Calderdale Safeguarding Children Board

CHILD N
SERIOUS CASE REVIEW

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CLARE HYDE

THE FOUNDATION FOR FAMILIES

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Key People in Child N's Life

- Mother - Child N's Mother
- Father - Child N's father
- FM - Mother's foster mother
- MGF - Mother's father and Child N's Maternal Grandfather
- MGM - Mother's birth mother and Child N's Maternal Grandmother
- MA - Mother's sister and Child N's Maternal Aunt
- PGM - Father's mother and Child N's Paternal Grandmother
- Male 1
- Male 2
- Male 3
- Male 4
- Male 5 - Living with Child N at the time of his death
- Male 6 - Friend of Mother present in the home at the time of Child N's death

Glossary of Acronyms

- LCSW - Leaving Care Social Worker
- GP- General Practitioner
- FNP practitioner - Family Nurse Programme Practitioner
- HV - Health Visitor
- PO - Police Officer
- SW - Social Worker
- P- Paediatrician
- CSC - Children's Social Care
- SNP - Senior Nurse Practitioner
- CP - Child Protection

Child Protection Medicals timeline

- 12th August 2015- Leeds General Infirmary (LGI)
- 8th July 2016 - Calderdale and Huddersfield Foundation Trust (CHFT)
- 18th July 2016 - CHFT
- 21st July 2016 - CHFT
- 3rd August 2016- CHFT

Introduction

1. This Serious Case Review (SCR) concerns Child N. Male d.o.b. 26 02 2014
2. Child N died on 8th August 2016 when he was aged 2 years and 6 months.
3. Child N was at home with his mother, his mother's boyfriend of 3 months (Male 5) and a friend of his mothers' (Male 6) at the time of his death.
4. An ambulance crew were called by Male 5 on the morning of the 9th August 2016 after Child N was found lifeless in his bed. The ambulance crew arrived and found the Child N lying on the bedroom floor not breathing cyanosed* with markings to his neck, under his jaw line and right eye. Resuscitation was commenced on arrival and throughout transportation to Calderdale Royal Infirmary where after a full assessment he was pronounced dead.
   *Cyanosis refers to a bluish cast to the skin and mucous membrane.
5. The cause of Child N's death was ascertained as Natural Causes.
6. Child N underwent a Child Protection Medical in August 2015 whilst resident in Bradford and 4 further Child Protection Medicals on 8th July, 18th July, 21st July and 3rd August 2016 whilst living in Calderdale.
7. Child N lived with his mother in Bradford from his birth until sometime in May 2016 when they moved to Calderdale therefore this SCR focused upon both area's agency involvement with Child N's and his family in order to identify learning and missed opportunities to safeguard Child N.

The SCR: Process and Methodology

8. The Local Safeguarding Children Board (LSCB) agreed on the 19th January 2017 to commission a Serious Case Review (SCR) concerning the death of Child N. The scope of this SCR was to cover the timeframe from 1st July 2013 which was the date that Child N's pregnancy was confirmed to 9th August 2016 which was the date of the Child N's death. (It was agreed by the SCR Panel that any significant events prior to this date would also be included within the scope of the SCR).
9. Bradford Safeguarding Children Board and partner agencies from Bradford made significant contributions to the SCR process as Mother and Child N had lived there until May 2016. This report was produced in collaboration with Bradford Safeguarding Children Board.
10. The Case Review Sub Group made a recommendation that the LSCBs should conduct a proportionate, appropriate and participative SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place.
11. The SCR was designed and led by Clare Hyde MBE, independent reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms. Hyde developed a review model that would enable participants to consider the events and circumstances, which led up to the tragic death of Child N.
12. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from SCRs 2009 -2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from SCRs can be most

effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.

13. A SCR Panel was convened of senior and specialist representatives from agencies involved with the family in the time covered, to oversee the conduct and outcomes of the review.
14. The panel established the identity of services in contact with the family during the time frame agreed for the review.
15. Reviews of all records and materials that were considered included;
    - Electronic records
    - Paper records and files
    - Patient or family held records.
16. Agencies that identified significant background histories on family members pre-dating the scope of the review provided an account of that significant history.
17. The agencies that had significant involvement were required to provide an individual management review (IMR) which were completed by senior members of staff who had no direct involvement or responsibility for the services provided. Individual management reviews were completed using the LSCB template and were quality assured and approved by the most senior officer of the reviewing agency.
18. The following agencies have provided an IMR:
    - Bradford Children's Services
    - Calderdale Children's Services
    - Bradford District Care NHS Foundation Trust
    - Calderdale and Huddersfield NHS Foundation Trust
    - Together Housing
    - Leeds Teaching Hospital
    - Bradford Teaching Hospitals NHS Foundation Trust
    - West Yorkshire Community Rehabilitation Company
    - West Yorkshire Police
    - General Practitioners for Child N and mother
    - Child N's Nursery School
19. All IMRs have been challenged robustly and where appropriate, subject to review and revision since their initial submission.
20. A full day Learning Event for practitioners and their line managers who had worked with the family (or who could contribute to learning) was held in November 2017. The outcomes from the Learning Event were twofold:
    - Practitioners and managers were able to share their experiences of working with the family and contribute to the information provided by agency chronologies and IMRs i.e. understanding not just 'what happened' but 'why it happened'.
    - Practitioners and managers were able to contribute to discussions about what improvements in policy and practice are required.

Key Lines of Enquiry

21. The SCR Panel agreed the scope of the SCR. The SCR panel also considered key lines of enquiry which were then included in the terms of reference. These included:

A. Were single and multi-agency assessments and interventions child focussed, accurate and acted upon? Did agencies recognise and assess risk in respect of Child N? The detailing of each individual risk that was identified and how each was assessed.
B. Was the parenting capacity of Child N's Mother assessed effectively? In particular did agencies consider historical information with regards to the Mother of Child N and the affects this could have on her parenting of the child? (Including history of childhood sexual abuse, becoming a looked after child, domestic abuse)
C. What, in this case, reassured practitioners that Child N was safe and well? Were any signs of abuse missed by practitioners?
D. What can we learn from our response to Child N and his family and from the engagement with the Mother of Child N, partners, and extended family in fully understanding vulnerability, harm, risk, and effective interventions?
E. Were the frequent changes in relationships of the Mother considered in respect to the effect on Child N's behaviours? How were the risks each different partner presented to Child N identified and assessed? With the detail for each individual partner and Child N's father.
F. Explore whether Mother and/ or Mother's partners were able to collude or deceive agencies, why this was able to happen and whether there are lessons that can be learnt.
G. Was professional practice informed by appropriate and effective supervision?
H. Was professional practice and supervision informed by research and evidence-based practice?
I. Were single and multi-agency communications and information sharing appropriate, accurate and acted upon? How well was information shared, understood, and responded to between agencies?
J. Determine whether the National, Regional and Local policies, procedures, thresholds, and practice expectations of the agencies in use were followed during this period.
K. Consider whether there are any common themes from previous serious case reviews or critical incident reviews and the effectiveness of agency's actions in relation to these.
L. Identify learning that will help partners and the LSCBs to strengthen understanding of and response to Child N and to all vulnerable children and young people.

Independence

22. The lead reviewer Ms Hyde is independent of any service or agency in Calderdale. Ms Hyde was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.
23. Ms Hyde is currently working with local health, social care and criminal justice commissioners and families to re-model how support services are commissioned and provided.
24. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair and Reviewer of several SCRs and a Domestic Homicide Review and has designed and led several Learning Reviews on behalf of local safeguarding children and adults boards.

Serious Case Review Panel

25. The SCR Panel met on a number of occasions between June 2017 and February 2018.
26. The overview report was ratified at the Calderdale Local Safeguarding Children Board meeting on 19th July 2018
27. The Panel comprised of:
    - Calderdale Safeguarding Children Board Business and QA Manager
    - Bradford Safeguarding Children Board Manager
    - Service Manager, Children's Social Care, Calderdale MBC
    - Named Nurse Safeguarding Children, Calderdale and Huddersfield NHS Foundation Trust
    - Consultant Paediatrician, SUDIC, Calderdale and Huddersfield Foundation Trust
    - Senior Children's Centre Manager, Calderdale
    - Named Nurse for Safeguarding Children/Deputy Head of Safeguarding Leeds General Infirmary
    - Designated Nurse Safeguarding Children, Calderdale Clinical Commissioning Group (CCG)
    - DCI, West Yorkshire Police
    - Network Developer, The West Yorkshire Community Rehabilitation Company
    - Principal Child and Family Social Worker, Calderdale MBC, Interim Calderdale Safeguarding and QA Service Manager (February – November 2017)
    - Head of Income and Tenancy Sustainment, Together Housing Association
    - Named Nurse Adults and Children, Bradford District Foundation Trust
    - Head of Service, Children's Specialist Services, Bradford City Council
    - Named Dr for Safeguarding Children, Bradford NHS Trust
    - Deputy Designated Nurse, Bradford Airedale Wharfedale and Craven CCG's
    - Clinical Quality Lead, Family Nurse Partnership National Unit

Confidentiality

28. Working Together to Safeguard Children (2015) clearly sets out a requirement for the publication in full of the overview report from SCRs:
    "All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."

Family involvement

29. It was not possible for the Lead Reviewer to meet with Mother or Father or other family members during the course of the SCR as there were on-going police investigations.

Staff involvement

30. The staff who were involved with Child N's family participated in a Learning Event in November 2017. The Learning Event was attended by practitioners who had had direct

involvement with Child N and his family, in addition to the Lead Reviewer who facilitated the event and the Calderdale LSCB Business Manager, Designated Nurse for Safeguarding Children (Calderdale) and the Calderdale LSCB Business Support Co-ordinator.

Race, Religion, Language and Culture

31. Child N's family are White British. The cultural identity of other people involved in Child N's life is not known therefore this did not inform assessments by services or the SCR process. Similarly, it is not known if religion was a feature of the family's life. The family's first language is English.

Summary of Family history

32. What is known about the Child N's family history and the history of some of the other adults involved in his life is detailed below.
33. Mother and her family originate from the Bradford area.
34. Mother was removed from the care of her parents (MGF and MGM) at the age of six due to her younger siblings having suffered non accidental injuries. Mother also underwent a Child Protection Medical at the age of 6 for a suspected cigarette burn and unexplained bruising.
35. Whilst in foster care Mother disclosed sexual abuse naming her maternal uncle, maternal grandfather, and father as the perpetrators. There is some uncertainty as to whether her father was a direct perpetrator as Mother called her uncle and father daddy. An assessment was undertaken and concluded that both birth parents were unable to protect their children and Mother and her siblings remained in the care of the local authority.
36. Mother's mother (MGM) had an alcohol addiction.
37. Mother's father (MGF) was convicted of 3 counts of sexual assault against a 9 year old girl in 1990.
38. Mother remained in foster care with the same foster parent (FM) until she was 18 years of age and in May 2013 moved into her own tenancy.
39. Mother became pregnant with Child N in July 2013. The baby was diagnosed in utero with Hydronephrosis; a serious kidney condition in November 2013. Hydronephrosis is the swelling of a kidney due to a build-up of urine. It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction.
40. Child N was born in February 2014 and remained in hospital for a total of 3 weeks (Bradford then Sheffield then Leeds then discharged)
41. At 3 weeks old and whilst he was in hospital MA and others are alleged to have threatened to abduct Child N from the ward as MA had been told she could not visit the baby due to her being in an abusive relationship.
42. Throughout her pregnancy Mother was being supported by the Bradford leaving Care service and was still in close contact with her FM.
43. Mother was uncertain who Child N's father was, and a DNA test later confirmed who this was.
44. Father was not known to agencies beyond universal services.
45. Child N and Mother moved into Fathers home and lived with him and PGM for periods of time during 2014.
46. The relationship between Father and Mother ended in December 2014 although he and PGM maintained regular and frequent contact with Child N. Mother moved into her own tenancy at this point.

47. The relationship between Father and Mother was difficult and Mother described him as controlling and paranoid. She admitted to a practitioner that she had hit him.
48. It is known that Mother was in brief relationships with 6 males (including Father) throughout her pregnancy and throughout Child N's life.
49. Little is known about the males other than Male 5.
50. Male 5 appears to have moved in with Mother and Child N very shortly after Mother's tenancy in Calderdale began.
51. Male 5 was known to agencies as a child as he was living with domestic abuse which he witnessed.
52. Male 5 was a prolific offender from the age of 14 and was convicted of several offences. He was known to have taken amphetamines and to carry a knife (which he stated was for self-protection).
53. Male 5 was under the supervision of the probation service in Bradford at the time of Child N's death.

Overview of events and agency involvement

54. Although the timeframe for this SCR was 1st July 2013 to 9th August 2016 agency records held historical information which is relevant to the case and this has been considered.
55. This section of the report does not chronicle every single agency contact with Child N and his family but describes key contacts and other information held by agencies.

Child N and Mother

56. Mother who is now aged 23 became a looked after child at the age of 6. Mother remained in the same foster placement until she was 18 years of age and had a close relationship with FM until shortly before Child N's death
57. Mother did well both academically and at her workplace where she had previously completed a work experience placement.
58. When she was 15 in November 2009 Mother's boyfriend threw a mobile phone at her face. She was aged 15 at the time and sought treatment in A & E for her injuries.
59. An incident occurred in July 2013 involving Mother, MA and Male 1. Mother was pregnant with Child N at this time. This was recorded by the police as a domestic abuse incident.
60. Mother became pregnant with Child N in July 2013 a few months after leaving FM's home and moving into her own tenancy.
61. Mother was recruited onto the Family Nurse Partnership (FNP) programme November 2013. The Family Nurse Partnership is an evidence-based Nurse home visiting programme developed in the USA. It is offered to first-time young mothers early in pregnancy ideally before 17 weeks gestation, continuing until their child is 24 months old. There are three main aims, to improve maternal and child pregnancy outcomes, to improve child health and developmental outcomes, and to improve parent's economic self-sufficiency. The Family Nurse Partnership (FNP) works with parents aged 24 and under, partnering them with a specially trained Family Nurse who visits them regularly, from early pregnancy until their child is two).
62. The FNP practitioner was given limited information about Mother's history specifically about Mother's experience of childhood sexual abuse and domestic abuse which was known by the Bradford Leaving Care team.

63. In January 2014 Mother who was in a relationship with Father at this point told the FNP practitioner that she was unsure if he was Child N's father. She described him as paranoid and controlling and said that there is a lot of verbal conflict.
64. In January 2014 Mother discussed adverse childhood experiences with the FNP practitioner and felt angry about her own upbringing.
65. Also, in January 2014 whilst heavily pregnant Mother attended the labour ward at BTH and reported that she was experiencing pain. She stated that she had fallen. She also told the FNP practitioner that she had fallen twice. It is not apparent from the information available whether or not any professional asked Mother about domestic abuse or considered that the falls may have been caused by an assault.
66. In February 2014 Mother introduced a new partner Male 1 to the FNP practitioner and said that he may be the father of the baby.
67. Also, in February 2014 MGF was present during an FNP visit. The FNP practitioner recorded that MGF dominated the conversation. She also recorded that Male 1 was present but was on his phone the entire time and that there was no engagement by him.
68. In February 2014 the FNP practitioner telephoned Mother's Leaving Care Social Worker (LCSW) to discuss her concerns about Mother's relationships with males. The LCSW explained that Male 1 was being 'investigated' by Social Care due to his background. (This was a Criminal Record Check)
69. Child N was born in Bradford on 26th February and was transferred to Sheffield Children's Hospital and then to Leeds General Infirmary (LGI) Special Care Baby Unit on 5th March 2014.
70. On 13th March 2014 threats were made by MA and MA's boyfriend that they would kidnap Child N from hospital as they had been told they could not visit him because of their violent relationship. This was reported to the police by Mother.
71. On 18th March 2014 an assessment carried out by a LCSW concluded that Mother was able supervise MGF's contact with Child N (this was because of his history of committing sexual offences against children). MGF visited Mother and Child N whilst they were in hospital.
72. Child N was discharged as an in-patient on 19th March 2014.
73. On 20th March 2014 the FNP practitioner was unable to gain access to visit Mother and Child N. She telephoned the LCSW who explained that Mother's phone was being held by the police in relation to the threats to abduct Child N. The FNP practitioner and the LCSW discussed Mother's relationships with males and the LCSW stated that she and a Children's Social Worker would visit Mother the following day to discuss her relationship with Male 1.
74. On 24th March during the rescheduled home visit mother confirmed the identity of Child N's father to the FNP practitioner and stated that she had no further contact with Male 1. Her mood was 'flat', and she was exhausted.
75. During April and May 2014 Mother was attending all health appointments and caring for Child N and her own mood was stable and her physical health had improved.
76. On 16th May the FNP practitioner carried out a home visit to Mother and Child N at MGM's house in Calderdale.
77. On 29th May at the FNP practitioner's 16th home visit Father was present. No issues were noted.
78. During June 2014 Mother moved in with Father and his PGM. Child N was noted to be thriving. PGM was noted to be a nurturing influence.
79. In July 2014 Mother disengaged with the FNP practitioner but continued to attend the majority of health appointments with Child N (one missed immunisation July 14). The FNP

practitioner made attempts to visit / contact Mother on 30th July, 29th August, 4th November and 4th December 2014.

80. On 11th December 2014 the FNP practitioner carried out a home visit. Mother was in her own tenancy and informed the FNP practitioner that she and Father had split and discussed Father's increased cannabis use.
81. During February 2015 Child N was admitted to LGI for a week due to an illness. During the same period Mother disengaged from FNP.
82. On 8th July 2015 Child N was not taken to a hospital appointment.
83. On 10th July 2015 during a FNP home visit Child N was noted to be agitated. A new male partner was present and introduced as Male 2.
84. On 16th July 2015 Child N was not taken to a hospital appointment.
85. On 24th July 2015 the FNP practitioner carried out a home visit. Male 2 had ripped up parenting information provided by the FNP practitioner and she noted increased tension between Mother and Male 2.
86. On 26th July 2015 mother made a call to the NHS 111 help line to ask for advice about Child N who had sustained head and knee injuries. This did not result in a hospital admission and it appears that Child N was treated at home. Mother stated that she was not present at the time of the injuries.
87. On 6th August 2015 Mother attended a 'pre op' clinic with Child N who was due to have a medical procedure related to his kidney condition. During the clinic Mother raised concerns with the paediatrician (P1) as she and FM had noted that Child N appeared to be sustaining bruising for no reason. The paediatrician planned, during Child N's admission some 6 days later to carry out appropriate blood tests to rule out any physiological cause which could explain the bruising.
88. On 12th August 2015 whilst Child N was in recovery following the procedure the anaesthetist noted bruising on both sides of his chin and elsewhere on his body and made a referral for a child protection medical which was carried out on the same day.
89. P2 carried out the Child Protection Medical and concluded that the bruising was most likely caused by accidental injury and that a full skeletal survey was not indicated at this stage (Mother later alleged that injuries had been caused by Male 2).
90. On 18th August 2015 the FNP practitioner carried out a home visit. Mother and Child N were staying at FM's house. Mother reported that she had ended the relationship with Male 2 as he was shouting at the hospital and at home. Mother was 'stressed' about Child N bruising and his sleep patterns and behaviour.
91. On 2nd September 2015 the FNP practitioner noted a possible disordered attachment between Child N and his mother. Child N was agitated.
92. On 14th September 2015 Child N was not taken to a hospital urology appointment
93. On 23rd September 2015 the FNP practitioner saw Mother and Child N on the street. An unknown male was pushing Child N in his pram and he was not introduced. Mother reported that they were on their way to A&E as Child N had blood in his nappy. Child N was subsequently admitted to hospital with nephritis (inflammation of the kidneys).
94. On 3rd October 2015 whilst Child N was still in hospital concerns were raised by the ward staff and surgical team regarding Mother's new partner (Male 3) being aggressive to staff. He was removed from the ward by police.
95. On 7th October 2015 Child N was discharged from hospital. MGF had visited him and Mother during his inpatient stay and the hospital informed Bradford CSC of the visits.

96. During October 2015 Mother cancelled 3 FNP appointments and said she that she was moving home.
97. On 14th November FM in a discussion with Mother's LCSW mentioned that Child N had what appeared to be a cigarette burn to his hand. This prompted the LCSW to make a referral to the Initial Assessment Team (Bradford CSC).
98. On 3 December 2015 Bradford CSC carried out an assessment. It was during this assessment that Mother disclosed that the bruises to Child N were caused by her ex-partner Male 2.
99. It was also recorded that following this she separated from Male 2. It was further noted that whilst Mother had acted protectively by separating from Male 2 who caused the injury there were concerns that '*she is introducing a number of unknown males to the household who may present a risk to Child N'*. The case was closed by CSC with a plan of support from the FNP and Children's Centre around parenting work and healthy relationships.
100. On 7th December 2015 the FNP practitioner carried out a home visit. Mother was then living at her sister's house. She reported that she had fallen out with FM because of the referral to CSC about the burn to Child N's hand. Child N was noted to be agitated and aggressive.
101. 22nd December 2015 Child N was registered as new patient with a Bradford GP.
102. On 4th Jan 2016 a referral to Bradford Early Childhood Services for support for Mother and Child N was made by the FNP practitioner.
103. During a home visit on 7th January 2016 the FNP practitioner noted inconsistent parenting. Advice and strategies were given to Mother. Mother's frequent changes of male partners and the impact of this on Child N was also discussed.
104. Throughout January 2016 Bradford Early Childhood Services (Children's Centre) attempted engagement with Mother.
105. During January Mother cancelled a hospital appointment for Child N and a FNP visit.
106. A re-scheduled FNP visit was carried out 29th January 2016. An unknown male was present and was not introduced. Mother was noted to be distracted and Child N's behaviour was problematic. Mother was reported to be tense and occasionally annoyed at her child. She said that she felt he had ADHD. Child N's destructive behaviour was observed. No affectionate behaviour noted between Mother and Child N. The FNP practitioner asked to see Mother alone at her next visit.
107. During a home visit on 4th February 2016 by the FNP practitioner Mother identified the unknown male as Male 4. Mother also said that she was pregnant but did not want Male 4 to move in with her. The FNP practitioner again discussed the impact of frequent changes of unsupportive and verbally abusive male partners upon her child's wellbeing.
108. On 9th March 2016 the FNP practitioner discovered that Mother had moved to Calderdale (her exact address is not known at this point). Mother stated that her relationship with MGF and FM had broken down. The reason for the breakdown in Mother's relationship with MGF is not recorded. It was noted that MGM lived in Calderdale.
109. Despite living at an address in Calderdale Mother did access Early Childhood Services (Children's Centre) in Bradford during April 2016 until she informed them that she would be moving permanently to Calderdale.
110. In April 2016 the FNP practitioner telephoned Bradford CSC to check that MGF was allowed contact with Child N. She was advised that he was allowed supervised contact only.
111. On 2nd May 2016 Mother's tenancy in Calderdale began.
112. On 3rd May 2016 the FNP practitioner contacted the Health Visiting Service in Bradford to transfer Mother and Child N and arranged a home visit to the new address in Calderdale.

113. On 7th May 2016 Mother was admitted to Bradford and suffered a mid-trimester miscarriage.
114. On 17th May 2016 Mother registered Child N at a Children's Centre in Calderdale.
115. On 18th May 2016 the FNP practitioner carried out a home visit. An unknown male was present. Mother stated that she had ended the relationship with Male 4 and was in another relationship with Male 5 and that the unknown male present today was not him, but an old school friend not introduced to the FNP practitioner by name. The FNP practitioner arranged to transfer Mother and Child N to the Calderdale health Visiting Service from June 2016.
116. On 23rd May 2016 Child N attended his first nursery session at the Calderdale Children's Centre.
117. On 27th May 2016 Mother attended her GP. It was noted that she was still grieving the loss of the baby.
118. On 31st May 2016 a complaint was received by Mother's social landlord. A neighbour reported that there was loud music playing until late at night. A Housing Officer visited Mother the same day and noted that there was a young male present.
119. On 2nd June 2016 Male 5 told his Probation Officer that he had moved to an address in Calderdale (this was Mother's property). There was no indication given or recorded that anyone else was living at the property.
120. On 7th June 2016 Male 5 advised his Probation Officer that he was living with Mother and Child N and that they had been in a relationship for a short period of time.
121. On 13th June Male 5's Probation Officer telephoned Calderdale CSC to ask if Child N was known to them. He was advised that someone would call him back.
122. On 15th June Mother had an appointment with a Senior Nurse Practitioner (SNP) at the GP surgery. The SNP noted Mother's '*depressed mood. Late miscarriage at 20 weeks, waiting psychological support – was told 6-8 weeks. Has a family support worker in the meantime struggling to cope, goes days without eating, not wanting to get up, struggling to cope with her son. Son has gone to stay for a few days with his Dad to give her a break. Her mum is concerned about her. Has fleeting thoughts that people would be better off if she were dead but son protective factor. To start Sertraline (anti-depressant) review in 2 weeks or sooner if any worsening thoughts*'.
123. On 24th June 2016 Mother informed the CC nursery that Child N had been in hospital due to complaining of tummy pain. The hospital said they could not find anything but to keep an eye out for blood in his stools. Mother also stated that Child N would be absent the following Tuesday due to an ultrasound appointment.
124. On 24th June 2016 an 'Accident at home form' was completed by Mother when she took Child N to the Children's Centre nursery detailing that he had walked into a door, causing a bruise to his right cheek. Mother also stated that Child N also fell onto some glass causing a cut to his right hand, she explained that she was unsure of when the accident happened due to him being at Father's.
125. On 27th June 2016 a second 'Accident at home form' was completed by Mother when she took Child N to nursery. Mother stated that she had noticed a red mark on Child N's forehead and his nose but was unsure as to how he did it. Mother stated that Child N told her he did it on a door and window.
126. On 30th June Mother attended an appointment with the SNP to review how she was feeling. Mother reported that she was "managing ok. Feels slightly more positive, appetite has improved, sleep disturbed, managing childcare ok, supportive family and partner. No Suicidal

Ideation or Self Harm family are protective factor. Euthymic (normal mood), good eye contact and rapport"

127. On 4th July 2016 a third 'Accident at home form' was completed at Child N's nursery. Mother explained that a bruise had happened at Father's house and she was unaware of how it happened.
128. On 7th July the FNP practitioner and a Health Visitor (HV1) from Calderdale carried out a joint home visit. This was the 'handover' visit between services.
129. During the visit 2 'pit bull type' dogs were present in the home. Mother stated that Child N spent weekends with his Father. HV1 noted superficial interaction between Mother and Child N. Child N was noted to have small bruises to either side of his head, close to his temples. Mother reported that she believed these were sustained during play and that he occasionally came home from PGM's home with bruises. Child N was noted to be very active during the visit and climbed up onto a window ledge by using a telephone socket point. Mother expressed concerns managing his behaviour and HV1 discussed a possible referral to the early intervention panel to request support from a family support worker. Mother declined a referral to Insight for counselling for herself. Mother was noted to have a laceration on a finger on her left hand which she stated was infected and that she sustained it 'play fighting' with her current partner. Male 5 was present throughout the visit but did not interact with anyone.
130. On 8th July Child N was taken to the Calderdale A & E department after reportedly falling down a flight of stairs at 06.00 am. He had bruising to both sides of his face and eyes and a left conjunctival haemorrhage. A referral was made to Calderdale CSC Multi Agency Safeguarding Team (MAST).
131. On 8th July 2016 a Strategy discussion was held between CSC and the Police, a S.47 enquiry instigated, and CP medical undertaken by a Paediatrician 3 with a social worker attending. The medical concluded that Child N's bruising was consistent with the explanation provided by Mother that Child N had accidentally fallen down the stairs at home. A plan was agreed to continue with Single Agency Assessment by CSC to determine if there were any unmet needs.
132. The CP medical undertaken by Paediatrician 3 recorded 12 different marks to Child N's body and requested medical photography. Paediatrician 3 concluded that the bruising to his cheeks and forehead could have happened as described by Mother and the petechia on his upper eyelids and posterior aspects of his ears were in an unusual distribution – blood tests were performed which suggested viral infection. There was a crusty lesion to his right palm and Paediatrician 3 felt it was difficult to say exactly what caused this. Bruises were noted to his thighs and shins. Paediatrician 3 advised further assessment and that information was obtained from other agencies.
133. Also, on 8th July a police record details *'In August 2015 Child N was 17 months old and he was seen by Dr1 due to him having a condition of severe Hydronephrosis. At the appointment he was observed to have multiple bruising to both shins and then in unusual places back, buttock, jaw and neck which were all unexplained. The Doctor queried NAI. Neither Health nor Bradford CSC could provide any further information in relation to this. In December 2015 Child N noted to have what looked like a cigarette burn on his arm*' (the suspected burn was to Chid N's hand but recorded here as to his arm)
134. On 11th July 2016 the Deputy Children's Centre Manager phoned the MAST to share information about Child N. She informed the Child Assessment Team Social Worker (CATSW) that Mother had informed the Children's Centre nursery of the CP medical. The Child

Assessment Team Social Worker explained that Social Worker 1 was overseeing this case but was on leave and the social worker doing the assessment would be Social Worker 2.

135. The Children's Centre Deputy Manager explained that she wanted to make social care aware that Child N had presented at nursery with injuries on 4 occasions and they were all head injuries. The CATSW explained that a Single Assessment would be completed by SW 2 who would make contact with nursery regarding the historic injuries.
136. Also on 11th July a further 'Accident at Home form' was completed at Child N's nursery this was in respect of the injuries Child n sustained on 8th July.
137. Also on 11th July 2016 P3 reviewed Child N and noted the rash to his eyelids and ears had gone and the bruises on his cheeks were better. His facial swelling had subsided and P3 was able to examine inside his mouth – his throat was slightly red.
138. On 13th July 2016 Mother contacted the FNP practitioner and described what had happened and how stressed she felt about social care's involvement. The FNP practitioner advised Mother to contact her Calderdale Health Visitor. The Health Visitor spoke with Mother on the same day.
139. On 15th July a further 'Accident at Home form' was completed at the Children's Centre nursery. Child N had a graze to his elbow and Mother said this must have happened at Father's home as Child N had been staying with him.
140. On 18th July 2016 the Children's Centre Nursery contacted CSC and reported two bruises to Child N's chest, chin and penis, for which Mother had no explanation. A decision was made to carry out a CP medical. Paediatrician 4 carried out the medical and concluded that on the balance of probabilities the injuries were accidental (during the medical Child N was noted to be pulling on his penis). Paediatrician 4 expressed concerns about Mother's supervision of Child N. A social worker attended the medical and the police were informed that this had taken place and the outcome but did not attend. A decision was made to continue with the single assessment.
141. Paediatrician 4 also noted that some of the marks to Child N's body were unexplained.
142. On 18th July CSC telephoned the Police and advised them of the outcome of the CP medical (however this telephone call was logged by the police against the entry for 8th July instead of a triggering the creation of a new entry which would identify this as a separate incident).
143. On 19th July Male 5 having missed a scheduled appointment with his Probation Officer on 12th July spoke to him by telephone. The Probation Officer asked Male 5 about his move to Halifax. Male 5 stated that things were going well with his partner (Mother) and that it was good for him to be away from Bradford.
144. The Probation Officer asked for full details of Male 5's address, partner and child so that he could undertake checks prior to arranging a move of supervising officer to Calderdale.
145. On 20th July Mother telephoned CSC to state that Child N had woken with bruising to his jaw and within his ear. A home visit was undertaken by SW2 during which mother stated that Child N had gone to bed the previous night and there had been no bruising. SW2 advised Mother that she would seek management advice to consider what further action is required. A decision made that a further CP medical was to be undertaken.
146. Child N underwent a further CP Medical on 21st July which was undertaken by Paediatrician 5 who concluded that some of the bruises could be the result of Child N's fall down the stairs on 8th July. It was noted during the medical that Child N was very active and boisterous during the examination and that Mother struggled to supervise him. P5 concluded that the extent of

bruising was a concern and the fact Child N had had 5*CP medical examinations in his short life. A social worker attended the medical.

147. *Child N had a total of 4 CP medicals at this point in time. There was confusion about the number of CP medicals carried out as the burn to Child N's hand, although reported to Bradford CSC, had not resulted in a medical this incident was mistakenly 'counted' in as a medical.

148. CSC record that Paediatrician 5 had highlighted that Mother struggled with Child N's behaviours and she did not supervise him. '*It is clear that she needs some intense support. We have attempted to obtain immediate support from the Short Term Family Intervention Team but they have no current capacity. We will refer for a Family Support Worker. The social worker will explore if his nursery provision is all year round as the mother needs some respite and Child N needs to be visible to agencies. The social worker will speak to extended family to determine what support they can offer. We will convene a professionals meeting to ensure we are all working together to ensure Child N is safe and well. Social Worker will speak to mum about a Family Group Conference. Lead professional will visit regularly and will ask that health visitor visits regularly so that we can monitor his wellbeing. The consistent bruising is concerning but we have no evidence to suggest the mother is physically harming her child. Practice Manager will discuss further with Team Manager to determine any need for strategy discussion. We need to consider there is a potential risk as we have on-going incidents of bruising and put in place a plan of monitoring and support to be able to manage any risk*'.

149. CSC arranged a multi-agency professionals meeting which took place on 25th July 2016. Attendees included:

- Children Assessment Team Practice Manager
- Children Assessment Team Social Worker
- Deputy Manager of Children's Centre Nursery
- Health Visitor attending on allocated health visitors behalf

150. Actions agreed included:

- Health visitor to visit Mother and Child N on the 2nd August 2016
- Health visitor to explore Community Nursery Nurse support
- Social worker to chase blood test results for conditions which may cause bruising.
- Nursery to report further bruising and if Child N missing from Nursery
- Nursery to explore explanation of bruising with Mother if Child N presents with a bruise.
- Strengthening families to be considered with Mother
- Referral to Early Intervention Panel for family support - completed
- social worker to arrange a home visit
- Requested Police information received on Male 2

151. Also on 25th July Child N attended nursery with a small bruise beneath his eye. Mother stated that this was an old bruise and no 'Accident at Home' form was completed on this occasion.

152. On 26th July Child N attended nursery and an 'Accident at Home' form was completed by Mother who stated that Child N had come home from his Father's with a small graze on his right knee. Mother also collected Child N 30 minutes early from nursery and stated this was because he was staying at Auntie's tonight and she was "getting him sorted"

153. On 27th July SW2 recorded that she had made a telephone call to the Police and queried the outcome of an incident relating to child sexual exploitation (July 2015) in which Male 5 was

implicated. The police reported that there was no further action taken due to insufficient evidence.

154. SW2 also carried out a home visit to Father and PGM and discussed the assessment process with them. They spoke about Child N being very boisterous and active and the SW recorded that "*They are concerned but do not feel Mother or Male 5 (a childhood friend of Father's) would be physically harming him*".
155. On 28th July during a contact with his Probation Officer Male 5 confirmed the name of Mother and Child N and confirmed that Children's Services were involved with the family. He supplied the name of social worker and her contact mobile phone number.
156. The Probation Officer contacted SW2 and was informed that she was undertaking an assessment due to Child N having been taken to hospital with bruising. Hospital staff were told he had fallen down the stairs. The paediatrician assessed the injuries were not consistent with the given explanation. SW2 explained Child N had a number of medical problems and tests are being carried out to see if any of his conditions might cause him to bruise easily. The Probation Officer shared details of Male 5's offending history.
157. The Probation Officer emailed the CRC Manager in Calderdale to request a transfer of management of Male 5's probation order and detailed his conversation with SW2.
158. Also on 28th July 2016 Mother attended her GP surgery and was seen by the SNP for a review. The SNP recorded that Mother was '*Managing ok, under social services care at present re child protection concerns, feels anxious about this. Managing child care, feels partner is supportive, no Suicidal Ideation or Self Harm. Diagnosis; ongoing depressive disorder. General discussion and support, continue meds and review 1-2 month as appropriate, safety netting advise, crisis contact given'*.
159. On 29th July 2016 Child N was missing from nursery who contacted Mother to ask where he was. Mother explained that he had gone to PGM's earlier than planned and they were going away for the weekend. Nursery contacted CSC and SW2 was able to confirm that this was the case.
160. On 1st August 2016 Child N attended nursery with more bruising and marks. Mother explained that all but one of the bruises had happened whilst Child N was in the care of PGM. SW2 contacted PGM to confirm whether this was the case.
161. On 2nd August 2016 Mother contacted the FNP practitioner in Bradford by text message (she had contacted her on more than one occasion since moving to Calderdale) and explained that she was stressed by CSC involvement. The FNP practitioner repeated her previous advice which was to contact her Health Visitor.
162. The Health Visitor carried out a home visit the same day. During her visit the Health Visitor carried out Child N's 2.5 year developmental assessment using the ASQ (Ages and Stages Questionnaire). His assessment indicated that his fine motor skills were borderline and Mother gave consent for the child development support worker from the Health Visiting team to visit to give advice regarding managing his behaviour and to discuss activities to help him develop his fine motor skills.
163. At the same visit the Health Visitor noted a new bruise on the left side of Child N's jaw bone – Mother and Male 5 stated that they did not know how it occurred. On entering the house the Health Visitor noted that Male 5 was trying to get Child N to sit on his knee and Child N seemed distressed and indicated he wanted to sit with Mother. This went on for about 5 minutes until the Health Visitor pointed out that he wanted to sit with his Mother. The Health Visitor noted that Child N was wary of Male 5 and she raised this with both of them and Male

5 stated he felt that Child N was scared of him and he acknowledged that he shouted at him when he didn't do as he was told. When talking about Child N's diet, Mother reported that Child N was reluctant to eat with Male 5 and the Health Visitor discussed the importance of not attempting to force him to eat.

164. The Health Visitor immediately shared information about the bruise to Child N's jaw with SW2.
165. SW2 received confirmation from an SNP at Child N's GP practice that the results of Child N's blood tests were normal i.e. there was no indication that he had a condition which would cause him to bruise.
166. SW2 visited Child N at nursery and it was agreed that a further CP medical was required. Attempts were made to book a medical for the same day however an appointment could not be offered until the following day.
167. On 3rd August 2016 Mother contacted SW2 to advise that she had noticed bruising behind Child N's left ear. She also stated he had banged his head on a table last night and when she went to check on him later in the night she had found him asleep under the bed.
168. Also on 3rd August 2016 a CP medical was undertaken by Paediatrician 6. P6 noted that blood tests, clotting screening and Von Willibrand* screen had all shown normal results. P6 recorded 11 marks to Child N's body; 6 of which were unexplained. P6 documented that the pattern of Child N's injuries was worrying and P6 was concerned that some injuries may have been non-accidental. P6 was concerned that the number of injuries for a boy of his age was unacceptable and that there were significant safeguarding concerns and further assessment should be undertaken under the category of neglect. Medical photography was arranged. A Social worker attended the medical. * Von Willebrand disease (VWD) is a common inherited condition that can sometimes cause heavy bleeding.
169. On 4th August 2016 CSC made a decision to hold Strategy Discussion with the police with the view to convene an Initial Child Protection Conference. Although there was no definitive evidence (which there rarely is) to suggest the bruising was caused non-accidentally there were increasing levels of concern from both CSC and health on the number of presentations in such a short time frame.
170. On 5th August 2016 CSC held a strategy discussion was held the police.
171. Also on 5th August SW2 carried out a home visit and explained the outcome of the Strategy Discussion to Mother and Male 5. She explained that an Initial Child Protection Conference would be arranged.
172. An initial Child Protection Conference was arranged for 26th August 2016.
173. Child N died on 8th August 2016.

Analysis

174. The analysis is set out in response to the key lines of enquiry set by the SCR Panel which formed the terms of reference for the SCR. The analysis is informed by:
    - chronological information provided by agencies,
    - IMRs,
    - the views and contributions of the practitioners who attended the Learning Event,
    - Research,
    - Analysis of other serious case reviews

Were single and multi-agency assessments and interventions child focussed, accurate and acted upon? Did agencies recognise and assess risk in respect of Child N?

175. Information about the risks posed to Child N from the adults in his life were not always shared between agencies. Nor were all risks to Child N recognised by some agencies. This impacted upon how risks were assessed.

Risks from new male partners

176. Child N's mother was his primary carer. She was a young mother who had experienced significant childhood trauma including possible sexual abuse by more than one family member. Her ability to assess risk for herself and for her child was undoubtedly impaired and she introduced a number of males into Child N's life some of whom had histories which indicated risks to children e.g. domestic abuse, offending, substance misuse, age/ immaturity.
177. Bradford's CSC records and the IMR highlight that from her first boyfriend, at the age of 15 onwards "*Boyfriends that Mother had were controlling, they had what were described as 'scuffles', were experimenting sexually against her wishes and she was transient in her choices with young men*".
178. The nature of Mother's relationships with males was that they were short lived lasting only a matter of weeks. This made information gathering or ongoing assessment very difficult. However it was the **pattern and nature** of the relationships which was an important indicator of risk to Child N and to Mother herself.
179. The triennial analysis of serious case reviews (2011 to 2014) highlights that the person causing harm to children varies according to the type of harm suffered; if it were a physical assault which proved fatal or seriously injured the child, the perpetrator was most likely to be the father or father figure/mother's new partner.
180. Further analysis established that the presence of a criminal record in itself should also be seen as a risk factor for serious or fatal maltreatment, particularly when combined with other parent/carer risks such as domestic abuse, substance misuse or mental health problems.
181. In February 2014 just before Child N was born the FNP practitioner shared her concerns about Mother's attachment to unknown males with the Bradford Leaving Care Team. Mother had by this time ended her relationship with Father and was in a relationship with Male 1 who Mother, at that time, thought may be the father of Child N.
182. As a result of this contact by the FNP practitioner the LCSW and FM carried out a visit to Mother and undertook some 'relationship work' with her although it is not clear what this work addressed and whether or not it focused on risk to her child. It was apparent however that this intervention was not effective as Mother continued to quickly form new relationships exposing Child N to potential risk from other young males.
183. In July 2015 when Child N was 17 months old Mother began a relationship with Male 2. The FNP practitioner noted that this relationship was potentially abusive (Male 2 had ripped up parenting information and 'tension' was noted between them). The FNP practitioner also noted that Child N's behaviour was agitated. (It was this partner who Mother later alleged had caused injuries to Child N)
184. It was in July 2015 that Child N suffered a head and a knee injury and Mother raised concerns for the first time that he was 'bruising easily' the following month.

185. That there had been no concerns about bruising or indeed any bruising or injuries reported prior to Mother's relationship with Male 2 was significant but professionals did not appear to challenge Mother or Male 2 about this.
186. On 12th August whilst Child N was in recovery following a procedure carried out in respect of his kidney condition the anaesthetist noted bruising on both sides of Child N's chin and elsewhere on his body and arranged for a child protection medical to be carried out.
187. The outcome of the medical was that the injuries were 'likely' to have been accidental.
188. The full context of Child N's life however did not appear to have been fully shared by Bradford CSC i.e. that Mother had begun a new relationship and that there were signs that this relationship was abusive, that Child N was showing signs of distress and notably that Child N had not displayed any tendency to bruise easily before this point in time.
189. Mother ended the relationship with Male 2 in August 2015 and told the FNP practitioner that it was because he was shouting at home and at the hospital. This was an opportunity, which was missed, to ask Mother about domestic abuse and about the injuries to Child N.
190. In December 2015 during a home visit by Bradford CSC as part of a single agency assessment following FM's reporting of a burn to Child N's hand*; Mother alleged that Male 2 *had* caused injuries to Child N. Bradford CSC reported this to the police however no further action was taken in pursuing this allegation as a potential criminal offence because "*Comments in the Paediatricians report regarding injury likely accidental. Age of alleged crime would make it difficult to get a conviction within statute barred time limits. Disclosure from Mother is that she was told by Male 2 that injury resulted from 'rough play' and would therefore fall under the realms of inappropriately handling of a child rather than more serious offences*." * There was no medical carried out in respect of this burn.
191. During this assessment process the SW spoke to the FNP practitioner and shared information that there had been conflict between Mother and FM over Mother's involvement with a man called ****, who FM had concerns about. It is not clear who this male was or what the nature of the concerns was. (He is referred to as Male 3 in the key at page 2 of this report).
192. The relationship with Male 2 lasted less than 2 months and Mother was assessed as 'protective' because she had ended the relationship because of his behaviour.
193. Crucially the allegation made by Mother that Male 2 had caused the injuries to Child N and the fact that she had not reported this at the time or during the 4 months following the relationship ending was not shared with the FNP practitioner.
194. This meant that the FNP practitioner was unaware that Mother had been untruthful about the cause of Child N's injuries and had possibly colluded with Male 2. Knowing this may have influenced her assessment of risk to Child N.
195. This also meant that the FNP practitioner could not, in turn, share this information with the Health Visiting service and other agencies when Mother and Child N moved to Calderdale and it consequently could not influence subsequent child protection medicals, future risk assessments or decision making. (It is not clear if this allegation was shared retrospectively with the paediatrician who carried out the initial child protection medical).
196. This information could also have influenced Mother's ongoing narrative that Child N may have a medical condition which could cause him to bruise easily.
197. In September 2015, within a month of the relationship with Male 2 ending Mother was in a relationship with Male 3. The identity of Male 3 was never confirmed.

198. On 3rd October 2015 whilst Child N was being treated as an in-patient Male 3 was removed from the hospital ward by security staff due to his aggressive and threatening behaviour. He was then allowed access to the ward on the understanding that he would be respectful to the ward staff. He was, however, removed again by security due to his aggressive behaviour. He was then granted access again. On the 3rd occasion the Police were contacted and attended the ward. The named social worker (Mother's LCSW) was contacted by hospital staff and informed of the incidents. This did not prompt consideration of the impact on or risk to Child N of an aggressive male partner and no further action was taken by CSC. There was nothing in the information provided by Bradford CSC to suggest that information about this incident was shared with other agencies.
199. Although Bradford CSC were aware of it, this relationship with Male 3 does not appear to have influenced the single agency assessment carried out on 3rd December, specifically that Mother had ended one abusive relationship and moved on almost immediately to another.
200. During the single agency assessment Mother reported that she was in a new relationship with Male 4 and asserted that she had not introduced him to Child N and would only see Male 4 when Child N was at Father's house.
201. During a home visit from the FNP practitioner in January 2016 however, Male 4 was present. Child N's behaviour was problematic and Mother was noted to be 'distracted'. It was during a subsequent home visit on 4th February that Mother told the FNP practitioner that she was pregnant and that Male 4 was the father but that she did not want him to move in with her.
202. In May 2016 as Mother moved to Calderdale she was in a relationship with Male 5 and he moved in with her and Child N by the end of May.
203. Male 5 was the only known partner about whom agencies held significant information.
204. The CRC IMR author noted "*around a dozen separate incidents relating to anti-social and criminal behaviour activity between the period 2011 and 2014; these incidents included: hate crime; criminal damage; burglaries. Additionally, Male 5 was the child witness to at least 6 domestic abuse incidents between 2000 and 2008, from age 4 to age 12*".
205. Male 5 was assessed using CRC assessment processes as being '*Low Risk of Serious Harm, with a high likelihood of re-offending*'.
206. On 31st May in response to a nuisance complaint made by a neighbour a Housing Neighbourhood Officer (NO) visited Mother. The Together Housing IMR author notes "*Child N was observed and present at the address. He was running in and out of the house and was being supervised by a male who was unknown. The NO observed the male was" a bit too hard" in his handling of Child N. This should have prompted the NO to ask who this male was to be more professionally curious. During the same visit Mother reported that she had "lost her baby". Again this could have prompted the NO to ask sensitively about how she was coping which could possibly have opened up a wider conversation about any help she may need*".
207. On 2nd June 2016 Male 5 told his Probation Officer that he was moving to Halifax and on 7th June explained that he was moving in with Mother and Child N.
208. The Probation Officer telephoned Calderdale CSC on 13th June 2016 to ask if Child N and Mother were known to them. He was told that 'someone would get back to him' (this telephone call was not logged by Calderdale CSC as it was a general enquiry and at that point in time the family were not known to Calderdale CSC).
209. Between June and July 2016 Male 5 missed appointments with the Probation Officer but spoke to him by phone on 28th July and Male 5 re-confirmed that he was living with Mother

and Child N. He also told his Probation Officer that Calderdale CSC were involved and supplied the Probation Officer with the name and contact details of the allocated SW.

210. The Probation Officer contacted the SW by phone who confirmed that Child N had sustained bruising which could be non-accidental. The Probation Officer shared details of Male 5's offending however this was limited to information held by the CRC and did not include information held by the Youth Offending Service or the police (this information was not known by the CRC at this point). This information included an allegation that Male 5 had perpetrated a serious offence against a young woman (the allegation was later retracted) and that he had been known by the police to be carrying a knife whilst living in Nottingham in order to protect himself.
211. On 2nd August 2016 the Probation Officer completed a further risk assessment having obtained this fuller information from the police about Male 5. As a result Male 5 was assessed as 'posing a potential risk to children'.
212. This re-assessment of Male 5 occurred 2 months after he first informed his Probation Officer that he had moved to Calderdale and was living with Mother and Child N.
213. Whilst there was nothing, at that point to indicate that Male 5 was a risk to others, research and learning from other serious case reviews has established that new male partners, offending and immaturity are all individual indicators of risk to children and when risks exist in combination there is often a compounding effect.
214. The risks posed to Child N by Mother's new partners were recognised by the FNP practitioner and she discussed her concerns with Mother on more than one occasion. Mother acknowledged that her relationships had a negative impact on Child N.
215. The FNP practitioner also discussed her concerns with Bradford CSC on more than one occasion and contributed to the December 2015 assessment following the referral by the LCSW (which had been triggered by a possible cigarette burn disclosed by FM). The FNP IMR Author notes "*When the Family Nurse is informed by Children's Social Care that there has been a referral around concerns in regards to a burn seen on Child N the Family Nurse shares information about her involvement and knowledge of the family situation to date. This telephone call is recorded in the Safeguarding template of the Family Nurse records. At this point the Family Nurse records "I highlighted to Social care that I felt there were potential risks to Child N's emotional and possible physical well-being caused by a series of male partners of Mother each one verbally abusive towards Mother*."
216. To summarise; it appears from the information provided in the agency chronologies, the analysis contained in the IMRs and from discussions with the practitioners during the Learning Event that ***some*** of the risks to Child N from male partners were recognised whilst Mother and Child N were living in Bradford.* That Mother ended the relationships within weeks appears to have reassured practitioners that she was acting protectively and also meant that full risk assessments of the males could not take place as they were not present for more than a few weeks and in one case (Male 3) was never identified. *Risk assessments and other events which occurred once Mother had moved to Calderdale are analysed separately elsewhere in this report.
217. All of the relationships, including that with Father, displayed elements of abuse which would have presented a risk to Child N and there were indications that all was not well for him. These included:
    - Fluctuating attachment to Mother
    - Deteriorating ASQSE scores (December 2015)

- Behavioural problems including clingy/ defiant/ aggressive/ swearing
- Bruising and other injuries which could have indicated lack of supervision through to physical abuse.
- Some missed medical appointments
- Fluctuating engagement by Mother with some agencies which meant that Child N was not seen for periods of time by, for example, the FNP.

218. The fact that Mother ended the relationships quickly did not reduce the overall risk to Child N as she quickly formed new relationships despite acknowledging that this was potentially harmful for Child N.
219. The overall **pattern and ongoing nature** of these quickly formed attachments with males together with the signs that all was not well for Child N was not given careful consideration by Bradford CSC when assessing risk to Child N and did not therefore result in actions which could have reduced risk.

Risk from other Family Members

220. Father and PGM were involved in the life of Child N and he stayed with them and was in their care on a regular basis.
221. There is very little agency information about either Father or PGM but observations by the LCSW commented on by the IMR author suggest that PGM in particular was considered by the LCSW to be a protective person in Child N's life.
222. However when Mother reported to nursery that injuries had occurred whilst Child N was in the care of Father and / or PGM the nursery did not verify this or consider that Father and/ or PGM may have been a risk to Child N. Nursery staff did not ask for Father's name and address at any point so effectively had no idea who he was. The IMR author has highlighted learning from and made recommendations to reflect this issue.
223. Mother had also told the LCSW that Father was abusive and had alleged to the FNP practitioner that he was using cannabis. This does not appear to have prompted an assessment of risk posed by Father to Child N.
224. Mother remained in contact with her birth parents throughout her pregnancy and throughout most of Child N's life.
225. Her birth parents had caused Mother and her siblings harm and Mother was removed from their care at the age of 6.
226. MGF has been convicted of sexual offences against children and Mother, whilst in foster care, alleged that he, a maternal uncle and her grandfather had sexually abused her.
227. Mother's social worker noted that MGF had asked Mother if she was still a virgin; Mother was aged 16 at the time and was still a looked after child.
228. Mother's social worker also noted in 2011 when Mother was 17 that her birth parents were constantly manipulating her.
229. The FNP practitioner during a home visit at which MGF was present observed that he dominated the conversation and it was also observed by some practitioners who contributed to the Learning Event that Mother's demeanour changed when MGF was present and that she became 'child-like'.
230. The relationship between Mother and MGF broke down sometime in 2016 but there is no information available to explain what caused the break down or any information to suggest that any practitioner was curious enough to enquire about it.

231. The risk to Child N from MGF was not viewed from the perspective of what Mother's 'willingness' to maintain a relationship with him meant in terms of her own mental and emotional wellbeing or her capacity to recognise and assess risk.
232. This 'willingness' to maintain a relationship is explained by research which focuses on survivors of abuse "*Many survivors of childhood abuse have such profound deficiencies in self-protection that they can barely imagine themselves in a position of agency or choice. The idea of saying no to the emotional demands of a parent, spouse, lover or authority figure may be practically inconceivable. Thus, it is not uncommon to find adult survivors who continue to minister to the needs of those who once abused them and who continue to permit major intrusions without boundaries or limits*." (Trauma and Recovery Judith Herman, M. D. New York: Basic Books, 1992 pg. 81)
233. Mother also maintained a relationship with MA who had allegedly threatened to abduct Child N from the hospital just after his birth. MA was, at that time in an abusive relationship herself. In other words, there is nothing to suggest that MA was a protective factor in Child N's life and she may have posed a risk to him.
234. This ongoing relationship with MGF (and MGM) was an indication that the impacts Mother's traumatic childhood may have been ongoing and could, in turn, have impacted upon her ability to recognise and respond to risk to Child N.
235. In summary Child N presented signs of distress and sustained injuries which may have been non accidental on many occasions. He was exposed to risks from a number of males (one of whom was alleged to have caused some of his injuries). His Mother who was extremely vulnerable did not change her pattern of behaviour during Child N's lifetime despite being advised about and acknowledging the impacts her frequent changes in relationships were having on her child.
236. Child N's behaviour and development was observed to have deteriorated and he was observed to be frightened of at least one of Mother's partners by more than one professional.
237. In addition Mother's relationships with her birth parents and her sibling were a further source of potential risk to Child N and to herself.
238. Mother's mental health, at the time of Child N's death, was already compromised and she was diagnosed with depression following the late miscarriage of her second child.
239. Child N underwent 5 child protection medicals during his lifetime. The first 4 of these medicals concluded that his injuries were likely to have been accidental.
240. It is not possible to say that the outcome of all but the first of the medicals would have been different if the information concerning Mother's delayed allegation that Male 2 had caused injuries to Child N had been shared however it was a crucial piece of information which would undoubtedly have influenced the overall assessment of risk to Child N.
241. Child N was the focus of a CSC single agency assessment by Bradford CSC for the first time in December 2015 following FM's disclosure that he had what appeared to be a cigarette burn to his hand (FM had mentioned the burn during a general discussion with the LCSW). N.B. No medical was carried out in respect of this injury and there is no record to suggest that a medical was considered.
242. It was during this assessment that Mother alleged that Male 2 had caused the injuries which led to Child N's first child protection medical.
243. The SW carrying out the assessment contacted the Leeds hospital where Child N underwent his first CP medical and reviewed the information they held. In light of the allegations made

by Mother that her ex-partner had caused injuries to Child N it would have been good practice to speak to the paediatrician who carried out the medical and share this information to enable to paediatrician to review her opinion about the injuries.

244. The IMR author's analysis of this assessment is that it was a 'quality piece of work' and whilst it was comprehensive in some regards and included Father and PGM (it did not include MGF, MGM or MA) the recommendation that Mother accessed a parenting course and the Children's Centre's services did little to reduce the ongoing risk of Mother's relationship patterns or assess the risks presented by her ongoing relationships with MGF and MGM.
245. The Children's Centre (who made several attempts to engage with Mother but were not successful) informed Bradford CSC that Mother had not engaged. Given the nature of the concerns i.e. that Child N had been physically abused non –engagement could have represented an escalation of risk.
246. Bradford CSC did not share the outcome of the assessment including the allegations Mother had made against Male 2 with the FNP practitioner nor is there any information to suggest that the FNP practitioner contacted CSC to ask about the outcome.

Were assessments and interventions child focused?

247. Overall there was significant professional empathy for Mother demonstrated by FM, the LCSW and the FNP practitioner in particular. However as described in the 2011 to 2014 triennial analysis of serious case reviews "*The quality of empathy embraces considering both the voice of the child and the needs of the family. It must be grounded in the centrality of the rights and needs of the child, while being sensitive but not colluding with the needs and views of the parents; to maintain high expectations of parents, provide the support to enable them to try and meet those expectations, and to challenge and act when they are unable to do so*". In this case consideration was not always given to what Child N's daily life was like. In other words; there was not sufficient empathy shown towards him. For example when hospital staff had to remove Male 3 three times from the hospital (finally involving the police) because of his aggression they reported this to Bradford CSC however there was no further action taken by Bradford CSC. The fundamental question about what it must be like for a very small and very young child to be living with such frightening aggression does not appear to have been asked.
248. A number of interventions were provided by the different agencies and practitioners who worked with Mother both during her time as a looked after child, as a care leaver and once Child N was born. It is not possible to establish from the information provided by agencies what actions were put in place to measure the effectiveness of the interventions or what would happen if the interventions did not achieve their outcomes.
249. The interventions (including focused conversations with Mother) which took place after Child N's birth did little to reduce the ongoing risk to him from the new males introduced into his life by his mother.
250. Child N's behaviour was a manifestation of his distress, he witnessed domestic abuse and he suffered injuries some of which were a consequence of neglect or of physical abuse. At times Mother's attachment to him was observed to fluctuate. Whilst some of his behaviours were recognised as distress (by the FNP practitioner) overall interventions and assessments do not appear to have focused on what his daily experience of life was likely to be. Ultimately his experience of daily life remained unstable and unsafe.

Key Learning

The LSCB's and partners should consider current their single and multi-agency risk assessment approaches and determine whether or not they encourage and facilitate 'big picture' analysis of risk which would include:

- Routinely gathering information from other agencies and other family members
- Full parental history including parents' childhood experiences of abuse, loss or trauma.
- Current family context specifically focusing on fathers / male partners with specific consideration of offending history.
- Consideration of who is part of a child's life and whether or not they are a protective person.
- Routine ongoing analysis of whether or not risk is decreasing/ increasing/ static particularly paying attention to patterns / capacity and willingness to change.
- Evidence and research including lessons from other serious case reviews
- Routinely sharing the outcome of assessments or seeking information about the outcome of assessments particularly when there are multiple vulnerabilities and risks.

The LSCB's and partners should consider what arrangements may need to be put in place when non-engagement with 'early help' services may be an indication that a child's needs are not being met or that risk is increasing.

The LSCB's and partners should ensure that for interventions carried out with families:

- The aims of the interventions are clearly articulated and shared with the families (and other professionals if appropriate)
- Timescales for the interventions and outcomes are agreed
- Measures of effectiveness are agreed and take place within the timescales
- The outcomes of interventions must be measured against sustained improved outcomes for children and young people.
- If interventions do not achieve the agreed outcomes this must be considered as part of the assessment of risk/ unmet need for children and young people and whether or not an escalation of concerns is appropriate.
- That supervision is effective and is used to review and reflect upon progress and outcomes.

Was the parenting capacity of Child N's Mother assessed effectively?

251. Mother's complex and traumatic childhood experiences included neglect, physical abuse, sexual abuse and being removed from her family when she became a looked after child.
252. Research consistently shows that such adverse childhood experiences have an impact on childhood development including:
    - Neurobiological Effects (e.g., brain abnormalities, stress hormone dysregulation)
    - Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
    - Health Risk Behaviours (e.g., smoking, substance abuse, promiscuity)
253. The long term consequences of these impacts include:
    - Intergenerational transmission of abuse
    - Teenage pregnancy
    - Unintended pregnancy
    - PTSD, major depression, suicide
    - High use of health and social services

254. Several research studies have sought to examine how traumatic experiences may affect parenting practices. One study with low-income, parenting women found that "*physical abuse was associated with increased hostile-intrusive behaviour toward the infant," while "sexual abuse was associated with decreased involvement with the infant*." (Lyons-Ruth K, Block D. The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. Infant Mental Health Journal 1996; 17(3): 257-75.)
255. Another study looking at poor parenting practices, which includes factors such as neglect and aggression toward the child, found that maltreatment as a child was associated with poor parenting practices for mothers, and that childhood sexual abuse specifically was associated with aggressive parenting behaviours. (Newcomb MD, Locke TF. Intergenerational cycle of maltreatment: A popular concept obscured by methodological limitations. Child abuse & neglect 2001; 25(9): 1219-40.)
256. Further, a number of studies have shown that outcomes associated with trauma are associated with parenting behaviours, such as insecure parent-child attachment (bond) and decreased maternal sensitivity (responding to a child's signals). Downey G, Coyne JC. Children of depressed parents: An integrative review. Psychological Bulletin 1990; 108(1): 50. Lovejoy MC, Graczyk PA, O'Hare E, Neuman G. Maternal depression and parenting behaviour: A meta-analytic review. Clinical Psychology Review 2000; 20(5): 561-92).
257. Mother was removed from her parents care at the age of 6 and was fostered by FM until she was 18 years old and maintained a close relationship with her foster family until November 2015.
258. Throughout her time as a looked after child Mother accessed support and interventions which aimed specifically to increase her self-esteem and to focus on healthy relationships. She was also able to discuss consensual sex with her social worker and the sexual abuse she disclosed as a child.
259. Despite her stable foster placement and despite her access to these programmes and interventions Mother's relationships with males was concerning from her first boyfriend at the age of 15 (who was physically abusive) onwards.
260. By 2011 concerns also included Mother being coerced into unwanted sexual activity. She was aged 17 at this point in time.
261. The LCSW described Mother as '*always flirting with males and wanting male attention*.' It was also noted that Mother's pattern of jumping from one relationship to another appeared to mirror her mother's (MGM). A case note in February 2014 refers to '*Mother previously had made allegations about Male 1 saying he had sex with her mother (MGM) and due to him being aggressive to her she ended the relationship'*. This case note indicates the level of relational dysfunction between Mother, a male partner and MGM.
262. There is no information to suggest that Mother's relationships with males and her behaviour towards males was considered to be a consequence of childhood sexual abuse (although she had been noted, at the age of 6, to be demonstrating sexualised behaviour).
263. Nor is there any information to suggest that Mother's ongoing contact with her birth parents was considered as a possible symptom of unresolved or ongoing trauma, coercion and abuse.
264. As previously described children who have endured trauma and abuse suffer psychological harm. There is a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more ***complicated effects of prolonged and repeated abuse.*** Therapeutic work which directly addressed the complex impacts of childhood sexual abuse

and neglect would be fundamental to Mother's recovery and her capacity to become a successful parent.

265. There is a paucity of research which addresses what therapeutic and other interventions can be used effectively with women and girls who have endured traumatic childhoods *specifically* in order to support them as they become parents.
266. Research does however evidence that girls who become parents when they are looked after children or new care leavers experience the highest rates of teenage pregnancy than any other group and their children are up to 66 times more likely to be taken into care than the general population (Jackson and Simon 2005).
267. From this we can surmise that children who are taken into care after experiencing adverse childhood experiences are more likely to need a thorough assessment of their parenting capacity and more likely to need intense and long term support as they become parents.
268. The FNP practitioner continually assessed Mother's parenting of Child N and noted their fluctuating attachment and the impact of this on Child N's behaviour and distress. This is summarised by the IMR Author "*As the Family Nurse recognises deterioration between the relationship with Mother and Child N she makes plans to utilise FNP materials and resources such as Partners in Parenting Education. The Family Nurse also completes a Diadic Assessment for the Naturalistic Caregiving Environment assessment during the toddlerhood period, and concludes from this, in regards to Mother's parenting capacity that "observations have highlighted confused, disordered attachment processes whereby when Mother becomes stressed her attunement, consistency, responsiveness, emotional availability, sensitivity, pacing and limit setting all fluctuate greatly*".
269. It is of note that because of Mother's fluctuating engagement the FNP completed 50% of the FNP programme and was unable therefore to meet the programme's outcomes in full. This was due to Mother disengaging and changing address frequently sometimes without letting the FNP practitioner know (this pattern of disengagement and re-engagement is discussed in more detail elsewhere in this report).
270. Where parents have unresolved or disorganised attachments, their resultant behaviours will impact on the nature of the relationship with their own children. Hesse and Main (2000) suggest that parents with unresolved or disorganised attachments may exhibit inconsistent behaviours or ones which frighten or alarm children who look to them for safety and care. The authors describe children in these circumstances as being confronted with a '*biologically channelled paradox: the simultaneous needs to approach, and take flight, from the parents' and suggest that this leads to disruptions in the child's behaviour'* (Hesse, E. and Main, M. (2000) 'Disorganised infant, child, and adult attachment: collapse in behavioural and attentional strategies.' Journal of the American Psychoanalytic Association 48, 1097-1127).

Learning Points

- Validated parenting assessments should be considered for parents with pre-existing vulnerabilities including their own adverse childhood experiences which can indicate that parenting may be compromised.
- In order to carry out an accurate analysis when assessing parenting capability ***and*** capacity to change, practitioners need to formulate a case conceptualisation, setting out the various internal and external factors that influence parents' ability to meet their children's needs.

What reassured practitioners that Child N was safe and well?

271. A combination of factors reassured practitioners that Child N was safe and well these are discussed in more detail elsewhere in this report but they include:
    - Mother's general presentation and the fact that Child N appeared well cared for i.e. clean, fed and well dressed.
    - Mother's assertions that she had ended abusive relationships.
    - PGM and Father's view of Male 5's character
    - Mother's ongoing narrative that Child N had an underlying medical condition which may cause him to bruise easily.
    - The outcome of the first child protection medical which concluded that Child N's injuries were *likely* to have been accidental.
272. It is notable in this case that practitioners also reassured one another about risks to Child N and by inference provided reassurance that Child N was safe and well.
273. For example Male 5's Probation Officer reassured the Calderdale SW that there were no concerns about Male 5 living in the family home despite him not being in possession of all the facts to inform a risk assessment at that point.
274. The CHFT IMR author describes that in interview with the HV the HV reported being reassured that the FNP practitioner had known the family for a long time and understood the family dynamics. (It is important to note again that the FNP practitioner was not aware that Mother had alleged that Male 2 had caused injuries to Child N and therefore was also unaware that Mother had not been truthful about this.)
275. FM also shared her view with other practitioners that Mother would not deliberately harm Child N.
276. During the Calderdale CSC assessment process following Child N's 3rd child protection medical the CSC IMR author notes "*Weight was given to paternal grandparent's assessment of the situation. Both father and grandmother were concerned about the bruising, but did not feel mother or partner (birth fathers former friend) would harm him*".
277. This pattern of reassurances may have been a symptom of 'contagious' professional over optimism (or naivety) but this was not challenged even when a 'fresh pair of eyes' was introduced to Mother and Child N for example the SW and HV in Calderdale.
278. Similarly other serious case reviews identify 'professional authority' as a critical element in safeguarding work. Professional authority involves both confidence and competence; it '*requires the application of appropriate evidence, combined with the experience of the practitioner and their responsiveness to the current context. Authoritative practice will enable professionals to be curious and exercise their professional judgement in light of the circumstances of particular cases even when this means challenging an accepted viewpoint*. (Sidebotham, P., Heron, J. and ALSPAC Study Team (2006) Child maltreatment in the "children of the nineties": A cohort study of risk factors. Child Abuse & Neglect, 30(5): 497-522).
279. In this case, as in many others, the paediatricians who carried out the first 4 child protection medicals were unable to conclude that the injuries to Child N were non accidental.
280. Determining whether injuries have been caused accidentally or represent abuse is often challenging and other factors should always be considered including parental capacity, domestic abuse and full family history. In this case there was no opportunity to discuss (and

challenge) the view that the injuries were likely to have been accidental following the 3rd medical as there was no strategy discussion.

281. The National Institute of Social Care Excellence carried out analysis of SCR reports and states "The analysis within the SCR reports for these cases highlights a number of reasons for wrong interpretation of advice from health professionals, including a general over-reliance on medical opinion to determine risk, rather than the weighing up of a range of types of evidence".
282. In other words the medical opinion was not necessarily the most significant contribution to deciding whether physical abuse had taken place.
283. The 4 medicals which took place once Child N moved to Calderdale happened within a four week period. During that time Calderdale CSC were gathering information about the family's history and were reassessing risk 'on the hoof' as new information was confirmed
284. The decision to proceed to child protection arrangements was made because of neglect not because of physical abuse i.e. the 'work in progress' consensus was that the injuries to Child N were as a consequence of lack of supervision/ neglect rather than physical abuse.

Key Learning

- Multiple Child Protection Medicals should increase the suspicion of non-accidental injury or neglect.
- Extensive or unusual bruising without adequate explanation should increase the suspicion of non-accidental injury or neglect.
- Through peer review and safeguarding supervision paediatricians should be supported and challenged to recognise over optimism in personal practice.
- Professional authority enables professionals to adopt a stance of professional curiosity and challenge from a supportive base, rather than relying on undue optimism.

Were Mother's relationships with men considered in respect of the effect on Child N's behaviours?

285. The FNP practitioner in particular considered the impact of Mother's frequent change of partner on Child N and she directly observed Child N's behaviours some of which were possible manifestations of his distress.
286. The FNP practitioner discussed this with Mother and Mother acknowledged that the frequent change in male partners was having a negative impact on Child N but she continued to form quick attachments with males.
287. By May 2016 Mother had just ended a relationship with Male 4 and had begun a relationship with Male 5 and the FNP practitioner noted that Mother seemed unable to change her own behaviour.
288. Analysis of other serious case reviews notes that numerous moves and a transient lifestyle often overlap with a context of multiple, often violent, partners, who may also be caregivers, to create a damaging environment for the children.
289. By May 2016 when Mother was moving to Calderdale there were significant indicators that Mother's frequent changes of male partners was having a negative impact on Child N and taken together with Mother's allegation that a former partner had caused injuries to Child N which had led to a child protection medical and a queried cigarette burn this could have been an opportunity to reassess risk and need.

290. The FNP practitioner in handing over the care of Mother and Child N to the Health Visiting Service in Calderdale shared Mother's case history (Mother's case history was lacking the information gathered during the December 2015 Bradford CSC assessment as this had not been shared with the FNP Practitioner) and she and the Health Visitor carried out a joint home visit in July 2016.
291. Male 5 was present at this visit. He was introduced to them but did not interact throughout the visit.
292. Mother had an injury to her finger which she told them had been caused in 'play fighting' with Male 5 (she had earlier told a health professional that she had cut her finger of a key chain when seeking treatment for the injury).
293. At this visit both professionals noted bruises to Child N's temples and Child N's behaviour was problematic.
294. This visit presented a snapshot of multiple risks; another unknown male, Child N's distressed / problematic behaviour/ facial bruises and possible domestic abuse. It is difficult to understand why this visit did not lead to an escalation of concerns to CSC and there is nothing in either the HV or FNP records to indicate that this was discussed.
295. The fluctuations and latterly the deterioration in Child N's attachment and behaviour were apparent to the FNP practitioner and she attributed this to the impact of new male partners noting also that Mother was 'stressed' or 'tense' on occasion.
296. The deterioration may or may not have been entirely due to the change in family dynamics or the influence of individual males but there were definite indications that at least 3 of the men who were briefly part of Child N's daily life had a negative impact upon him and upon his Mother's wellbeing.
297. In respect of Mother's relationship with Father; he was observed by the LCSW to be immature and a 'typical' young man. Mother also reported to the LCSW and to the FNP practitioner that he was paranoid and controlling, that he used cannabis and that he had coerced her to have unwanted sexual activity (she also reported that she had 'hit' Father).

Key Learning

(Please also see Key Learning listed on page 50)

- Specific consideration and information gathered of all adults who have shared care of children or who live in the household where there are existing or emerging concerns for children should be considered.
- Where those adults are transient the impact of their influence on the family should be assessed with direct work taking place with children whenever possible.

Explore whether Mother and/ or Mother's partners were able to collude and deceive agencies, why this was able to happen and whether there are lessons that can be learnt.

298. It is apparent that Mother was able to deceive agencies in August 2015 when Child N, who was then 18 months old, underwent his first child protection medical.
299. Mother was in a relationship at that time with Male 2. The FNP practitioner had observed that there were tensions in the relationship between Mother and Male 2 and that Male 2 had ripped up parenting information she had supplied.

300. At his admission to hospital for an elective procedure Mother herself raised concerns that Child N was bruising easily. Child N as an active 18 month old would have displayed a tendency to bruise easily from the age where he became independently active but this had not been raised as a concern by Mother or FM previously.
301. Mother also continued the narrative that Child N was undergoing tests for a condition which would cause bruising even after the tests had proved negative i.e. he had no known condition which would cause him to bruise easily.
302. Mother changed her account of injuries to her hand in July 2016 stating that she had cut it on a key chain but later saying that she had injured it during 'play fighting' with Male 5.
303. Mother's allegation that a former partner had caused injuries to Child N did not appear to have been explored from this view point i.e. that she and / or Male 2 had colluded and deceived professionals about the cause of Child N's injuries.
304. Mother had been exposed from very early childhood to the language of 'social care' and had studied Level 3 Diploma in Health and Social Care and the IMR author for Bradford CSC notes that the SW who carried out the December 2015 single agency assessment had noted that Mother used "*social work language and repeated back to him very professional sentences and statements. The SW reflected that he discussed this with his supervisor whether Mother was demonstrating disguised compliance or she was simply a product of having been part of a social work system for most of her life*".
305. The SW did consider that Mother was demonstrating disguised compliance and this; taken together with her allegation that Child N's injuries had been caused by a former partner meaning that, by default, she had deceived professionals was sufficient to be respectfully sceptical about Mother's engagement in the assessment process and the actions agreed at the outcome of it.
306. The most significant issue of Mother's continuing pattern of attachments with abusive males who were introduced into Child N's life despite Mother acknowledging the harm and distress this was causing him was also a form of disguised compliance. In other words; Mother reassured practitioners that she understood and would not introduce unknown males into Child N's life but continued to do so. This does not appear to have been considered as disguised compliance by the LCSW and the SW who carried out the December 2015 assessment.
307. Throughout the agency IMRs and in discussion with the practitioners who attended the learning event it became apparent that Mother was regarded by some practitioners as a 'loving mum' and it is also apparent that she is academically bright. This together with her willingness on occasion, to share personal information with professionals may have made her plausible and also made it difficult to consider that she and/ or a male partner may have physically abused Child N.

Key Learning

- For many parents, child protection agencies are perceived as a threat, which means they may be reluctant to work with professionals, hide or cover up information, or appear to be complying. Practice and supervision must therefore reflect that there is a perceived disincentive for parents / families to be honest or, in some instances to ask for help.

Was professional practice informed by appropriate and effective supervision including safeguarding?

308. The IMR authors responded to this key line of enquiry and detailed the supervision provided to the FNP practitioner, the paediatricians, the LCSW and the SW in Calderdale, nursery staff, and Male 5's Probation Officer.
309. The BTHFT Midwife, the Health Visitor and the Housing Officer in Calderdale did not access supervision or safeguarding advice in this case.
310. The effectiveness of the supervision in challenging the status quo of a case and identifying patterns of concerns or cumulative and compounding risks is not always apparent in this case. This is particularly relevant to the FNP practitioner and the Bradford LCSW.
311. The FNP practitioner's supervision was completed in line with FNP programme requirements. Supervision provided in this case by the Family Nurse supervisor does incorporate safeguarding supervision.
312. Effective safeguarding supervision is a theme that emerges frequently in serious case reviews. When functioning well it is seen as a positive and empowering system by practitioners and managers alike; it facilitates reflective practice and continuous improvement, along with a more proactive approach to case management.

Key Learning

- Effective safeguarding supervision needs to balance support and challenge for the professional. It must include appropriate scrutiny and accountability. Above all, supervision must be child focused.

Was professional practice and supervision informed by research and evidence based practice?

313. With the exception of the FNP IMR, there is little information to suggest that practice and supervision were informed by research and evidence.
314. Some of the evidence and research cited within this report was shared with practitioners who attended the learning event and presenting research and evidence in a 'joined up' way specifically relevant to this case enabled the practitioners to consider their own and the multi-agency response to the family.
315. This opportunity for practitioners to review cases against the wealth of research and evidence based practice which exists does not routinely take place and when it does attendance is often on a voluntary basis.
316. The common themes which emerge from many serious case reviews are referred to throughout this report as are references to research and evidence based practice.

Key Learning

- Research is continually producing new findings of key importance which should inform decision-making, and should be an integral part of continuing professional development for all those who have responsibilities for safeguarding children.

Were single and multi-agency communications and information sharing appropriate, accurate and acted upon? How well was information shared, understood and responded to between agencies?

317. There were instances of excellent information sharing in this case. For example Child N's nursery were prompt, appropriate and accurate in sharing information with CSC.
318. The FNP practitioner shared information and concerns with the LCSW and her record keeping was comprehensive.
319. There were also instances when multi-agency communications and information was poor for example:
    - The referral to WYP of 18th July 2016 relating to the injuries reported by Child N's nursery was filed against the record which was created to record the referral received on 8th July 2016. A separate Niche Child Protection Occurrence should have been created for this referral and allocated for investigation.
    - WYP were not informed in advance about the child protection medicals which were undertaken on 21st July or 3rd August 2016 or the outcome of these. (See next chapter for more detail)
    - The FNP practitioner was not aware of Mother's full history and was unaware that PGF had been convicted of sexual offences against children as this information was not shared with her by the Bradford leaving care service.
    - Child N's electronic GP record shows that the family had registered with a GP in Calderdale in April 2016. The HV was not informed of a new patient move or of the Emergency Department attendance in April 2016.
    - The outcome of the single agency assessment carried out by Bradford CSC was not shared with the FNP practitioner (nor did she seek information about the outcome). This was crucial as it was during the assessment process that Mother alleged that Male 2 had caused injuries to Child N.
320. The single agency assessment commenced on 3rd December 2015 and concluded on 7th January 2016.
321. One of the actions agreed as an outcome of the single agency assessment was that Mother would access support and parenting skills at a local children's centre.
322. Despite repeated attempts by staff from the children's centre to engage with her Mother did not access any support or the parenting courses. The children's centre communicated with both the FNP practitioner and Bradford CSC in January 2016 to advise that they had not been able to engage Mother (they succeeded in carrying out a home visit on 10th February 2016 a month after the single agency assessment had concluded).
323. Within the period of time taken in carrying out the assessment the FNP practitioner carried out a home visit (7th December) and noted that Mother "*Advised that she has fallen out with her foster mother as she spoke to the leaving care social worker re burn on Child N's arm who then referred to duty social care, Child N agitated, swearing, hitting, 18 month *ASQSE scores deteriorated*". Mother also stated that she felt like '*doing a runner'* and was '*scared*' about social care's involvement. Mother was, at this point, living with MA. The IMR author notes "*There seems to be a notable difference in the Family Nurse's observation of Child N and his*

interactions with Mother at this visit, in addition to an observation that there has been some deterioration in his ASQSE development scores".*Ages & Stages Questionnaires: Social-Emotional Development Screening Tool

324. There is no information to suggest that the FNP practitioner shared the outcome of this visit and her observations about Child N's deteriorating ASQSE scores with Bradford CSC.
325. A further home visit was carried out by the FNP practitioner on 7th January 2016 (which was also the date the single agency assessment concluded) and she noted Mother's inconsistent parenting styles and that Child N was defiant and agitated. Again this information does not appear to have been shared with CSC.
326. At the FNP's next home visit on 29th January another male was present. This was Male 4 but he was not introduced to the FNP during the visit. At the 4th February home visit Mother advised the FNP practitioner that she was pregnant and that Male 4 was the father.
327. Mother reported that she "*does not want Male 4 her current partner to move in. Nurse notes current relationship causing Mother to become stressed and that verbal conflict has happened which Child N has heard*". This is not described by the FNP practitioner in her records as possible domestic abuse. However she does record that "*Mother noted to be accepting that the frequent changes of partners having a detrimental effect on her own emotional wellbeing and that the lack of stability has contributed to Child N's behaviour as well as frequent hospital admissions*". There is no information to suggest that the FNP practitioner considered sharing this information with CSC despite a new pregnancy, a new partner and possible domestic abuse being noted.
328. This was the FNP's last home visit to Mother and Child N in Bradford and she did not see the family again until 18th May 2016 by which time they were living in Calderdale.
329. In summary between December 2015 when Bradford CSC carried out a single agency assessment and February 2016 there were indications that Child N's safety and wellbeing were compromised these included:
    - Non engagement with the children's centre
    - Child N's deteriorating ASQSE scores
    - Child N's behaviour
    - Mother's inconsistent parenting
    - Mother's increasing stress and anxiety
    - Mother living with MA and the loss of her relationship with FM
    - A further unknown male present in the family home
    - Possible domestic abuse (Mother's disclosure that the relationship with Male 3 was verbally abusive and that Child N had heard this).
    - Mother's unplanned pregnancy-Male 4 being the father.
330. This information, had it been shared *and* discussed, may have prompted a re-assessment of risk and need which could, in turn, have determined what information was shared with agencies in Calderdale when the family moved there in April 2016.

Cross Boundary Information Sharing

331. This case highlights a systemic issue with children/ families with vulnerabilities which are compounded by frequent changes of address. Where a change of address also involves a change of local authority area this can be a particularly challenging for agencies to keep track of families but also can be a time of increased risk for children as they can become 'invisible' to agencies.

332. In this case the fact that Child N was assessed as not meeting the threshold for ongoing CSC intervention meant that there was no requirement for Bradford CSC to alert Calderdale CSC about the family.
333. Mother advised the FNP practitioner that she had moved to an address in Calderdale on 9th March 2016. (Mother did not move into her own tenancy until May 2016).
334. A FNP practitioner (this practitioner was covering for Mother's allocated FNP practitioner during a period of absence due to illness) contacted Bradford CSC on 11th May to ensure that they were aware of Mother's move to Calderdale and to check that PGF was allowed contact with Child N.
335. The process of 'handing over care' from the FNP to the Health Visiting service was delayed by several factors (including a delay in allocating the case to a health visitor and Mother reporting that she was going away on holiday for 2 weeks).
336. The 'hand over' joint visit of the FNP practitioner and the Calderdale Health Visitor took place on 7th July 2016 and bruising to Child N's temples was observed at this visit at which Male 5 was present. Neither the FNP practitioner nor the Health Visitor shared this information with Calderdale CSC.
337. Child N underwent his second child protection medical the following day (8th July) having been taken to A & E by Mother following what she reported as a fall down the stairs. (A & E staff had concerns about the cause of his injuries and requested a child protection medical).
338. The information available to the paediatrician, the 2 SWs and the 2 police officers in attendance was limited but did include information that Child N had undergone 2 previous child protection medicals (although this was not correct as he had not undergone a medical in relation to the burn).
339. Within the space of 4 weeks Child N underwent 4 child protection medicals and during that time Calderdale CSC were gathering information which was held by agencies in Bradford about the family. If this information had been available from the date of the family's arrival in Calderdale it may well have influenced decision making and the timing of the decision to hold an initial child protection conference.

Key Learning

- When families with existing vulnerabilities and specifically where there have been recent child protection concerns move from one area to another there is potential for delay, confusion and misinformation between agencies. There may be benefit from considering that, for example, the FNP cohort of mothers have specific vulnerabilities which would warrant a system alert when families move area.

Determine whether the National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies were followed.

340. National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies were not always followed during the timescales considered by this SCR. These instances are described in more detail by the agency IMR authors however key examples include:

- The WYP IMR author notes that "*There is no record of any discussions taking place between West Yorkshire Police and Children's Social Care when bruising to Child N was reported on 21st July 2016 and 2nd August 2016. There are no record of any strategy discussions being held in the Calderdale CAT in relation to the bruising. There is nothing recorded that indicates that West Yorkshire Police were informed that paediatric medicals were to take place nor is it recorded that West Yorkshire Police were informed of the outcome of these paediatric medicals*".
- "*If the referral relates to a situation in which a crime has or may have been committed, including sexual or physical assault or physical injury caused by neglect, the worker receiving the referral must discuss the referral with the Police at the earliest opportunity. The Police, in consultation with Children's Social Care Services and any other agencies involved with the child, must consider whether there should be a criminal investigation and/or a Children's Social Care Services led intervention.*
- *Children's Social Care Services must hold a Strategy Discussion whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer Significant Harm.*
- *Any decision made after a Strategy Discussion that further child protection action by Children's Social Care Services and/or the Police is not necessary as there is insufficient evidence of risk of Significant Harm to the child may only be made providing it is agreed by a Children's Social Care Services Manager and the Officer in Charge of the Police Child Abuse Investigation Unit and the reasons recorded*".

341. The 2011 -2014 Triennial Analysis of SCRs points out that strategy discussions provide opportunities for information and opinions to be clarified. Appropriate attendance or representation of all relevant professionals is essential so that effective challenge and clarity can take place when ambiguity is identified. ***This may particularly apply where medical opinions are provided where it is not possible to be certain about the cause of any particular injury or presentation, as in this case.***

342. There is no evidence from Calderdale CSC records as to why a strategy discussion was not held in respect of the injuries reported on the 21st July. The injuries reported on the 2nd August led to a child protection medical taking place on the 3rd August and a strategy discussion with the police on the 5th August. There is no evidence on Calderdale CSC records as to why the strategy discussion did not take place earlier.

343. The Together Housing (TH) IMR author notes "*TH has robust safeguarding policies and procedures in place which are regularly reviewed to ensure they remain aligned with multiagency procedures and also to incorporate best practice and ongoing learning. Clearly within this case our safeguarding procedures have not been followed, which has highlighted a training need for the specific staff member. Albeit extensive refresher training has recently been provided, including overlaps (with ASB/domestic abuse/safeguarding), this review has highlighted that there could still be further training required for other neighbourhood staff*".

344. In respect of the third child protection medical carried out in Calderdale the IMR author notes "*The RCPCH child Protection companion states that abusive bruises are often located away from bony prominences and are found predominantly over soft tissue areas. Sites include the ear, neck, cheeks, buttocks, back, chest, abdomen, arms, hands and posterior thigh. However, no site is pathognomonic and a careful history must be taken in all cases. Noted bruise in the ear, genitalia and multiple other sites again without an explanation but*

accepted as either evolving since the previous child protection medical or a new trauma though does not extrapolate to how this might have occurred

345. No clear opinion as to the cause of the injuries or recommendations given to social care.

346. *In the absence of a plausible explanation for numerous bruises in a child, in addition to pattern of bruises being in unusual sites such as the sternum, left side of the chest, penis and inside the ear. This presentation was highly concerning for physical abuse. Accepted without question another Colleagues opinion on injuries. This was a potential missed opportunity to safeguard child's wellbeing*". CHFT Named Doctor for Child Protection now undertakes a review of all child protection medical reports on a monthly basis to review language used and opinions given to monitor for overly optimistic language or opinions. This information also is used to audit our practice and assess for common themes or risks and provides peer review and supervision.

347. All CHFT paediatricians are aware that multiple Child Protection Medicals increases the likelihood and concern that there are safeguarding issues in these children and that this should be documented and communicated to Social Care.

348. Key Learning from this line of enquiry is reflected in Single Agency Action Plans

Common themes from previous serious case reviews or critical incident reviews.

349. Themes which the LSCB's may wish to consider which have emerged from previous serious case reviews have been referred to elsewhere in this report. To summarise these include:
    - Unknown males / new partners
    - Vulnerable young parents
    - An incident led response.
    - Over reliance on medical opinions.
    - Failure to hold strategy discussions/ meetings
    - Cumulative and ongoing nature of risk not recognised.

350. In particular significant important learning exists from cases where children have presented with potential non accidental injuries and how these have been responded to and this is referred to in detail throughout the report.

351. In the Triennial Analysis of Serious Case Reviews (2011 to 2014) the authors; in respect of children who suffer fatal injuries state "*Most notable are the risks presented through situations of domestic abuse, particularly when this is in a context of a young or immature mother, or one who has ambivalent feelings to her child, and perhaps exacerbated through a transient or chaotic lifestyle with multiple partners, frequent house moves or overall social isolation*".

352. Overall, there are common themes from other serious case reviews, critical incident reviews and a recent domestic homicide review which are also present in this case.

Key Learning

- Child protection practice should be grounded in an evidence-informed approach
- Good evidence-informed practice is dependent on practice-informed research
- There are many opportunities for wider learning and developing arising from serious case reviews

Identify learning that will help partners and the LSCBs to strengthen understanding of and response to Child N and to all vulnerable children and young people.

353. Key learning is identified within each chapter covering the key lines of enquiry within the report. However other learning has been identified and is summarised below.
354. It is only by taking into account Mother's own childhood experiences of trauma and abuse, her on-going vulnerability and troubled and abusive relationships with males that we might consider that her capacity to parent may have been compromised.
355. Mother had experienced significant historical traumas and exposed Child N and herself to risk from her relationships with men and with her own parents.
356. Factors that are known to be associated with risk to babies and very young children (Ward et al 2012) include parents who have experienced abusive childhoods themselves and have not come to terms with the abuse. Additional risk factors include domestic abuse and environmental stressors such as housing. Significant protective factors are the presence of a supportive non-partner, wider family and informal support and parent's insight understanding and capacity to change. Severe risk of harm is most likely where there is an absence of protective factors as in this case. (Ward, H., Brown, R., and Westlake, D. 2012) Safeguarding Babies and Very Young Children. London: Jessica Kingsley Publishers.
357. Women with Mother's history of extreme trauma may suffer from Complex Post Traumatic Stress Disorder (C-PTSD) which results from chronic or long-term exposure to emotional trauma over which a victim has little or no control and from which there is little or no hope of escape, such as in cases of domestic, emotional, physical or sexual abuse.
358. The impact of C-PTSD on parenting (and in this case specifically on being a mother) is not fully understood. However there is significant research about women with similar experiences of childhood trauma and abuse which continues into adult hood and the impact that this has on parenting.
359. It is also only by considering Mother's full history and understanding the impact of trauma and possible on-going abuse and coercion on her capacity to parent and her ability to keep herself and her child safe that we would see the need for a much more pro-active and evidence based approach to assessing risk and need.
360. What this may mean for practice is that a highly individualised or personalised approach should be taken with girls and young women who have multiple vulnerabilities. In this case a trauma informed, *gendered approach which took into account Mother's full history had the potential to safeguard Child N. * Research indicates that the impacts and consequences of childhood trauma are experienced differently by men and women. This means that gendered approaches when working with people who have experienced childhood trauma will be more effective and help further our understanding of what works. (Examples of gender and trauma informed approaches can be found at cannarratives.org and at centerforgenderandjustice.org).
361. The implications of much of the learning from this serious case review applies to foster carers (alongside the other professionals) who are uniquely placed to work alongside girls and young women who share many of Mother's vulnerabilities.
362. In summary there is cumulative risk of harm to a child when several risk factors are present in combination over periods of time. The 2011 to 2014 National Triennial Analysis of SCR's

qualifies this " *We previously noted this particularly in relation to **domestic abuse**, **parental mental ill-health**, and alcohol or substance misuse, but it also includes other risks **such as adverse experiences in the parents' own childhoods**, a history of violent crime, a **pattern of multiple consecutive partners**, acrimonious separation, and **social isolation**. When presented with **any** of these risk factors, practitioners should explore whether there may be other cumulative risks of harm to the child, as well as any protective factors. The impact of all domestic abuse is harmful to children and a step-change is required in how we understand and respond to domestic abuse. There is a need to move away from incident-based models of intervention with domestic abuse to a deeper understanding of the ongoing nature of coercive control and its impact on women and children, and also on men*".

363. A further issue which would benefit from specific focus is the transient lifestyle of young parents who share Mother's and by default, Child N's vulnerabilities. This transient lifestyle means that parents and children can 'disappear' from an area where they were receiving support ***and*** monitoring and re-surface in a new area where they are unknown to agencies.
364. In this case when Mother left her home in Bradford (where she had also changed address frequently) and moved to Calderdale she became more isolated as her relationship with FM had broken down and her contact with the FNP practitioner who works to a specific geographical location also had to end.
365. Calderdale CSC's contact with Mother and Child N occurred over a 4 week period between July and August 2016. During this time Child N underwent 4 child protection medicals.
366. The CSC IMR author points out that "*The first two child protection medicals indicated that the harm was in the context of providing appropriate supervision and indications that birth mother was struggling to provide appropriate positive behaviour management. The family context was being explored, including indicators of protective factors such as the role of Child N's birth father and paternal family. However the assessment was interrupted by the bruising and, in my opinion, this then redirected the focus of the work*".
367. This gathering of information and exploration of the whole family context was taking place at a fast pace in response to reports of bruising to Child N. It is not difficult to imagine how challenging this was for Calderdale CSC and how much safer a full and contextualised hand over of care ***and*** concerns would have been if it had taken place when Mother moved to the area in May 2016.
368. In light of this and the learning identified from other serious case reviews (and domestic homicide reviews) where families with established risk factors move into a new area it may be worthwhile focusing on how information can be transferred with them.

What have agencies already done in respect of the learning from this Serious Case Review?

Bradford LSCB and Partners

369. The Signs of Safety framework continues to be embedded into practice (BCSB)
370. Pre- birth policy to include care leavers (implemented) (BCSB)
371. Professional Challenge and escalation learning events and raising awareness programme (implemented) BSCB
372. Strategic guidance and expectations communicated to foster carers and staff regarding healthy relationships with ex foster children (BCSB)

373. The handover process from FNP to Health Visiting universal service has been strengthened with Tiered assessment provided. This will be included in the transfer documentation on the child's record. (FNP and HV)

Calderdale LSCB and Partners

374. Calderdale CSC have agreed, as part of a current review of practice standards that the following is added and disseminated to staff via usual routes:
    - 'For all open cases where a medical is required, a strategy discussion must be held with the Police as a minimum, and this arrangement will apply to any subsequent medicals. If 3 medicals are held within a 12 month period, a formal strategy meeting must be held with the clear expectation that the Police and Paediatrician attend as a minimum. The local authority legal representative must also be invited to that meeting'.
375. Funding has been secured for an innovative, evidence based, new way of working 'Positive Choices', to better support young people in care. Positive Choices uses a behaviour change model to provide early, intensive interventions to young women, and where appropriate, their partners, throughout pregnancy and the early years.
376. A new workshop 'Taking the Difficult out of Difficult Conversations' has been introduced into the multi-agency safeguarding training programme to develop skills in professional challenge and curiosity
377. Resolving Professional Disagreements and Escalation policy has been implemented
378. Information Sharing Guidance (including cross borders) has been updated and implemented
379. Assessment guidance document and the Risk Indicator Tool (refreshed to include references to ACE's) will continue to be used and promoted in multi-agency training.
380. The Pathway and Letter to use with 'Hostile and Resistant families' has been re-launched and the 'Was Not Brought' message will continue to be promoted in training.
381. SMART planning practitioner workshops, EISA training and the Strengthening Families Approach in Assessing and Planning promotes child and outcome focused practices.
382. Introduction to Safeguarding Supervision training has been refreshed and emphasises the importance of reflective, child focused practice.
383. The Calderdale Children's Centre now routinely gather information at registration about children's fathers and other carers.

How will the learning from this Serious Case Review be shared and how will the LSCBs know that it has impacted upon practice?

384. The two LSCBs will ensure that areas of improvement to joint working practice are reflected in the Business Planning processes as appropriate. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.
385. Progress and impact will be managed through the appropriate LSCB work streams, with the Calderdale LSCB Case Review sub- group monitoring an overarching action plan, working with BSCB Case Review Sub-group.

386. The LSCB and its members will formally and regularly monitor the implementation of the action plan and recommendations in order to ensure progress is being made.
387. The CSCB Case Review sub group will maintain a register of all recommendations and require both the CSCB and its partner organisations to report on progress and sustainability through challenge events with front-line practitioners and managers. The BSCB will also undertake this process.
388. The LSCBs will review policies and procedures and where necessary update or put in place appropriate amendments or new policies.
389. The LSCBs, in their annual reports, will report on the progress made and the wider impact across partners of the learning, in order to consider whether progress and impact has been good enough.
390. The CSCB will work with partners to progress the single and multi-agency recommendations.
391. The BSCB will work with partners to progress the single and multi-agency recommendations.

Dissemination, implementation and monitoring of impact of learning

392. The Boards and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained and we will test this through regular monitoring and review. Our approach to this is outlined in the Learning and Improvement Framework; these are some examples of how the learning from this review will be promoted and embedded in practice:
    - Training and briefings to professionals
    - Newsletters, briefing papers and learning lessons for front line practitioners
    - Quality assurance through audit
    - Performance management of indicators which outline practice improvements
    - Publication on website
    - Challenge events for front line practitioners to ensure the learning has been absorbed

Conclusion

393. It is apparent that; despite the commitment and efforts of the practitioners working with the family, Child N was living with multiple risks and was displaying signs of distress. Some of the serious injuries suffered by Child N throughout his short life were non –accidental and the learning from this review reflects what learning may be applied to help partner agencies respond to vulnerable children in the future.

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Serious Case Reviews considered

Baby F Rochdale 2013.
Baby Bailey 2017 Durham
Child H 2013 Lambeth