer considered Mums behaviour and concludes that there was not any case of disguised compliance, quite the opposite as there was a lack of contact with services and she was presenting in crisis. Nor was there a "rule of optimism", services seemed to have a realistic view of the situation and responded to the evidence presented to them by facilitating services and putting in place wrap around support, and supervision.

12.24. However, the evidence that Mum was not able to engage with necessary service was apparent pre-birth and escalated further from birth and so the agreed strategy was not working and the use of earlier pre-birth planning, joint risk formulation and legal processes could have been applied earlier.

12.25. Redbridge Safeguarding Children Partnership uses a "Neglect Toolkit" which is an approach to neglect that captures strengths and resources. The positive aspects of Mums care was based on this, which is good, and this needed to be better balanced with the child's lived experience to best consider the context of Mum's complex circumstances, mental health issues, cannabis use, ACEs and recent traumatic experience of exploitation and social isolation. The plan in this case was agreed to reduce the risk of the dangers/harms identified but supporting Mum at home and by putting relevant services in place. In this case there was the planned use of the support package on discharge from hospital as part of the safety plan. It is important that there are clear bottom lines however, with robust testing of the plan which includes the skilful use of decision making and a transparent focus on risk. This should ensure that the multiagency team around the child considers evidence and reviews progress. That bottom line of what was acceptable and what was risky was perhaps not defined well enough by the multi-agency team.

12.26. In terms of progression, Redbridge is currently considering its approaches to proactive practice which is very encouraging. The consultation and progress of the Family Hubs in Redbridge outlines its response to the local profile and needs of the population and includes a focus on some of the key areas of risk identified within this review such as mental Health, ACES, and trauma informed practice with an ambition to strengthen joint approaches at an earlier stage.

12.27. This review is mindful of emerging approaches but indicates that it may be timely to reconsider the application of approaches to neglect and the timelessness of legal planning processes when indicated.

12.28. An additional consideration is the particular vulnerability of a new born infant, particularly when born before the expected date of delivery, time frames for statutory meeting may require adaptation given a baby's specific vulnerabilities.

12.29. The reviewer identified key multi-agency policies and procedures that, when used appropriately, provide children with protection. Relevant to this case is the pre-birth assessment procedures and the implementation of a fairly new service (Baby and Me), it may be helpful to consider this from a multi-agency perspective in terms of its application and impact.

12.30. Likewise, policies within agencies around discharging people when they persistently "do not attend" or fail to engage should be considered to ensure they are considered from a safeguarding perspective. Within this case, Mum was discharged from mental health services because she did not engage. Was this applied in the context of safeguarding with a vulnerable care leaver and impact on parenting?

**Learning**

- Strengths based models of assessment and planning for children need to have a clear focus on risk and ensure that all available information is considered when deciding on the safety plan for a child.
- Timely application of statutory safeguarding and pre-legal/ legal threshold procedures need to be considered by professionals at key points in a case and this should be flexible to the needs of the individual e.g. with a new born baby.
- Measurement of the effectiveness, application and impact of policy and procedure should be regularly considered.

## 13) Impact of COVID-19

13.1. There was no evidence to suggest that the COVID-19 pandemic directly caused or contributed to the incident although it can be acknowledged that it did exacerbate some of the issues faced by Mum and the professionals involved. All agencies needed to adapt their practice swiftly to ensure that they were able to provide services to all vulnerable families, including Baby A. The pandemic undoubtedly had an impact on the engagement of professionals with the family, on the ability of some services to make complete assessments and on the need to reinforce case specific advice regarding issues like safer sleeping whilst ensuring Covid-19 safe practice for staff and service users alike.

13.2. The Lullaby Trust published a recent survey in March 2021 which showed 'a concerning indication that lockdown restrictions combined with the increased pressure placed on public health services by Covid-19, means less support and information for new parents, which is putting babies at risk.' In Baby A's case there was a lot to consider in the days following her birth. There was a multi-agency focus on the plan for support, and the need to monitor Mum's mental health. There were no delays caused by COVID-19 restrictions in terms of multi-agency meetings which went ahead with the frequency required.

13.3. For any mother the postnatal period is a vulnerable time where they require high levels of support. A study published in May 2021[10]acknowledges that a lack of social support increases the risk of depression in new mothers and that this was exacerbated by the Covid-19 lockdowns. In this case there was a package of face-to-face support that was implemented, and this was adapted around the required COVID-19 risk assessments.

13.4. It can be acknowledged that prior to the restrictions of the first lockdown Mum was receiving weekly face to face sessions with a psychologist and she engaged well with that. She moved into her own accommodation in the first week of the lockdown and her sessions thereon were via telephone. Following this were the challenges of accessing adult mental health services one of which was not receiving referrals due to COVID-19.

13.5. The review has not found there to be any learning points directly related to the plan for Baby A, however the restrictions did increase social isolation for Mum which impacted on her mental health and access to mental health services.

## 14) Progress against areas of learning

14.1. Throughout the process of this review significant progress has been identified against some of the areas of learning.

[10] Communication Across Maternal Social Networks During England's First National Lockdown and Postnatal Depressive Symptoms. Myers and Emmott. University College London

14.2. **Cross boundary working-** With reference to occasions where cross boundary issues created difficulty, it is noted that this is learning from various areas across London. In response, the London Safeguarding Children Procedures have been strengthened relating to children moving across borough boundaries and relevantly to this case, the Editorial Board intends to develop a protocol with areas surrounding London to ensure the same principles can be applied.

14.3. **Transition into adulthood, Mental Health-** The 18-25 mental health offer was formally reviewed in November 2021- March 2022 and has led to ongoing transformational work for young adults transitioning into adult mental health services. Some of the key lines of enquiry include consideration of age-based thresholds for 18-year-olds, joint working arrangements between CAMHS, adult mental health services and partners, and specifically for care leavers. This transformational review includes immediate plans to recruit an "18-25 practitioner" to navigate the current pathways.

14.4. **Transition into adulthood, safeguarding-** There is currently an ongoing joint priority between Redbridge Safeguarding Children Partnership and Redbridge Safeguarding Adult Board to develop approaches for an effective response for the needs of young adults entering adulthood where there are specific safeguarding concerns including risk of exploitation. Part of this priority work proposed a Multi-agency Transitional Safeguarding Panel to facilitate a plan of support for any young person turning 18 in the next six months as they transition into adulthood. Of relevance, for a child in care or a child under the children with disabilities service, this would still be managed via the existing transitions panels. The new panel has not yet been implemented and updates are scheduled to be reported into the RSCP and RSAB in October 2022.

14.5. **Domestic Abuse informed approaches**- In recognition of the "hidden/un-identified male" in this case and the controlling and coercive behaviour that came to light in the course of this review, it has been helpful to consider approaches in Redbridge to strengthen professional curiosity and ways of working. The Home Office have funded The London Partnership (including Redbridge) to implement the Safe and Together Model. The model is being embedded in a variety of ways including training, practitioner consultation, launch of a toolkit and audit and evaluation. The model aims to help Child Protection professionals to take a domestic abuse informed approach in assessments, interviewing, documentation, and case planning.

14.6. **Proactive and preventative approaches to Neglect**- the development of the trauma informed Family Together Hubs provide a foundation and focus on some of the key areas of risk identified within this review such as mental health, ACES, and trauma informed practice with an ambition to strengthen joint approaches at an earlier stage.

14.7. **Absent Fathers**- Children's Social Care have developed a specific training module on "absent father" which is currently being rolled out and disseminated within the agency. There is however scope for this to be promoted across the partnership.

## 15) Conclusion

15.1. The injury caused to Baby A was significant and due to the welfare visit that took place in January medical intervention was sought quickly and baby has recovered well and is currently living within a stable foster placement with supervised contact with Mum. Childcare legal and criminal proceedings are ongoing.

15.2. Baby A's mum contributed significantly to the review allowing the process to see her experience of motherhood through a different lens. The Partnership recognised that there were lessons to be learned for the way that agencies worked together in this case

and the way that they engaged with and supported Baby A's Mother in respect of her predisposing vulnerabilities and the risks these might pose to her baby.

15.3. There was a picture known to agencies of Mum's life and the vulnerability factors as a result of this. This includes a history of childhood abuse, abandonment and rejection, sexual exploitation, cannabis use and significant mental health issues. Mum was open in telling services how anxious, scared, and lonely she felt and how worried she was about being a Mother. During pregnancy and after birth there was a deteriorating picture of Mum not coping well living alone with Baby A and despite the best efforts of services, this continued to get worse. Mum stated, "I was alone, I had no one".

15.4. There is learning within this case about the vulnerability of care leavers entering into adulthood and how they could be better supported. There is also learning about how best to apply policy and procedure to have an impact on outcomes and the important of robust pre-birth planning and innovative neglect approaches. The review concludes that had the pre-birth planning been conducted sooner, it is probable that legal planning processes would have been considered far earlier. The review also highlighted learning about the identity of the Father, who in this case was hidden.

15.5. There has been a high degree of cooperation and engagement from agencies in the area with the review. These have already resulted in changes being made, such as consideration of the transition pathways within mental health services and Trauma informed Family hub approaches.

15.6. The purpose of providing recommendations is to ensure that the Partnership are confident that any areas identified as being of particular concern are addressed.

15.7. Six recommendations were made to the Partnership where assurance is required, or developments indicated.

## 16) Recommendations

**Recommendation 1:** The Partnership to make promoting the involvement of fathers a key focus of its work.

**Recommendation 2**: The Partnership to consider the scope of the Leaving Care Service and how it aligns with the wider partnership offer of services

**Recommendation 3:** Transition from child to adult mental health services are not only relevant for care leavers, therefore the Partnership should assure itself that the transitional pathways are flexible and seamless.

**Recommendation 4:** The Partnership to consider the timeliness of pre-birth assessment and reassure itself of application and impact.

**Recommendation 5**: The Partnership to seek assurance that risk formulation applied in statutory meetings is realistic, consistent, timely and reflective of a full multi-agency view. Furthermore, that when progress is not evident, and risk is increased that Legal Planning threshold is always revisited and tested.

**Recommendation 6:** The Partnership should review its approaches to neglect and seek assurance that consistent trauma informed, strengths-based models of working are being implemented across the agencies.

**Recommendation 7:** The Partnership should seek reassurance that agency policies that are applied when people "do not attend" or "do not engage" with services are reflective of safeguarding risk.