Serious Case Review

Overview Report

A Thematic Review Concerning the Non-Accidental Injury of Three Infant Children

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1. Introduction

1.1.1 On the recommendation of the Serious Case Review Group, a decision was taken in March 2018 by the Independent Chair of the Southampton Safeguarding Children Board (hereafter referred to as the Southampton Safeguarding Children Partnership) to commission a Serious Case Review into the death of one baby and serious injuries to two others. All three cases were considered individually by the Serious Case Review Group, which decided that they met the criteria for Serious Case Review under Working Together 2015[1].

1.1.2 All the babies were male and at the time of the injuries and death, were aged between 6 to 10 weeks. Because there were similarities in the age and background of their parents, and due to all three incidents occurring within a two-month period, in order to maximise the opportunity for learning and improvement of professional practice, it was decided that it would be appropriate to consider all three cases together.

Purpose

1.1.3 This Serious Case Review[2] is a thematic review with an analysis of common issues concerning non-accidental injury to babies whose parents were teenagers or young adults. The review is presented as one report, which will also include an assessment of particular circumstances pertinent to each individual case.

2. Who were the three babies?

Circumstances leading to the commissioning of this Serious Case Review

2.1.1 For the purposes of anonymity, the three babies subject to review are known as:

- Baby Connor
- Baby Danny
- Baby Ethan

2.1.2 **Baby Connor** was born in December 2017 and died at the age of six weeks in February 2018.

2.1.3 At the time of Baby Connor's death, he was living with Mother in a flat, which was part of a supported, independent living unit for parents and babies. It was not a Mother and Baby Unit and was not staffed 24 hours a day. Partners were allowed to visit 3 nights a week, however it is known that Father may have been residing at the flat with Mother. The Unit where Baby Connor was living was well known to Police because of concerns about residents engaging in parties, drug and alcohol use and anti-social behaviour.

[1] All three incidents occurred in January or February 2018.
[2] Known as Child Practice Safeguarding Reviews, Working Together 2018

2.1.4 Police were called by ambulance staff attending Baby Connor early in the morning of 11 February 2018. On arrival Baby Connor was not breathing and paramedics were undertaking CPR. Bruising was noted to his legs and arms, but primarily to his thighs and under his arms. Baby Connor was taken to Southampton General Hospital but was declared deceased. A post-mortem examination found that he had suffered bilateral and complex fractures to the skull, as well as other fractures to his leg and collar bone.

2.1.5 On 21 December 2018, Father was convicted of murder and sentenced to life imprisonment. Mother was convicted of child cruelty and sentenced to 30 months imprisonment. Father was aged 17 at the time Baby Connor died and Mother was 19 years old.

2.1.6 **Baby Danny** was born in October 2017. When he was 10 weeks old, on an evening in early January 2018 Police were contacted by Children's Social Care Out of Hours Service to inform them that they had been called to attend Southampton General Hospital. Baby Danny had been brought into the hospital that morning by ambulance. Father reported that he had given Baby Danny his feed early in the morning and shortly afterwards he had struggled to breath and became floppy.

2.1.7 On arrival at hospital Baby Danny was no longer floppy and presented as a well-baby, however further examination revealed swelling to the fontanel, which indicated swelling to the brain. A CT scan revealed bi-lateral retinal haemorrhaging and a subdural hematoma. There were no other signs of external injuries.

2.1.8 Prior to his birth Baby Danny was subject to Child Protection Planning under the category of neglect. He was deemed to be at risk of significant harm due to concerns in relation to Mother's mental ill heath, self-harm, volatile behaviour and unpredictability.

2.1.9 Baby Danny is now placed with foster carers on a Special Guardianship Order. The CPS decided that no charges should be brought against his parents.

2.1.10 **Baby Ethan** was born in October 2017. In January 2018, when he was 10 weeks old, he was taken to the GP Surgery by his parents. During a medical examination, Baby Ethan was found to have bruises and marks all over his body (25 in all). These injuries were considered to be non-accidental. Police and Children's Social Care attended the surgery and Mother and Father were arrested.

2.1.11 On arrival at Southampton General Hospital, in addition to the bruising, a skeletal survey revealed that Baby Ethan had suffered fractures to the proximal and distal metaphyses of the left tibia.

2.1.12 On discharge from hospital Baby Ethan was placed with foster carers. His parents were charged with causing or allowing serious injury to a child. Father was convicted of this offence and was sentenced to a term of imprisonment. Mother was acquitted.

3. The Process of the Serious Case Review

3.1.1 The Terms of Reference, purpose, methodology for the review and details of the Lead Reviewer can be found in Appendices 1 - 3.

Practitioner Event

3.1.2 A practitioner event was held on 3 April 2019. Prior to arranging the event, the Police and Crown Prosecution Service were contacted to ensure that by holding such an event any outstanding criminal proceedings would not be compromised. Confirmation was received that the event could proceed, and 20 practitioners attended. The purpose of the event was to consider key questions and themes arising from the review and to provide an opportunity for those attending to reflect on events, professional practice and to assist the Lead Reviewer in forming her analysis of the issues arising from this case.

3.1.3 The event proved helpful to the Lead Reviewer and the consensus from those attending was that it proved useful and beneficial to their understanding of the cases and events leading to the death and serious injury of the three babies.

3.1.4 The Lead Reviewer would like to express her thanks to all those who attended the event and who contributed to this Serious Case Review. Most especially, the assistance provided by the Southampton Safeguarding Partnership support staff, which ensured that the event and the review process as a whole was smooth, efficient and professional.

3.2 Scope and Terms of Reference

3.2.1 The full Terms of Reference and Scope for the Review can be found at Appendix 1.

3.2.2 **The time period under review for each child is:**

Baby Connor: 11/05/2017 -11/02/2018

Baby Danny: 10/03/2017 – 6/01/2018

Baby Ethan: 4/04/2017 – 10/01/2018

3.2.3 The start date for each review is the date the Mother's pregnancy became known to agencies. The end date is the date of the death/injury to the child.

Analysis issues

3.2.4 This review will consider the issues that could have a bearing on the circumstances of these cases and will include:

- Support offered to young parents
- Assessment of parenting skills and risk to the unborn baby
- Impact of mental health issues, self-harming behaviour and substance misuse on parenting capability
- Impact of lack of good parenting experiences on young parents
- Impact of homelessness
- Anger management and domestic abuse
- Robustness of decision making concerning the child protection process
- Evidencing of the child's lived experience within the family
- Over optimism on the part of professionals as to the parents' capacity to care
- Involvement of Police and Criminal Justice.

3.3 Involvement of the Families

3.3.1 Statutory Guidance: Working Together to Safeguard Children (2015), requires that families should be invited to contribute to a Serious Case Review. Southampton Safeguarding Children Partnership informed the families in October 2018 that a Serious Case Review was being undertaken. Only Baby Danny's parents met with the Lead Reviewer. Due to the Covid Pandemic the meeting took place virtually in November 2020. The meeting proved helpful to the review and the views of the parents are reflected in the report. The Lead Reviewer would like to thank the parents for taking the time to meet with her and for talking about Baby Danny.

Developing a picture of the lives of Baby Connor, Baby Danny and Baby Ethan

4.1.1 The purpose of this section of the review is to provide a background history of each baby and his parents. Key events for each child are included and evidence of their lived experience within the family. Relevant information concerning the background of each family, which falls outside the period under review is also included.

4.1.2 The information included in the report is taken from documentation provided by agencies participating in the review. Baby Danny is an exception, as when interviewed, his parents provided their views to the Lead Reviewer on the way in which agencies worked with them, as well as some additional information concerning themselves and Baby Danny. The views of Baby Danny's parents are reflected in the sections of the report concerning this child.

Baby Connor
Mother

4.1.3 It is believed that Baby Connor's parents had been in a relationship when Mother was almost 17 and Father was just 16. When she became pregnant, Mother was living at home with Maternal Grandmother and her two younger siblings. Maternal Grandmother was supportive of the pregnancy.

4.1.4 There had been some previous concerns about Mother, however, Children's Social Care's main focus of involvement was with Mother's younger sibling, who had special needs.

4.1.5 When Mother was 12 years old, she attended the Emergency Department (ED) having taken an overdose following an argument with Maternal Grandmother. She was admitted overnight and assessed as not having mental health concerns. Six months later, in April 2012, Mother attended the ED again. She was drunk and was admitted overnight. A safeguarding proforma was completed by the hospital and having been assessed by a paediatrician and CAMHS, Mother was discharged.

4.1.6 In April – June 2014 Mother was not attending school due to bullying and low self-esteem and there was also concern that she may have been subject to grooming for the purpose of Child Sexual Exploitation. This was investigated by Children's Social Care and Maternal Grandmother gave assurance that this was not the case. A Strategy Discussion took place, but no further action resulted.

4.1.7 Children's Social Care was contacted by ED staff in March 2016, when Mother and Father were admitted with smoke inhalation following a house fire at Paternal Grandmother's flat, whilst she was not in attendance. They escaped serious injury having been rescued by firefighters. At the time of her admission to hospital, it was noticed that Mother had a large bruise to her upper left arm and multiple bruises to lower legs. When asked about the bruising Mother said she couldn't remember how it had happened and that all was fine. Maternal Grandmother expressed her concern about the relationship with Father.

4.1.8 Mother's relationship with Father was volatile and there were concerns that she was subject to domestic abuse. Police had recorded three incidents in 2016 which were domestic abuse related involving Mother and Father. They were all recorded as verbal domestic arguments and a Child and Young Person Report (CYPR), safeguarding notification was submitted on each occasion.

4.1.9 In 2017, Maternal Grandmother and the family were an open case to Children's Social Care. This was because of concerns about the significant special needs of Mother's 13 year old sibling, and had at times been violent towards herself and Mother.

4.1.10 When she was 7 weeks pregnant Mother booked for midwifery care and it was recorded that it was "*an unplanned pregnancy but happy, Boyfriend supportive, will live at home."* (Source: Primary Care IMR). Due to the age of the parents, care

was completed by East NEST (Needing Extra Support Team) and a referral was made to both the Family Nurse Partnership (FNP) and the Hospital Maternity Safeguarding Team. During the antenatal period there were no missed appointments and no concerns were raised concerning Mother's presentation or appropriateness at appointments. Father was present for some of the antenatal appointments. Mother was said to be emotionally well during pregnancy and in the postnatal period.

4.1.11 In August 2017, the first visit was undertaken by the Family Nurse. At the time Mother and Father were living with Maternal Grandmother, her stepfather and siblings. Children's Social Care had supported a referral to housing for Mother to secure her own accommodation, because of the risk presented to Mother and her unborn child from her sibling. The FNP recorded excellent engagement by Mother throughout her pregnancy and both she and Father appeared to be excited about the baby, had prepared well for the arrival, showed good insight into the risks that Mother's younger sibling might pose and was keen to secure her own accommodation, although they were also aware that this was a 'big step'. (Source: Solent NHS Trust)

4.1.12 By mid-November 2017, Mother was residing at a supported accommodation unit for young parents. Father was noted to be considering an apprenticeship. In mid-December two appointments with the Family Nurse were cancelled and when a meeting did take place in January 2018, 4 days after Baby Connor's birth, at the parents request, it was in a café. It was known by the Family Nurse that Father was residing at the young parent accommodation unit.

4.1.13 During the following weeks until the death of Baby Connor, the Family Nurse attempted six visits, but only managed to gain access to him and the parents on three occasions. The last visit taking place just over a week before he died, by which time the family had moved to another supported, independent living unit for parents and babies. Visits were cancelled by Mother, or the Family Nurse could not gain access to the property, nor could contact be made with Mother by phone. When the Family Nurse did gain access, no concerns were recorded about Baby Connor's care. During the last visit, it was noted that Mother was tired, Baby Connor was more unsettled at night and that there was decreased contact with Maternal Grandmother. By the time he was 6 weeks old Baby Connor had not been registered with a GP.

Father

4.1.14 There was a long history of involvement by statutory agencies with Father and his family. Father and his siblings had been subject to Child Protection Plans for emotional and physical abuse and were under a Public Law Outline (PLO) process for a number of years. There were also concerns about neglect. Paternal Grandmother had a history of alcohol and substance abuse, with periods of severe intoxication, as well as being subject to domestic violence.

4.1.15 Father's school attendance was poor, and his behaviour became increasingly violent when he reached adolescence. He was referred to CAMHS in 2017 but was not considered to meet the criteria for the provision of service.

4.1.16 Until the death of Baby Connor, Father had no previous convictions. However, Police were in receipt of nine incidents concerning Father from January 2017 until February 2018. These concerned reports of criminal damage at Paternal Grandmother's home, (which was reported to the Multi-Agency Safeguarding Hub (MASH) on 23/01/2017); domestic disputes between Father and Paternal Grandmother, and between Father and Mother; being present when Mother was assaulted by her sibling, being under the influence of alcohol and substance misuse, noise complaints and aggressive behaviour whilst staying at the independent living unit for parents and babies.

4.1.17 There was a notification of Father being involved in an aggressive incident, 6 days after Baby Connor's birth, when Police were called to Southampton General Hospital because of his behaviour towards ambulance staff. Father was under the influence of prescription drugs at the time.

Baby Connor's lived experience within the family

4.1.18 Baby Connor was born in hospital without complication. Mother had attended antenatal appointments and the parents were said to be excited about his birth. Whilst Mother engaged with midwifery appointments and the FNP when living with Maternal Grandmother, this began to deteriorate once she moved out of the family home. During the first weeks of his life Baby Connor lived with Mother in supported accommodation unit for mothers and babies. Father visited regularly and was staying overnight.

4.1.19 Whilst at this supported unit, Mother and baby were not considered to be at risk and, following the completion of the unit's 'My Safety and Support Plan' Mother and Baby Connor moved to an Independent Living Unit, which offered less support to parents. Once there, Mother began to fail to attend review sessions and concerns began to be raised with staff by other residents about arguments between her and Father.

4.1.20 Little is known about the quality of Baby Connor's short life. When the Family Nurse visited in late January 2018 Mother was described as 'slightly tearful' due to tiredness as Baby Connor had not slept for two nights. Father had been staying over to offer support. Money was a problem, as appropriate benefits had not been received and the FNP issued a 'Basics Voucher'. The Family Nurse noted that Father handled Baby Connor well, was gentle and caring and supported his head appropriately. There is, however, no description available to the review of whether Baby Connor was well fed and dressed, or whether he was generally a contented baby. The review has learnt that is it not usual for a Family Partnership Nurse to record such information, as only concerns about a baby's care is noted. (NB Practice has changed since the review was commissioned).

4.1.21 When the Family Nurse made her last visit before Baby Connor died, she noted that Mother said he was becoming more unsettled at night and she was increasingly tired. Mother reported that a complaint had been made by another resident about the noise from her flat and that she was having decreased contact with Maternal Grandmother.

4.1.22 By this time, Baby Connor was five weeks old, but had not been registered with a GP. There is no information available as to whether Baby Connor's six to eight-week check had been arranged, nor whether it was questioned as to why he had not been registered with a GP.

4.1.23 At the end of January 2018, Police Officers attended an incident which concerned another resident at the unit. It was during the arrest of this resident that the officers were told that Baby Connor had been seen with blood coming from his mouth. Banging and shouting was heard coming from Mother's flat. Mother requested that Father leave, which he did at the request of the officers. The flat appeared clean and tidy and no further concerns were reported. Although Father was arrested, he was then de-arrested and returned to the accommodation. Unfortunately, the concerns expressed by the resident about Baby Connor seen bleeding from his mouth were not investigated at the time by the attending officers. See Para 5.1.20.

4.1.24 At the practitioners event, information was shared that on the night that Baby Connor died, there had been a party involving drugs and alcohol. There had been an argument between Mother and Father relating to jealousy, which resulted in domestic violence and then violence to Baby Connor.

4.1.25 At the criminal trial of both parents, distressing evidence was given of the injuries which Baby Connor suffered and the actions resulting in his death. Father confirmed that he had taken ecstasy and drunk vodka and lager shortly before his son's death.

4.1.26 The picture which emerges from the limited information available about Baby Connor's short life is one of domestic arguments between young and inexperienced parents, living in an environment where alcohol and drugs were prevalent. Little is known about his day to day experience, but given the toxic mixture of immature parents, limited engagement with professionals, substance misuse and violence, Baby Connor was a vulnerable child who was seriously at risk of harm, which tragically resulted in his violent and painful death.

Baby Danny
Mother

4.2.1 Mother was 18 years old when Baby Danny was born.

4.2.2 When she was 10 years old, Maternal Grandmother died. Mother had experienced a traumatic childhood. She was placed with Maternal Great Grandmother, until 2013 when Mother became a Looked After Child by another authority. Mother had

numerous foster care placements and was first admitted to hospital when she was 12 years old, because of self-harming behaviour, which was to continue throughout her teenage years. Concerns began to emerge about Mother being at risk of Child Sexual Exploitation. Mother was placed in secure accommodation and subsequently admitted to a hospital for children with mental health needs.

4.2.3 Mother became known to Police, in the main for assaulting care staff and serious self-harming behaviour. As a Looked After Child she had experienced 35 different placements. Mother was sectioned under the Mental Health Act, 1983, on numerous occasions because of the serious risk she presented to herself, as a result of extreme self-harming behaviour

4.2.4 In March 2017 a referral was made to Southampton Children's Social Care from the Children's Services Care Leavers Team in the local authority where Mother had been looked after. Mother was now residing in Southampton having been recently discharged from hospital having been Sectioned under the Mental Health Act. She had been diagnosed as having a personality disorder, complex PTSD which manifested itself through flashbacks, dissociative episodes, feelings of hopelessness, low mood, anxiety and suicidal thoughts. Mother was in the early stages of pregnancy.

4.2.5 Mother had met Father via the internet. Within 8 weeks of knowing each other, Mother became pregnant, and they had moved in together. Mother was seen by midwifery services in March 2017, where further concerns were raised about her being overweight, cannabis use, cigarette smoking and high alcohol consumption. Mother was on medication for her mental illness, which was reviewed throughout her pregnancy. It was noted on the midwifery assessment form that Father had mental health and substance difficulties. Mother was referred to the Specialist Midwife. (Source: Solent NHS Trust Scoping document).

4.2.6 There were also concerns about the condition of the accommodation in which the parents were living.

4.2.7 On 24 November 2020, the parents met with the Lead Reviewer and when asked whether she had any anxieties or fears about being pregnant, Mother agreed that she felt frightened about having a baby. '*She didn't feel she was ready for a baby but as the pregnancy progressed, she started to feel ready for it.'* Mother explained that she had only just left care when she found out she was pregnant with Baby Danny. Given her experience of being a Looked After Child, Mother did not trust Children's Social Care to become involved with her pregnancy.

4.2.8 Prior to and throughout her pregnancy, the Care Leavers Team was involved with Mother and visited her and Father regularly. They were also part of the Child Protection and Discharge Planning Meetings. During the meeting with the Lead Reviewer, Mother explained that at this time she was having to learnt to trust different people in a way that she had never done so before. Mother said she had moved to Southampton to live with Father and had been asked by Children's Services to register with a new GP Surgery and request a referral for local Perinatal Mental Health Services. Mother told the Lead Review she had done so but was told that she did not

meet the criteria for the service. At a Child Protection Conference, Mother said it was inferred that she refused to go to the GP to seek this referral.

4.2.9 The Lead Reviewer asked if Mother had challenged this suggestion, and Mother explained that she '*struggled with communication at the time and when she did manage to communicate it probably did not come across in the most articulate way.'* Mother went on to say that she felt she was never really listened to by professionals and that she was seen as argumentative rather than trying to make a point. Mother told the Lead Reviewer that she was '*a lot calmer now and has worked on her communication.'*

4.2.10 In May 2017 Mother attended the Emergency Department because of self-harming behaviour, however, she did not stay to be seen and Father said he was dressing the wound at home. A week later, the Family Nurse undertook a recruitment visit and was advised by Mother that she had not self-harmed recently.

4.2.11 In June 2017, Mother and Father came under the care of the FNP. Mother was expressing anxiety about her ability to care for the baby. Concerns were also noted about the condition of the flat. It was considered that Mother was engaging well with the FNP. Mother was referred to the Perinatal Mental Health Team by the midwife.

4.2.12 In the first two weeks of July the Family Nurse visited Mother at home. Father was at work. Mother said she found it difficult to get up and walk around the flat before 3pm. The flat was described as cluttered and untidy. At the second visit the flat was described as cluttered, and Mother was smoking heavily. The Family Nurse noted concerns that Mother was struggling to meet her own needs and questioned the level of support needed after the baby was born. She planned to follow up with the Social Worker.

4.2.13 In mid-July the Perinatal Mental Health Team visited Mother at home. It was concluded that there was nothing that could be additionally offered, which was not already being provided by the FNP.

4.2.14 At the end of July 2017, an Initial Child Protection Conference (ICPC) decided that the unborn baby should be subject to a Child Protection Plan. A Legal Planning Meeting was held, which recommended: further perinatal assessment, non-negotiable mental health assessment of Mother and a capacity to care assessment of the parents.

4.2.15 The GP informed the Social Worker in early August 2017 that the Adult Mental Health Team would not consider Mother appropriate for their service as she had already been seen by Perinatal Mental Health Team, who had concluded that she was not mentally ill. The Social Worker made a telephone call to the Perinatal Mental Health requesting that Mother was offered support, as had been recommended in the parental assessment, however, the response was that this could only be offered if Mother was deemed to be mentally ill during her pregnancy.

4.2.16 Although Mother engaged well with the FNP, during the later stages of her pregnancy, there appears to have been little contact with Father, who was working. Toxicology tests relating to mother proved negative for alcohol and substance misuse. Mother had also stopped smoking. Child Protection visits were undertaken, and home conditions were considered 'good enough.' At a Core Group meeting in September 2017, the parents advised that Paternal Grandmother would be staying with them for two weeks after the baby was born to support with his care.

4.2.17 Baby Danny was born by emergency caesarean section in October 2017. He spent 4 days on the neonatal unit for observation as he was showing signs of withdrawal and was jittery, potentially as a result of Mother's mental health medication.

4.2.18 Following Baby Danny's birth, midwifery staff were concerned that Mother was regressing to childlike behaviour and was not caring for herself. There were also concerns about her high level of dependency on Father and what would happen when he returned to work. During the meeting with Baby Danny's parents and the Lead Reviewer, Mother denied this was the case.

4.2.19 On 30 October 2017, a discharge planning meeting was held. Concerns were raised about the hostile manner in which the parents communicated with staff and there was also a report of a smell of cannabis in Mother's room, which the parents denied. This was something which the parents also strenuously denied when they met with the Lead Reviewer. At time Mother agreed to a toxicology text, the results of which were negative. Father was not tested.

4.2.20 It was noted at the planning meeting that Mother and Father were responding well to Baby Danny and Father was caring for him overnight as Mother was drowsy due to medication. Because of Mother's mental health, Father was allowed to stay with her and Baby Danny overnight[3].

4.2.21 Baby Danny was discharged to his parents care on 30 October 2017, on the basis of them signing a contract of expectations drawn up at the Planning Meeting. The contract stipulated that Mother was not to have unsupervised contact with Baby Danny and that Father was to be the main carer. It also stated that professionals would visit every day for the first two weeks. From information provided to the review, it is not known who the professionals were, nor whether the visits took place. A Family Group Conference was to be arranged and pre-proceedings plans were to commence. A further assessment of Mother by the Perinatal Team was to be undertaken to assess risk. Father gave up his job to care for Baby Danny.

4.2.22 When meeting with the Lead Reviewer, Father stated that *'he thought it was outrageous that professionals expected him to be awake 24/7. He felt he couldn't go to the toilet unless he took Baby Danny with him and felt that it was unmanageable for him to have eyes on 24/7 as he needed to sleep.'* Mother agreed that it put '*unnecessary strain on Father and that he had to give up work pretty much overnight'.* Both parents considered they had no choice but to sign the agreement if Baby Danny was to come home with them. They explained that Father was earning a good wage

[3] The Trust occasionally allows partners to stay overnight, where mothers are experiencing difficulties.

and once he began caring for Mother and Baby Danny, the family faced severe financial difficulties. They had to wait six weeks for benefit payments to come through and were reliant on the Family Nurse who organised a food parcel from the local church. The Support Worker from the Care Leavers Team also gave them a voucher for a food bank.

4.2.23 The Lead Reviewer asked Baby Danny's parents whether the allocated Social Worker was aware of their financial situation at that time. Both said that the Social Worker told them to ask Paternal Grandmother for financial assistance and said that '*they needed to make ends meet or Baby Danny wouldn't be allowed to go home with them*.' Mother explained that this came across as '*threatening.*' Father said he had some holiday pay owed to him but both parents had to borrow money to ensure they had a roof over their heads and to pay for gas and electricity. They had to ask *'family for help to get nappies, baby milk and food as Christmas presents.'*

4.2.24 A Child Protection Review Meeting in mid-November 2017 was not quorate and the Social Worker was not in attendance. It was noted at the meeting that Mother became agitated when holding Baby Danny and that Father was responsible for the entirety of the baby's care. A Home Visit and Core Group Meeting at the end of November 2017 decided that the parents were showing signs of good parenting. They appeared to be '*providing good enough care to Baby Danny and were attentive and responded to his cues.*' Baby Danny remained subject to a Child Protection Plan, and PLO and Family Group Conference procedures. By this stage Father was not working and there had been a breakdown in the relationship between his brother and partner, which meant the support offered to Father by the couple in caring for the baby whilst he had some respite was no longer available. Financial pressures were also recognised, given that Father was now the main carer.

4.2.25 Until 6 January 2018 when Baby Danny was injured, visits by the Family Nurse and Social Worker continued. He was brought to his 6 week check with the GP and on Christmas Eve 2017 was taken to the Emergency Department when the parents were worried about him being unwell following his immunisations and that his head had a 'sunken soft spot'. On examination no concerns were noted, and the parents were reassured.

4.2.26 The Family Nurse last saw Baby Danny on 27 December 2017, when he was alert, kicking and had been fed. His fontanel appeared normal.

Father

4.2.27 Father was 27 at the time of Baby Danny's birth. Little information is available about Father's background. He was working at the time he and Mother met and claimed to be a paramedic. It is known that he lied about this. Prior to moving in together into privately rented accommodation, Father was facing homelessness. Father was seen to be supportive to Mother during her pregnancy and cared for her when she had episodes of self-harm. At the practitioners event it was stated that no assessment was undertaken of Father and his suitability to care for a baby (and for Mother).

4.2.28 Apart from what was registered at the time Mother had her midwifery assessment, there is no information available concerning Father's mental health. Some concerns have been noted as to the relationship between the parents. Following Baby Danny's injury and removal from his parents, the Care Leavers Team shared with mental health services that Mother was considering moving to a refuge due to Father's controlling and coercive behaviour. Mother also stated that Father was disappointed that the baby was not a girl, as 'he likes young girls' and that he had girlfriends aged 14/15 before he met Mother. This information was shared with police.

4.2.29 Prior to being arrested for the injury to Baby Danny, Father had no previous allegations or convictions against him.

Baby Danny's lived experience within the family

4.2.30 Baby Danny was born at full term via emergency caesarean section. His weight was within normal parameters. No concerns were noted by the Family Nurse when she visited him and the parents for the first time in hospital, after his birth.

4.2.31 When meeting with the Lead Reviewer, Father described Baby Danny as '*fantastic*.' Mother said *'he was so easy that she worried she was doing something wrong. He was so tiny that she was initially terrified*. Mother felt she was being constantly watched in hospital and everything she did with Baby Danny seemed to be wrong. When they got home, everything was so much better. Father explained that '*Baby Danny loved cuddles, he loved holding him and he was a little bundle of joy. Baby Danny made him smile and he would sit and cuddle him. Baby Danny was so easy to look after'*. Mother commented that she felt '*a lot of judgement from her family about her holding the baby too much'.*

4.2.32 When Baby Danny returned home it was on the premise that Father would be supervising his care 24 hours a day. Initially, Father's relatives were offering support with his care and consideration was given at the Family Group Conference in early November 2017 as to who, from the wider family, would be able to care for him if his parents could not do so. Three extended family members attended this meeting.

4.2.33 The new birth visit by the Family Nurse found that all appeared 'normal'. Baby Danny had good tone and reflex and was feeding well. Mother was gaining confidence and appeared gentle and caring. Father was doing the night feeds as Mother was not waking, because of her medication.

4.2.34 A home visit a week later in mid-November by the Family Nurse found Baby Danny thriving and Mother caring for him in a gentle manner, with support from Father. Baby Danny was also being cared for one day a week by Father's brother's partner. This was a recommendation of the Family Group Conference and was with a view to the couple being assessed to offer future overnight care to Baby Danny. This arrangement broke down after a family disagreement.

4.2.35 The home conditions in which Baby Danny spent the first weeks of his life were described as 'cluttered and untidy', but good enough. Finances were a problem, given

that Father had resigned from his job, but apparently plenty of baby clothes and equipment had been bought in preparation for his birth.

4.2.36 It is known that often the curtains were drawn in the flat and Mother did not like to leave the property. Thus, unless Baby Danny was taken out by Father, he spent most of his days inside the flat with his parents. When speaking with the Lead Reviewer both parents denied that his was the case.

4.2.37 By the end of November 2017, Mother told her Personal Adviser from the Care Leaver's Team that she was very happy, that Baby Danny was making a squeaky noise when he was happy and was sleeping better at night time. She was taking her medication and not self-harming.

4.2.38 Given Mother's history of self-harm, mental illness, trauma, alcohol and substance misuse and her lack of experience of positive parenting herself, it was more than optimistic that at the age of 18 she would be able to protect and care for her baby. The reliance on Father as a 24 hour a day, 7 day a week carer for Baby Danny, whilst also having to supervise Mother, was unrealistic. Such a task would have been difficult, if not impossible for most new parents, however, given the lack of background information concerning Father, particularly knowledge of his own childhood experiences, the risk of Baby Danny being at risk of significant harm was greatly increased.

Baby Ethan

Mother

4.3.1 In March 2016, when Mother was 15, a referral was received by Children's Social Care after she disclosed being hit by Maternal Grandmother following a verbal argument. Mother's attendance at school was poor. At this time Mother was living with Maternal Grandmother, Stepfather and her younger sibling who was disabled.

4.3.2 In November of the same year, a further referral was made to Children's Social Care by the school as Mother was refusing to return home and was living with Father's family.

4.3.3 By February 2017, Mother was 16 and was known to be pregnant with Baby Ethan and in May 2017, Children's Social Care allocated the case for a single assessment of the unborn baby. Following the single assessment, a S.47 investigation was recommended. During this time, Mother was living with Father and his extended family.

4.3.4 In June 2017, Mother and Father moved to live with Maternal Grandmother. Shortly afterwards, Father moved back to Paternal Grandmother's home and it was said that the relationship with Mother was over. By September 2017, the parents were back together.

4.3.5 A pattern developed throughout Mother's pregnancy and after Baby Ethan's birth of the parents moving between Maternal and Paternal Grandmother's home. At the time of Baby Ethan's injuries, he was living with his parents in a flat, the tenancy of which had been secured with the help of Paternal Grandmother.

4.3.6 During her pregnancy Mother was booked for maternity care with the Needing Extra Support Team (NEST). Regular visits were undertaken by the same NEST midwife and on the whole Mother's attendance at antenatal appointments was good. A referral was made to the FNP by midwifery staff in early April 2017. The Family Nurse managed to complete 8 antenatal visits to Mother, Father was present at 3, and 3 home visits postnatally, at which Father was present at one. There was a lack of engagement with the FNP by both parents and at times it was apparent that when they were living with Paternal Grandmother, she would falsely deny that Mother was available when the Family Nurse telephoned.

4.3.7 During her pregnancy Mother presented to hospital on five occasions for reduced foetal movements. Although nothing abnormal was found, on one of these occasions when she attended a hospital outside Southampton whilst visiting Paternal Grandfather, staff raised concerns about Father smelling of cannabis. A referral was made to Children's Social Care and a professionals meeting was convened in September 2017.

4.3.8 Following the professionals meeting in September 2017, when concerns were also expressed about the parents lack of engagement with agencies, and their capacity to deal with the needs of a new born baby, an Initial Child Protection Conference (ICPC) was recommended.

4.3.9 The ICPC in October 2017 decided that Child Protection Planning was not required, and a Child in Need Plan was agreed. This was on the basis that Mother stated she was no longer in a relationship with Father. The case was allocated to a Student Social Worker and the FNP was involved. After Baby Ethan was born in October 2017, Mother took her own discharge on 31 October, against medical advice. Clinicians wanted her to remain in hospital to monitor her and baby.

4.3.10 There was a lack of engagement with agencies including the FNP by Mother following Baby Ethan's birth. He was not brought for his 6 week check and hearing test. By the end of November, it was known that Mother was back with Father, whom it was believed influenced her contact with agencies. Concerns were raised by Children's Social Care about this development and a single assessment was to be completed with the likely outcome that the case would return to ICPC.

4.3.11 During December 2017, Mother did not return calls from the Student Social Worker and Baby Ethan was not seen until 22 December. A Duty Social Worker made a home visit to Paternal Grandmother's home. Home conditions were described as good and Baby Ethan was seen and appeared well, although asleep for most of the visit.

4.3.12 The next time Baby Ethan was seen by a professional was 10 January 2018, when he was brought to the GP Surgery.

Father

4.3.13 Prior to Mother becoming pregnant with Baby Ethan, Father and his family were known to Children's Social Care and Police.

4.3.14 Father was 15 years old when Mother became pregnant with Baby Ethan.

4.3.15 In 2012 Father suffered a brain injury following a road traffic accident. This had left him with anger management problems, which at times resulted in him displaying aggressive behaviour. School attendance was poor and Children's Social Care was aware that Father had caring responsibilities for his stepfather, Paternal Grandmother's partner, who was terminally ill.

4.3.16 In January 2017, when Father was 15, the school, which both he and Mother attended contacted Police as neither had attended school since the beginning of December 2016. Father and Mother were later found at Paternal Grandmother's home and had been hiding in the loft when teachers had previously visited. Mother was living at the address.

4.3.17 Police were called to Paternal Grandmother's address in February 2017 when Father was threatening Paternal Grandmother with a knife and threatening to harm himself. Father had been drinking, which had exacerbated his behaviour. A referral was made to Children's Social Care. A single assessment was completed in April 2017, which identified Father taking on caring responsibilities for Paternal Step-Grandfather, poor school attendance, self-harm and lack of care provided by Paternal Grandmother. Father was made subject to a Child in Need Plan.

4.3.18 Following Father's brain injury, attempts were made by CAMHS to identify specialist services for his condition, however he did not engage.

4.3.19 In September 2017, Children's Social Care closed Father's case (as a Child in Need) due to non-engagement. However, other agencies continued to be involved because of Mother's pregnancy.

Baby Ethan's lived experience within the family

4.3.20 It was reported by the Midwifery Team at a discharge planning meeting following Baby Ethan's birth that Mother was coping well with him. The parents were not together, but Father and Paternal Grandfather had visited. Following their discharge, Mother and Baby Ethan lived with Maternal Grandmother. Mother was seen by the Family Nurse and was said to be loving and caring towards Baby Ethan. He was alert and starting to smile, formula feeding well and thriving. At this time Mother was engaging with professionals.

4.3.21 Once Paternal Grandmother provided the means for Mother and Father and Baby Ethan to live independently, unsupported in private rented accommodation, contact with professionals deteriorated and monitoring of Baby Ethan proved increasingly difficult**.** Mother cancelled a visit by the Family Nurse at the beginning of November

2017 and two further visits were met with no reply. Baby Ethan was seen by the Family Nurse on 15 November 2017 and was noted to be smiling and appeared well.

4.3.22 Access was gained by the Family Nurse on 28 November 2017 when both parents and Baby Ethan were present. Mother was handling Baby Ethan with care, but Father became angry when contraception was discussed.

4.3.23 By mid-December 2017 the Family Nurse escalated her concerns with the Student Social Worker and with the Named Nurse for Safeguarding that the baby had not been seen for three weeks. A further visit was attempted, but although the Family Nurse could hear a baby crying there was no reply.

4.3.24 Children's Social Care had experienced similar problems to the FNP in gaining access to Baby Ethan and were planning to undertake a single agency assessment with a view to proceeding to an ICPC. Baby Ethan was not brought for his 6 week check with the GP and neither was he brought for two hearing test appointments. (He was subsequently discharged from the service). On 13 December 2017, the GP was very worried about Baby Ethan missing his 6 week check and informed the Student Social Worker of these concerns.

4.3.25 A Duty Visit was arranged by Children's Social Care after contact from the GP, the Family Nurse and the Safeguarding Midwife had all raised concerns about Baby Ethan not being monitored. The first visit was not successful and Maternal Grandmother was told that Police would be requested to assist if the baby was not seen.

4.3.26 On 22 December 2017 a Duty Social Worker gained access to Baby Ethan at Paternal Grandmother's address. Home conditions were described as good, Baby Ethan was sleeping but appeared well. The Family Nurse attempted two home visits after this visit, but without success.

4.3.27 By 8 January 2018 Children's Social Care decided that the case required progression to ICPC. However, on 10 January 2018 the GP contacted the Student Social Worker to say that Baby Ethan had arrived for his 6 week check, now 4 weeks late, and was seen with bruising, thought to be Non-Accidental Injuries (NAI). The GP considered that baby Ethan could wait for child protection medical, however the Team Manager insisted that an ambulance was called to transport Baby Ethan to hospital. The Police also arrived at the Surgery and arrested both parents.

4.3.28 On arrival at hospital, Baby Ethan was found to have 25 bruises to his body and a broken tibia in two places.

4.3.29 The age, immaturity and volatile nature of the parents relationship put baby Ethan at risk of significant harm. The lack of engagement and refusal to allow access by professionals to their baby meant that little was known of what life was like for Baby Ethan whilst in his parents care. When he was seen, it was said that he was well cared for and thriving. However, these occasions were very much dependent on the parents and members of both extended families agreeing to allow Baby Ethan to be seen. It is disturbing, that Mother and Father brought Baby Ethan to his delayed 6 week check when he had sustained substantial bruising and a broken tibia. Whether they

considered that the injuries would raise professional concern is not as yet known, however, it is fortunate that Baby Ethan was seen and the risk of him sustaining further injury was eliminated.

5 Key Themes and Analysis of Practice

5.1.1. At the time the Southampton Safeguarding Children Partnership made the decision to commission a thematic Serious Case Review, it was apparent that there were a number of significant similarities in the three cases. These can be summarised as:

- All were young parents
- All had experienced childhood trauma and/or Adverse Childhood Experiences
- All the babies were male and of White British ethnicity
- All three babies had received significant injuries, which resulted in the death of one child
- All of the incidents occurred within the same two-month period
- At least one of the parents of each of the children had exhibited violent behaviour in the past
- Alcohol and cannabis misuse featured in all three cases
- All the young parents had experienced homelessness

5.1.2 Having reviewed the information provided and constructed a narrative, it is evident that there are a considerable number of key themes emerging from this Serious Case Review, which are important to the improvement of practice. This section of the review will consider each of the themes in turn and will comment on professional practice at the time.

The importance of recognising parents as children/recently children themselves

5.1.3 Recent research[4] shows that the brain continues to develop through childhood and adolescence, even into the late 20s and 30s in some brain regions. White matter increases, grey matter decreases. These changes are thought to be caused by important neurodevelopmental processes that enable the brain to be moulded and influenced by the environment. When a risk is taken the brain's positive reward system gets activated. In adolescents, that activation is higher during risk taking than in adults.

5.1.4 These findings are particularly important when considering the events which led to the serious injuries sustained by these three very young babies. In all of the cases the parents engaged in risk taking activities, for example alcohol and substance misuse, risk of sexual exploitation and lack of stable accommodation. In the case of Baby Connor his parents were living in accommodation where parties, alcohol and drug use were prevalent features of the lives of the young parents living in the unit.

5.1.5 It is important for professionals to be aware of research findings concerning the workings of the adolescent brain if an informed understanding is to be developed and

[4] Blakemore Sarah-Jayne *Inventing Ourselves: The Secret Life of the Teenage Brain*, *2018*

maintained of the additional risk posed to young parents themselves and, more importantly to their babies and children.

5.1.6 It is also important for professionals to consider adolescent decision making with regard given to the Mental Capacity Act, 2005. The Act states clearly that mental capacity does not mean a young adult needs to make good decisions and indeed should be permitted to make decisions, even if others feel such decisions are not in their best interests. However, when a young adult is caring for another child as their parent safeguarding procedures will always be paramount in any decision making made by professionals.

5.1.7 Such findings are of particular significance when considered in light of the vulnerability, immaturity and limited life experience of all of the parents of the three babies. This is evidenced by the following:

- In two of the three cases the mother of the baby was a child herself when she became pregnant and in the third, the mother of Baby Danny, had only just reached 18.

- The fathers of the children, with the exception of Baby Danny's father, were under the age of 18. Baby Connor's father was 16 and in the case of Baby Ethan, Father was 15 when Mother became pregnant and had been a Child in Need himself until a month before Baby Ethan was born.

- All of the mothers, and from what is known, two of the fathers, had experienced difficulty at school and their attendance had been poor. Given the number of placements Baby Danny's mother had as a Looked After Child, together with her admissions to psychiatric hospital, with the resulting disruption to her education, it is surprising, and to her credit that she was literate.

- Two of the mothers had engaged in self-harming behaviour and in the case of Baby Danny's mother she had experienced a traumatic childhood prior to becoming a Looked After Child, which was further compounded by having 35 placements and being Sectioned under the Mental Health Act, 1983 on three occasions.

- The susceptibility of the parents to child exploitation featured in two of the three cases. Baby Connor's Mother was thought to be at risk of child sexual exploitation whilst at school and the mother of Baby Danny had been subject to sexual exploitation and violent sexual assault, not least because of her vulnerability due to her mental ill health.

- Although support was offered to the mothers throughout their pregnancy by midwives and the FNP, the reality of giving birth at such a young age and becoming a parent when still a child, can be and is a difficult, traumatic and frightening experience. It is not clear from the information provided to the review that this was fully explored with the mothers.

- Baby Connor's parents expressed excitement on learning that they were going to have a child, however, the consequences of looking after a baby independently, in accommodation with limited support, proved to be tragic for Baby Connor and for his parents.

- Prior to the birth of Baby Danny, Mother had displayed childlike behaviour and after his birth midwifery staff were concerned about Mother holding onto a comfort blanket when she required treatment following a caesarean section. Whilst recognising that Baby Danny's Mother had suffered significant trauma for most of her life, her experience as a young person of giving birth and the aftermath of having a caesarean section cannot be underestimated. The concerns of the midwifery staff on the postnatal ward were shared and known by professionals prior to Mother and Baby Danny being discharged from hospital, they went home.

- The heightened anxiety which can be experienced by a young, pregnant mother was illustrated by baby Ethan's mother attending the Emergency Department on five occasions, fearful that she could not feel a foetal heartbeat. Whilst anxious and concerned about her unborn child, once Baby Ethan was born, Mother ceased to engage with professionals, to the detriment of her baby's health, wellbeing and safety.

5.1.8 All of the above highlights the need for professionals working with young teenage parents to recognise that in the first instance they are children themselves. This is not always easy, given the difficulty, which is so often encountered when attempting to engage with young people. However, this review has attempted to illustrate that if this fundamental principle is not embedded in professional practice the risk to the babies and children of young parents is severely heightened and can lead to tragic consequences.

The need for comprehensive assessment of parenting skills and risk to the unborn baby

5.1.9 In none of the three cases is there evidence of comprehensive assessment of parenting capability and the risk presented to the unborn baby.

5.1.10 In the case of **Baby Connor,** no assessment was undertaken of either parent by Children's Social Care. The focus of social work involvement was on Mother's younger sister who had special needs. There had been referrals prior to Mother's pregnancy to Children's Social Care about Mother's lack of school attendance, risk of child sexual exploitation, and in 2016, contact had been made by hospital staff from the ED when both Mother and Father were admitted with smoke inhalation following a house fire. None of these resulted in an assessment, although information from Solent NHS suggests that Mother was an open case to Children's Social Care (see below para.5.1.15)

5.1.11 Baby Connor's Maternal Grandmother had said that she would offer support to her daughter and given the involvement of the FNP, it seems to have been assumed that

an assessment by Children's Social Care was not required. This decision was made in the knowledge that the family was well known to statutory agencies, with Father and his siblings having been subject to Child Protection Plans in the past, due to neglect. At the time Mother became pregnant, Paternal Grandmother and her children were an open case to Children's Social Care. Paternal Grandmother had a history of alcoholism, substance misuse and suspected drug dealing. It was known that Father was Mother's partner and the father of her unborn child, but there was no sharing of these concerns between the Social Worker for Paternal Grandmother and the FNP.

5.1.12 Both Father and Paternal Grandmother were well known to Police. When Police attended Paternal Grandmother's home, a Child and Young Person Report (CYPR, subsequently replaced by PPN1) was submitted on each occasion. The incidents included arguments between Mother and Father, excessive alcohol consumption on the part of Paternal Grandmother and Father, and violent behaviour between Paternal Grandmother and Father.

5.1.13 Whilst Police Officers attending these incidents followed procedure by submitting CPYRs/PPN1s, there was *"no assessment of the recent history nor family context and an apparent lack of understanding as to why they were submitting a PPN1……..an ongoing theme with PPN1s is that officers are frequently assessing incidents in isolation and not considering the context when assessing risk or considering exactly what the actual risks are…..There is also the potential that officers are not considering older teenagers as children at risk*." (Source: Police IMR)

5.1.14 When Baby Connor's Mother was first seen by midwives at the antenatal booking in June 2017, social risk factors were noted, and a concerns form was sent from the Community Midwife to the Maternity Safeguarding Team. However, it was not reviewed by the Maternity Safeguarding Team until mid- September 2017. The reason for the delay is not documented. It was at this booking that a referral was made to the FNP.

5.1.15 Further information was requested by the Maternity Safeguarding Team from Children's Social Care in September 2017. This showed that the case was open because of the special needs of Mother's sibling, but the Team Manager had requested that Mother's case be closed. Information concerning Father was shared with midwifery, which should have been recognised as increasing the risk to the unborn baby. A referral to MASH should have been considered but this did not happen. The recommendation from the Maternity Safeguarding Team was for Mother to remain under enhanced midwifery care, to offer an Early Help Assessment and to liaise with the FNP. However, the Early Help Assessment referral was not made.

5.1.16 Mother and Father were registered at different GP surgeries and no information was shared about Father's childhood history between practices. The GP Practice for Mother was aware of the risk presented by Mother's younger sibling and that it was initially proposed that Mother would reside at Maternal Grandmother's home. There was however no exploration of the safeguarding risk presented to the unborn child or to Baby Connor had Mother continued to live at the family home. The GP knew that Mother was under the care of the FNP and there was little involvement with the Practice thereafter.

5.1.17 Information provided to the review from the FNP states that: *"there is evidence of excellent engagement throughout the pregnancy with the Family Nurse. [Mother] and [Father] appeared to be excited about the baby, prepared well for the arrival, showed good insight into the risks that [Mother's] younger sister might pose to her and her unborn baby and was keen to secure her own accommodation although aware this was a big step."* There is no information from the IMR of a formal risk assessment of parenting capacity or risk to the unborn baby undertaken by the Family Nurse. This is particularly concerning. Once Mother moved into her own accommodation and contact with the Family Nurse significantly decreased, Baby Connor was not monitored, he was not brought to appointments and was not registered with a GP at the time of his death.

5.1.18 The assessment made of Mother, when she was pregnant, for her suitability for admission to the supported accommodation unit, showed that the only risk identified was that of her younger sibling. No risks concerning Father were identified, however it is not known to the review as to what the assessment consisted of. Once resident at the unit, the 'My Support Plan' for Mother, used at the time, was completed by staff as there was no engagement by Mother. No information is available as to whether Mother's non-engagement was questioned or whether it was usual practice for staff to complete a form on behalf of a mother.

5.1.19 Based on the assessment by the housing provider, Mother was deemed suitable to move to the independent living unit 18 days after she gave birth to Baby Connor, scoring the lowest possible risk score on the 'My Safety and Support Plan.' Once there, Mother attended three out of the five support sessions offered and at the last meeting in February 2018, before Baby Connor died on 11 February 2018, the arguments between Mother and Father were discussed. There is no indication that the risk to Mother and Baby Connor was considered to be increased because of the parents arguing.

5.1.20 There is no reference in the IMR submitted to the review by the provider of the supported Independent Living Unit, to Police visiting the Unit in January 2018 after 3am having received a complaint about noise involving another resident and Mother. Whilst investigating the incident, officers heard banging coming and shouting coming from Mother's flat. Mother and Father were arguing, and Mother requested that Father left. A PPN1 was completed for Baby Connor and the DASH[5] risk assessment completed with Mother. She answered no to most questions and therefore the incident was assessed as 'standard risk'. It was during the arrest of another resident that the officers were informed that on two occasions Baby Connor had been seen with blood coming from his mouth. This disclosure was not investigated by the officers attending and is the subject of further investigation, by the Independent Office for Police Conduct (IOPC).

5.1.21 Information provided to the review explains that when one of the two officers attending the incident returned to the flat of Baby Connor's parents to complete a domestic risk assessment with Mother, he found Father in the flat, holding Baby

[5] DASH risk assessment: Domestic Abuse Stalking and Honour Based Violence used by Police

Connor. Father was drunk and his behaviour argumentative. The Officer was concerned about how Father was holding Baby Connor who was crying. Father said: '*he hadn't done anything'* and thought the officer was implying he had hurt the baby. The Officer was not concerned for Baby Connor's wellbeing and put Father's behaviour down to inexperience. Unfortunately, none of this information was recorded in the PPN1, which with the information provided by the other resident about Baby Connor bleeding from his mouth was a significant omission. If this information had been included in the PPN1, it could have possibly resulted in a Grad A assessment by MASH ('*unexplained injuries or suspicious injuries to a child under 4)* which would have resulted in a referral to the Child Abuse Investigation Team (CAIT). (Source: Police IMR)

5.1.22 The need for professional curiosity by Police Officers visiting premises because of domestic abuse, is paramount. The importance of careful exploration, documentation and the reporting of concerns is crucial if children are to be safeguarded. The incident detailed above required further investigation and was a missed opportunity. It is a lesson learned arising from this review and is reflected in **Recommendation 3**.

5.1.23 Throughout her life as a Looked After Child the mother of **Baby Danny** had been subject to assessment. The concerns about her mental health, history of severe self-harming behaviour, alcohol and cannabis misuse were well documented and known when Mother moved to Southampton within weeks of becoming pregnant. Once the pregnancy was confirmed as viable, a Social Worker from Southampton Children's Social Care visited the offices of the local authority where Mother had been looked after to read their care records. Information was shared between the two local authorities. The care records were not reviewed by Social Workers subsequently involved in Baby Danny's case, so it is not clear how much of this detail was known to them.

5.1.24 In July 2017, a Section 47 assessment was initiated which resulted in the convening of an ICPC. The outcome of the ICPC, was for the unborn Baby Danny to be subject to a Child Protection Plan, category neglect. Legal advice was taken at the meeting.

5.1.25 A report concerning Mother was presented at the ICPC by the South East Care Leavers Team, which included the following:

5.1.26 "*I have concerns about Mother's ability to parent a child and keep herself and a child safe…….. [Mother] will need to be assessed very carefully and fully assessed once the baby arrives to ensure [she] is able to meet the child's needs and keep him safe. [Mother] will need to attend parenting workshops to ensure her child's developmental needs are being met."*

5.1.27 In August 2017, a legal planning meeting followed the ICPC, which requested a further mental health assessment of Mother. A Review Child Protection Conference was due to take place at the end of October 2017 but was cancelled as Baby Danny arrived early. A pre-discharge meeting was held on 30 October, at which concerns were expressed by the South East Care Leavers Team about Mother being able to manage with a child, to which Mother nodded her agreement.

5.1.28 Concerns were also expressed by the midwife as to how Mother would manage a baby and the midwifery staff from the ward explained the difficulty in obtaining Mother's cooperation with Baby Danny's care, that she smelt of cannabis when returning from smoking outside, having left him without a blanket and he was cold. Mother disputed this, however the midwife attending the meeting advised that she had concerns about Mother being able to provide any care to her baby.

5.1.29 The decision to allow Baby Danny to be discharged home into the care of his parents was made on the basis of Mother signing a contract of expectations, confirming that she was not to care for Baby Danny without supervision from Father. Mother was not happy about this but signed the agreement. Children's Social Care confirmed that further assessments would be completed in respect of Mother and Father, and that the legal planning process would continue.

5.1.30 However, it is evident that there was no further assessment undertaken of either parent's ability or capacity to care for Baby Danny. Little was known of Father's background. What is known is that he and Mother met on-line and within days of meeting, they were inseparable. Father lied about his profession, claiming to be a paramedic, and quickly assumed caring for Mother when she self-harmed. Yet he was deemed to be the protective factor for Baby Danny, having sole responsibility for his care and supervision.

5.1.31 Prior to Baby Danny's birth and on his discharge from hospital, the Family Nurse recorded that the parents engaged well with the Programme. However, it is evident from the information provided to the Serious Case Review that there was a lack of comprehensive, informed assessment of the parenting abilities of Mother and Father. The Family Nurse was aware that Mother was not engaged with the Perinatal Mental Health Team; that there were serious concerns about whether Mother had ceased drinking and using cannabis; that she did not like to go out of the flat and thus Baby Danny remained inside with Mother; that there were financial pressures on the family due to Father giving up his employment to care for mother and baby and that Father was expected to supervise Mother and ensure that Baby Danny was not put at risk.

5.1.32 Whilst Mother did co-operate with a mental health assessment late in her pregnancy, with regular input thereafter from the Community Mental Health Team (CMHT), there is no documented evidence of liaison between the Family Nurse and CMHT, or the GP. It appears that the content of the CMHT assessments was not shared or discussed either at the Child Protection Conferences or outside of meetings in multi-agency liaison. It is questionable whether the Mental Health Worker was invited to the Child Protection Conferences as she did not appear on the list of attendees.

5.1.33 Given Mother's history of chronic self-harm, mental illness, lack of parenting in her own childhood and recognition that she herself could not look after a baby, it could be argued that further assessment of Mother was not necessary to decide whether it was safe to discharge Baby Danny into her care. Given that so little was known about Father, for a decision to be taken at the pre-discharge planning meeting that he was a suitable parent, with the skills and capability to care for his child and supervise

Mother, without an evidence-based assessment of him, was not only poor but also dangerous practice, which sadly proved to be the case when Baby Danny was found to have sustained a serious head injury.

5.1.34 In the case of **Baby Ethan**, no comprehensive assessment was undertaken of the parents ability to parent, nor was there an assessment of the risk posed to their baby.

5.1.35 Father had been subject to a Child in Need Plan a month prior to Baby Ethan's birth, due to lack of school attendance and anger management issues as a result of a brain injury. An ICPC was convened in October 2017 because of concerns about the lack of agency engagement by the parents and questions about their ability to care for a new born baby. The decision was taken that as Mother was no longer involved in a relationship with Father, the case did not warrant a Child Protection Plan and was suitable for Child in Need procedures.

5.1.36 The case was then allocated to a student social worker. Given the known history of concerns about both Mother and Father, not least Father's controlling and volatile mood and behaviour, greater consideration should have been given to an assessment of parenting ability, which also involved a comprehensive exploration of the relationship between Mother and Father. This required qualified social worker involvement and the case should not have been allocated to a student. The fact that Mother was living with Maternal Grandmother prior to Baby Ethan's birth, whilst maintaining that her relationship with Father was over, meant that there may have been an element of complacency that the risk to the unborn baby was low. Insufficient consideration was given to the probability of the couple resuming their relationship, and what in turn, this meant for the safety and well-being of their child.

The importance of support for young parents

5.1.37 The IMR concerning Baby Connor submitted to the review by the provider of the supported Independent Living Unit states that: *"[Mother received support from a Family Nurse practitioner. She had no Social Services involvement. Our role was to assess [Mother] for housing and to provide her with suitable accommodation based on her tenancy readiness…..We do not provide parenting skills but support clients to access parenting skills where needed….Our staff did not raise any concerns relating to [Mother's] parenting skills and [Mother] and [Father] appeared to be attentive and caring parents".*

5.1.38 This statement not only raises serious concerns as to the responsibilities and expectations of the housing provider to young parents, it also brings into focus the nature of the 'support' offered to the parents and by which agencies. It is evident from information submitted to this review, that there was a perception on the part of professionals referring young parents to this service provider that the support offered was more substantial than it was in reality. The unit in which Baby Connor's mother was first placed was not a Mother and Baby Unit, with staff on duty 24/7. It was staffed during office hours, and limited support was offered. Once Mother moved into the Independent Living Unit, the support available was as described above in para 5.1.37.

5.1.39 The need for agencies to work together, as well as having a clear understanding of the context of the support offered and responsibility held by each agency for the safeguarding and well-being of young, vulnerable parents and their children, is a fundamental finding of this review. It is clear that there was a higher expectation of the provider by agencies using this facility of the care, monitoring and support available to young parents.

5.1.40 Whilst there was Children's Social Care involvement in the lives of Baby Danny and Baby Ethan, there was none in the case of Baby Connor. There had been Children's Social Care involvement with Baby Connor's extended families, but once Mother was pregnant and after the baby was born, the only support which the parents received was from the FNP.

5.1.41 Information provided by Solent NHS Trust to the review, describes the FNP as follows:

> *"The FNP is a voluntary home visiting programme, standard contacts are offered weekly for 4 weeks initially then fortnightly until the child is born. Then weekly contacts are offered for 6 weeks followed by fortnightly contacts until the child is 21months then monthly contacts until 24 months.*
>
> *FNP is structured - in that the tools it uses and the nature and number of visits is prescribed, based on years of research, evidence, successful implementation and constant evaluation - but it is also flexible. Within this structure, nurses deliver a highly personalised intervention based around the specific strengths and needs of each client.*
>
> *As part of FNP delivery facilitators which cover a wide range of topics including lifestyle and positive health changes, relationships, communication skills, medical information, life plans and goal setting, becoming a parent, focusing on the child's care and development, cues and responsiveness are shared with clients (and partners if present) during contacts. These are kept by the clients for their own records and for them to use as a resource. [In the case of Baby Connor] these have not therefore been available to form part of this review within the SystemOne records.*
>
> *Family Nurse Partnership is a voluntary home visiting programme, by focusing on their strengths, FNP aims to enable young parents to:*
>
> - *Develop good relationships with and understand the needs of their child*
> - *Make choices that will give their child the best possible start in life*
> - *Believe in themselves and their ability to succeed*
> - *Mirror the positive relationship they have with their family nurse with others".*

5.1.42 During the course of their engagement with Baby Connor's parents the two Family Nurse Partnership nurses involved in the case, assessed that they engaged well before and after the baby's birth. An appropriate number of appointments were kept, until Mother moved to the Independent Supported Housing Unit.

5.1.43 No pre-birth referral to social care was felt necessary as both parents were considered to be making appropriate choices, engaging with services and showed good signs of preparing for their baby both emotionally and physically.

5.1.44 Mother was seen to be keeping herself safe from her sister by moving into supported accommodation. The parents observed care of Baby Connor during contacts after delivery was loving and caring and he was thriving. The Family Nurse was aware of a little of Father's background but was not aware of the lengthy involvement of Children's Social Care, and the history of Child Protection concerns with Paternal Grandmother, and this was not disclosed by Father. The Family Nurse could only access information on the electronic recording system for health professionals (SystemOne), if there was an open referral, (as was the case for Mother). Father did not have an open referral, which meant that the Family Nurse was not aware of his history of violent outbursts. Since the death of Baby Connor, where is it is known that a partner is living with a pregnant mother, a form has been devised and used by FNP, which seeks to ascertain with consent access to a father's medical history.

5.1.45 It has also emerged in the course of this review that the provider of the Independent Living Unit, would only ascertain information concerning the father of a baby, if he was known to be living with the mother. If he was only visiting, such information would not be sought. The service provider has recognised this as an area which requires attention if safety for mothers and children living in their accommodation is to be improved.

5.1.46 The FNP was informed of Baby Connor's father arriving at the hospital Emergency Department drunk, violent and under the influence of Paternal Grandmother's medication, but the Family Nurses involved did not realise that the medication was prescribed and if taken by anyone other than the patient was an illicit drug. The incident was discussed with Mother on the telephone, who said she was aware that Father was drunk and had banged his head. It was planned to discuss the matter with Father, but Baby Connor died before this happened.

5.1.47 The Family Nurse was aware that Father had caused a disturbance at the independent living unit and in the two weeks up until Baby Connor was fatally injured, it was apparent that Mother was less engaged. When Mother was seen, she complained of feeling increasingly tired and that she was having decreased contact with Maternal Grandmother since moving into the unit.

5.1.48 Whether the Family Nurse assessed that Mother was in need of additional support in the care of Baby Connor is not known. Her next visit to the family was due to take place the week beginning 12 February 2018, by which time Baby Connor had already died.

5.1.49 It is evident that the FNP was not aware of the details of Father's background, nor was sufficient information shared by the housing provider about the arguments between Mother and Father and of the complaints made by other residents. The Police PPN1 submitted at the time of Police attendance at the end of January 2018, lacked detail of the alleged injury to Baby Connor's mouth. If this had been included, a more concerning picture would have been presented of child protection issues related to

Baby Connor. The sharing of all information concerning the safety and well-being of children, particularly in respect of very young vulnerable babies, between agencies is fundamental if children are to be protected from significant harm. Unless information referred into the MASH results in a Section 47 investigation, such information would not be reviewed by Children's Social Care. This is a lesson learnt from many Serious Case Reviews and sadly this review is no exception. **See Recommendation 10**

5.1.50 The assessment by the housing provider that Mother and Baby Connor were suitable to move to the Independent Living Unit has already been addressed above. However, how the decision was reached that Mother did not require additional support and supervised care, within 18 days of arriving at the supported living unit, is subject to question. It would seem from the information provided to the review that there was a lack of robust assessment of the support needs of mothers and the risk presented to babies by staff undertaking such assessments, none of whom were qualified social workers or health professionals. This finding is concerning and is reflected in **Recommendation 4.**

5.1.51 Baby Danny was subject to a Child Protection Plan, but how much support was offered to his parents by Children's Social Care is not clear. The plan was that Child Protection visits were initially to be undertaken on a daily basis by the Social Worker, however, this level of monitoring was not maintained after the first days of Baby Danny's discharge from hospital and was soon reduced to weekly and then fortnightly by mid-December. From information available, Baby Danny was not seen by a Social Worker after 14 December 2017, nor was there any contact until 6 January 2018, when the hospital contacted Children's Social Care to inform them that Baby Danny had been brought to hospital by ambulance in an unresponsive condition and that NAI was a possibility.

5.1.52 Given the known history of Mother and the pressures placed on Father having to care for Baby Danny and supervise Mother, the level of involvement by Children's Social Care was unacceptable, and is a lesson learned from this review. **See recommendation 2(a)**

5.1.53 There were regular and frequent visits by the Family Nurse to Baby Danny and his parents. The engagement by the FNP has already been explored in detail. Whatever support was being offered to Father, given the enormity of his responsibilities to Mother and Baby Danny, it would not have been sufficient to meet the requirements to keep Baby Danny safe. This was confirmed when Baby Danny's parents met with the Lead Reviewer, given they stated that whilst they received support from the Family Nurse, little if any assistance was provided to them or Baby Danny by their allocated Social Worker.

5.1.54 Whilst Baby Ethan was on a Child in Need Plan, the case was allocated to a student social worker. Given the complexities of Father's family history, his violent and aggressive behaviour resulting from a serious brain injury; that he had been a Child in Need himself just a month prior to baby Ethan's birth; the concerns noted about Father's cannabis use; the pattern of Mother moving from Maternal Grandmother's home to Paternal Grandmother's home and the lack of engagement with the Family

Nurse after Baby Ethan's birth, should have resulted in the case being escalated to one of Child Protection. It is evident that it was inappropriate for a student social worker, on placement to be given a case of this complexity and risk and is a lesson learned from this review. **See recommendation 8**.

Recognition of the risk posed by fathers in the lives of babies and children

5.1.55 In all three cases the importance of the risk of father's behaviour to the wellbeing and safety of these very young babies can be said to have been underestimated or was unknown by professionals.

5.1.56 In the case of Baby Connor and Baby Ethan the volatility of father's behaviour was known to Children's Social Care and to CAMHS professionals. This information was not known to the Family Nurses when they began working with the family and was not sufficiently explored once it was known that father was a constant in the life of the mother and baby. The need for professional curiosity, as well as information sharing concerning the childhood and life experiences of fathers, together with concerns about anger management, substance misuse and mental health is a pre-requisite if children are to be protected from significant harm.

5.1.57 Unlike Baby Connor and Baby Ethan, little was known about the background of Baby Danny's father. This was a concern in itself, given the way in which the parents met on-line and the immediacy of them moving into together when Mother became pregnant. The decision of the pre-discharge planning meeting and the subsequent Child Protection Conference to allow Father to assume, what was essentially, sole responsibility for caring for Baby Danny and Mother, 24/7 was misguided and inappropriate. To place such an expectation on any parent would be difficult, however, given Mother's behaviour and mental health needs, it proved to be dangerous to the health and well-being of Baby Danny.

The impact of mental health issues, self-harming behaviour and substance misuse on parenting capability

5.1.58 All of the parents engaged in using cannabis, some to a greater extent than others. Alcohol use by parents also featured in all three babies lives. This is a theme, which is prevalent throughout this review.

5.1.59 In the case of the father of Baby Connor, the Police IMR makes an important point, in that *"upon analysing the information within Police systems there was a general absence of recognition of alcohol misuse. Evidence is that officers <u>may</u> [emphasis of IMR author] have assumed, because Father was 16, this type of alcohol use was perhaps the norm. What is concerning is that Father was putting himself at risk of harm i.e. laying in the road, being out during the very early hours of the morning and displaying violent and aggressive behaviour. Crucially there was a real absence of the risk alcohol misuse posed to Baby Connor."*

5.1.60 Cannabis misuse by parents has become a feature of the day to day work of social care and health professionals. Such use and misuse cannot be treated with complacency. Cannabis misuse by parents is also increasingly featuring in Serious Case Reviews. The importance of professionals taking account of the impact of alcohol and substance misuse on the capacity of parents to care for their children, but also on the well-being of the children themselves, must not be underestimated. **See Recommendation 5**.

5.1.61 The review has highlighted that the brains of adolescents are usually still developing until the age of 25 and in some instances until 30. It is known that risk taking is more prevalent in adolescents. This lack of maturity combined with alcohol and substance misuse had a profound effect on the ability of these young parents to safeguard and care for their babies.

5.1.62 Similarly, self-harming behaviour is another feature of this review. Two of the three mothers were known to self-harm. The propensity to self-harm by the Mother of Baby Connor, was not a dominant feature of her behaviour, however, the degree of self-harm perpetrated by Baby Danny's mother was chronic and extreme. Her vulnerability to self-harm and the subsequent impact on her ability to care for her baby was not given sufficient significance by professionals, because Father was seen as the protective factor.

5.1.63 The mental health of parents featured in all three cases and is a theme arising from the review. For all three babies the mental health of Father was a concern. What little was known about Baby Danny's father included information that he had experienced depression, but no detail was known as to when, its extent or severity. If an assessment had been undertaken of Father's ability to parent, this aspect could have been explored and a risk assessment made of his capacity to keep Baby Danny safe.

5.1.64 Neither the father of Baby Connor nor Baby Ethan, both of whom had anger management issues, engaged with CAMHS professionals, although in the case of baby Ethan, CAMHS staff were aware that he was about to become a father/was a father. As a result of non-engagement both cases were closed. The need to take account of the mental health of fathers when assessing the parenting capacity and abilities of parents is an important theme arising from this review and is a recommendation. **(Recommendation 2).**

5.1.65 The mental health of Baby Danny's Mother has been documented throughout this review. What is surprising, is that despite being sectioned three times, during her pregnancy and was on medication for her mental health, Mother did not meet the criteria for a mental health assessment or intervention. Whilst there was some dissent, most notably by the South East Leaving Care Team and midwifery staff on the postnatal ward, the decision of the pre-discharge meeting to allow Baby Danny to return home with his parents from hospital raises real and serious concerns for the Lead Reviewer. In essence by taking such a decision, the NAI to this baby was predictable and preventable.

The impact of a lack of good parenting experiences on young parents

5.1.66 The history of a lack of good parenting experienced by at least five of the six parents has been evidenced throughout the review.

5.1.67 The absence of a stable, caring home environment, coupled with poor school attendance had a profound effect on all the young parents featured in this review, and in turn their ability to parent their own children. Because of the lack of good parenting by Maternal and Paternal Grandparents, there was in turn an absence of support from extended family members. This essentially meant that apart from the provision of the FNP service, all the parents were left to parent the babies themselves. There is no evidence of parenting classes and child development information being made available.

Over optimism on the part of professionals as to the parents' capacity to care

5.1.68 The review has found that there was over optimism on the part of the majority of professionals involved with these young families and is evidenced in detail in previous sections of the report. A lack of robust, comprehensive parenting assessment in all of the cases is at the centre of why these small, vulnerable babies were seriously injured and, for one resulted in his tragic death.

Impact of Homelessness

5.1.69 All of the parents experienced homelessness and it is a theme of this review. The lack of a safe, stable caring environment for all three babies increased their vulnerability and risk of significant harm.

Anger management and domestic abuse

5.1.70 The propensity for violence and lack of anger management by a parent was prevalent in all three cases. For Baby Connor and Baby Ethan, it was father who presented the most risk and in the case of Baby Danny, there was a long history of aggressive and dangerous behaviour on the part of mother. These factors were well known to Children's Social Care and should have been given greater significance at the IPCPs, Core Groups and Review Conferences.

5.1.71 In the case of Baby Ethan, the Police IMR author makes a very important finding concerning the need for professionals to be cognisant of identifying the risks of coercive and controlling behaviour. Father's behaviour was highlighted at the ICPC. However, the risk to the unborn baby was seen as reduced because the couple were no longer in a relationship and resulted in unborn Baby Ethan being made subject to a Child in Need Plan. Once the case became one of Child in Need, Police were no longer represented at the Core Group meetings. *"Bearing in mind concern regarding [Father's] mental health, [Mother's] description of being alienated from friends due to his behaviour, the fact it was understood that he influenced her to miss school and not engage with ante-natal provision",* should have prompted the police conference attendee to submit a fresh PPN1 identifying the risks of coercive and controlling

behaviour highlighted at the ICPC. "*Furthermore, there needed to be consideration as to how the presence of this may impact [Mother's] capacity to remain out of a relationship with[Father], which in turn could make it difficult for her to adhere to the outline Child in Need plan. In addition, consideration could have been given to the police proactively completing a DASH risk assessment (Mother was over 16 years old at this point) as a part of this PPN1 to enable a full assessment by MASH sergeants of the potential risk with consideration as to whether a criminal investigation was required".*

5.1.72 The University of Bristol's research findings on violence in teenage relationships[6] undertaken between 2005 – 2009 clearly show that physical, sexual and emotional forms of teenage partner violence constitute a major child welfare issue. More recent information provided by Dr Christine Barter[7] makes reference to teenage partner violence in two Serious Case Reviews. "*In 2016 two serious case reviews occurred due to the deaths of 'Lucy' and 'Jayden', aged 16 and 17 respectively, who were murdered by their partners. The reviews showed that both young women experienced very high levels of coercive control alongside other forms of intimate violence. The review into the death of 'Lucy', who was pregnant at the time, documented a relationship which started when she was 15 and quickly became controlling and abusive, with her teenage partner banning her from going out alone or seeing friends and family, stopping her wearing make-up and telling her how to dress, accompanied by incidents of physical violence. Jayden's abusive relationship followed a similar path."*

"The serious case reviews also highlight that Lucy and Jayden experienced additional vulnerabilities and challenges. However, professionals in both cases failed to see them as children requiring protection with significant risks in their lives and instead positioned them as difficult adolescents. Research has identified a range of risk factors which increases a young person's vulnerability to relationship abuse including: domestic violence and child abuse; attitudes which normalise violence including gender roles; anti-social peers; psychological factors – including low-self-esteem; bullying; early sex, and alcohol and drug use"[8].

5.1.73 Whilst the controlling behaviour of the fathers in this Serious Case Review did not result in the death of their partners, the concerns highlighted by the Police IMR author concerning the behaviour of the Father of Baby Ethan resonate with the two Serious Case Reviews described above. As Dr Barter asserts "*Professionals need to recognise the impact of these risk factors and understand that being in a controlling and abusive relationship will have an impact on a young woman's ability to recognise the abuse, and affect their decision making".*[9]

[6] Conducted by Christine Barter (Senior Research Fellow 2005-present), Professor David Berridge (Professor 2005-present), Dr Melanie McCarry (Research Associate/Lecturer 2004-2013), Ms Marsha Wood (Research Associate 2003-present) and Ms Kathy Evans (Research Associate 2006-2009).

[7] February 2017 Dr Christine Barter is a Reader in Young People and Violence Prevention in the Connect Centre for International Research on New Approaches to Prevent Violence and Harm, at the University of Central Lancashire http://www.safelives.org.uk/practice_blog/violence-young-people%E2%80%99s-relationships-%E2%80%93-reflections-two-serious-case-reviews

[8] ibid

[9] ibid

5.1.74 Information has been provided to the review as to current Police practice, which shows that Hampshire Constabulary is delivering Safelives Domestic Abuse Matters training to all frontline officers and staff, which provides information relating to the identification of coercive and controlling behaviour. Police conference attenders have attended this training. This is learning for all agencies involved in this review and is reflected in recommendation 2, which also explores the establishment of a DASH system and checklist for young people under 16.

Robustness of decision making concerning the child protection process

5.1.75 This review has highlighted the lack of robustness of decision making concerning the protection of these three babies and is a theme arising from this Serious Case Review, as illustrated below.

5.1.76 There was no child protection process for **Baby Connor** and thus no involvement by legal services. This was despite Father being subject to Child Protection procedures in 2015, followed by a Child in Need Plan. The lengthy history of safeguarding concerns in relation to Father should have alerted Children's Social Care, as the lead agency for Child Protection to undertake a Section 47 investigation, once it was known that Father was going to be a parent. Unfortunately, this did not happen, and the focus of social work involvement was in securing accommodation for Mother away from the family home due to the risk presented by her younger sibling. This demonstrated a lack of professional curiosity on the part of agencies about Father's background and the risk his behaviour may have presented to the unborn baby.

5.1.77 The lack of robustness, if not naivety, of the Child Protection Plan for **Baby Danny** has already been the subject of lengthy discussion in this review. Given Mother's known history and vulnerability, and the significant lack of information concerning Father, consideration should have been given to having a Legal Gateway Meeting prior to Baby Danny's discharge from hospital. Whilst Public Law Outline (PLO) meetings did take place, (the purpose of which is to obtain advice as to whether the 'threshold criteria' for a care order under section 31 Children Act 1989 have been met), once Baby Danny had been discharge to the care of his parents, the parents agreed to continue to engage with the Child Protection Plan, with mental health services, parenting courses, capacity to care assessments, assessments of family members and with the FNP. It was recorded that the parents were engaging with all professionals, that the family was visited regularly by different professionals and attended regular review meetings. Thus, it would appear that the threshold criteria were not met. What is not documented is an assessment of risk presented to Baby Danny and consideration given to his lived experience in the care of his parents. It is apparent from information provided to the review that the frequency of visits undertaken by the social worker fell short of expected statutory child protection practice and the monitoring of Baby Danny was left essentially to the Family Nurse.

5.1.78 In the case of **Baby Ethan,** the decision of the ICPC to make the unborn baby a Child in Need was based on Mother residing with Maternal Grandmother and the ending of the relationship between the parents. The Police ceased to be involved once the case was no longer one of Child Protection. The Child in Need Plan made no consideration

of any involvement of Father, assessment of him in case of future contact, arrangements for future contact or medical information concerning his mental health. There was no consideration given to the possibility of the couple reuniting; nor was there any understanding of the pressures on Maternal Grandmother and the previous poor relationship between Mother and Maternal Grandmother. The case was allocated to a student social worker and management oversight was by a temporary manager whilst the permanent manager was on leave. Legal advice was not sought during the ICPC or the Child in Need process.

6 Key Learning arising from this Serious Case Review

6.1.1 The need for professionals to recognise adolescent parents as children themselves, whose brains are still developing, is an important lesson arising from this review. Training focusing on brain development, risk taking behaviour by adolescents and the impact of these factors on their parenting ability would be beneficial to professionals working with young parents. The review has been informed that adolescent brain development is a key element of FNP evidence based training. Thus, those Family Nurses working with young parents, should have been equipped with such understanding. **Recommendation 1.**

6.1.2 Comprehensive, robust assessment of risk factors, in addition to the parenting abilities of young parents, is key if children are to be protected from significant harm. This is particularly important when decisions are made to move mothers and babies from supported accommodation to independent living units where there is a lack of monitoring by staff and substantial support to residents.

6.1.3 The need for suitably qualified staff working with young parents in independent housing is a pre-requisite if the risk posed to young babies by immature, vulnerable parents is to reduce. It is not sufficient for the current service provider to state that their responsibility is to offer intermediate accommodation and to simply signpost young parents to appropriate support services.

6.1.4 The review has been made aware that significant concerns have been raised by Police about the number of times and the reasons why they are required to attend the independent living unit provision in Southampton. If a tragedy such as that of Baby Connor is to be prevented in future, the provision of independent living accommodation needs to include professionally qualified social care staff to support the parents and babies residing at this unit.

6.1.5 Recognition of the need for appropriate support to young parents is a finding from the review. In all three cases the involvement of the FNP was seen as the main support to the parents. Additional social work support and Early Help intervention was also required.

6.1.6 Cases involving vulnerable parents of young babies should not be allocated to student social workers.

6.1.7 The propensity for domestic abuse, controlling and violent behaviour in teenage relationships has been highlighted in the review. Professional awareness needs to be raised about these issues and consideration needs to be given to introducing a DASH risk assessment and checklist for under children under 16 years old.

6.1.8 The review has illustrated that informed, evidence based decisions and challenge, as well as professional curiosity and robust child protection planning, with advice from legal services, is required at ICPCs and Child Protection Conferences.

6.1.9 As is a finding in so many Serious Case Reviews, it is also the case in this review that the need for comprehensive information sharing amongst agencies is fundamental if professionals working with families are to be fully conversant with and understand the risk of significant harm presented to children. This did not happen in the three cases subject to review.

6.1.10 It is however, recognised that is three years since the review was commissioned. Since then, it is important to note that improvements to information sharing have taken place across the partnership. The review has been informed that the FNP now has a stronger relationship with the MASH and an information sharing agreement is in place for MASH practitioners to request information concerning fathers/partners where there are concerns. (**Recommendation 2**).

6.1.11 FNP also now ask fathers and involved partners if they will agree to having records open on System 1 (health recording system) to link with the baby. Whilst this is dependent on gaining the permission of those concerned, if it is provided, then the FNP has access to information across the health economy, e.g. CAMHS, GP records where System 1 is used. Solent Trust are also involved in conversations with Children's Social Care, Police and Information Governance Teams as to how the sharing of PPN1 can be more robust with health, whilst fulfilling their statutory and Information Governance requirements. Such changes in practice are to be commended and should improve information sharing between agencies, which can only serve to benefit the protection of children.

7 Good Practice

7.1.1 The following good practice has been identified in this review:

- The decision of the Southampton Social Worker to visit the offices of Children's Social Care in another local authority to review their records concerning the past history of Baby Danny's Mother was good practice.
- The dissent by representatives of the Leaving Care Team and midwives from the postnatal ward with the decision of the pre-discharge meeting to allow Baby Danny to go home with his parents was good practice.
- The decision of the Team Manager to overrule the view of the GP that Baby Ethan could wait for a child protection medical and insist that an ambulance was called to transport him to hospital, was good practice.

8. Conclusions

7.1.2 The decision of the Southampton Safeguarding Partnership to adopt a thematic approach when commissioning the review has enabled the readers of this report to gain an insight into the difficult and often complex situations, which professionals from different disciplines face on a daily basis when working with young, vulnerable parents.

7.1.3 The report has highlighted significant themes which run throughout all three cases subject to review. These have been discussed in detail, but for the purposes of clarity can be summarised as:

- The importance of recognising parents as children/recently children themselves;
- The need for comprehensive assessment of parenting skills and risk to the unborn baby;
- The importance of support for young parents;
- The impact of mental health issues, self-harming behaviour and substance misuse on parenting capability;
- Over optimism on the part of professionals as to the parents' capacity to care;
- The impact of a lack of good parenting experiences on young parents;
- Recognition of the risk posed by fathers in the lives of babies and children;
- Impact of Homelessness;
- Anger management and domestic abuse;
- Robustness of decision making concerning the child protection process.

7.1.4 It is hoped that the findings of this review will provide a useful reflection of practice for all those working with young parents. However, it is fundamental to any professional when working with such parents to ensure that the safety, welfare and well-being of vulnerable small babies remains their first priority.

8 Recommendations for consideration by Southampton Safeguarding Partnership

Due to the thematic nature of this review, there are more recommendations than would normally be anticipated.

Recommendation 1 **(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.** **(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.**
Recommendation 2 **(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared**

with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Recommendation 3
Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Recommendation 4
The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

Recommendation 5
Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

Recommendation 6
The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

Recommendation 7
Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six week developmental check professionals need to consider this as a safeguarding concern.

Recommendation 8 **Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.**
Recommendation 9 **Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.**
Recommendation 10 **The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.**

Appendix 1:
Terms of Reference: Non Accidental Injury in Infants - Thematic Review

Reason for review
This thematic review has been commissioned due to three cases involving serious non accidental injury/death of babies aged between six to ten weeks. All three incidents occurred within a two month period. Each case was considered by the SCR Group and met criteria for Serious Case Review under Working Together 2015.

Purpose
This will be a thematic review and analysis of common issues regarding non accidental injury to babies whose parents are teenagers or young adults. The review will be presented as one report which will also include an assessment of particular circumstances pertinent to each individual case.

Period under review
The review will reference the three cases, known as Baby Connor, Baby Danny and Baby Ethan.

The period under review for each child is:
Baby Connor is 11/05/2017 – February 2018
Baby Danny is 10/03/2017– January 2018
Baby Ethan is 4/04/2017 – January 2018

The start date for each review is the date the Mothers' pregnancy became known to agencies. The end date is the date of the injury/death of the child.

This review will request relevant background and contextual information regarding key factors and significant events about the family that was ***known or knowable by the agency at the start of the review period***.

However, it is also important to include any relevant agency knowledge outside of the period of review. To include the time prior to the review period regarding the family background and any other important and relevant information.

The lead reviewer is Moira Murray.

The lead reviewer will work with a panel of agency representatives. Members to include:

- Police
- Social Care
- CCG
- Solent NHS
- UHS
- Education
- Housing
- Legal Services

Analysis issues

This review will consider all issues that could have a bearing on the circumstances of these cases and will include:

- Support offered to young parents
- Assessment of parenting skills and risk to unborn baby
- Impact of mental health issues, self harming behaviour and substance misuse on parenting capability
- Impact of lack of good parenting experiences on young parents
- Impact of homelessness
- Anger management and domestic abuse
- Robustness of decision making concerning child protection process
- Evidencing the child's lived experience within the family
- Over optimism on the part of professionals as to the parent's capcity to care
- Involvement of Police and Criminal Justice

Involvement of staff
The lead reviewer will consider from summary information provided the involvement of relevant staff in this case to ensure any possible learning opportunities are identified and acted upon.

Involvement of families
The lead reviewer will notify the family members of the review and they will be invited to participate as and when appropriate.

Methodology
The methodology for this review will consist of:

- Proportionate IMRs for each individual case (specific template for IMR authors to follow)
- A panel of representatives from relevant agencies
- A review of relevant multi agency policies, procedures and processes that are in place
- Facilitation of multi-agency learning event, to explore key themes arising with partner agencies
- This will be chaired by an Independent Reviewer who will produce a report outlining key findings and multi-agency recommendations. This will be presented to the LSCB.
- The Independent Reviewer will request details and further information where necessary to support analysis and scope of the review. This may involve minutes of meetings, written assessments made and other relevant information.
- Learning from the review will be disseminated with multi agency partners.

Addendum – Analysis questions for IMR
When answering the following questions, please try to take into account how and why decisions were reached at the time, as well as what decisions were made.

Parents
Was appropriate assessment made of:

- The parents' capacity and capability to care for an unborn baby? (to include consideration of their own parenting experience)
- Their needs as young people?
- What support was put in place to enable them to care for their baby? (to include the role of the Family Nurse Partnership, Mother and Baby Unit). Was this sufficient?

Was sufficient consideration given to and assessment made of:

1. The mental health needs of Mother and/or Father?
2. Self-harming behaviour and suicide ideation?
3. Disengagement/withdrawal from education?
4. The effect of alcohol and substance misuse on their ability to parent?
5. The seeming acceptance by professionals of the use of cannabis by the parents, and the effect this had on their ability to parent?
6. The possible involvement of young parents with a network of older adults misusing/dealing drugs?
7. The effect of homelessness?
8. Criminal activity?
9. Domestic abuse?

Were the views of the parents listened to when their own doubts may have been expressed about their ability to care for their unborn baby?

Voice of the Child

- Was there appropriate, robust pre-discharge planning after the baby was born?
- What was a typical day like for a baby in the household?
- Was there appropriate engagement with professionals to ensure that the baby's health and wellbeing was monitored and promoted?
- Was there disguised compliance on the part of the parents?

Child Protection and Legal Processes

- What were the reasons for the unborn baby/baby (and where appropriate, siblings of Mother and Father) to be made subject to a Child in Need Plan, rather than a Child Protection Plan?
- Where appropriate, why was the baby 'stepped down' from a Child Protection to a Child in Need Plan?
- Was there sufficient escalation of concerns?
- Was the Child Protection/Child in Need Plan robust, monitored and reviewed?
- Was the involvement of Legal Services, i.e. PLO process, timely and appropriate? Could intervention have been earlier?

General

- Was the case looked at holistically, from the perspective of the child?
- Were professionals over optimistic in the belief that the baby could be safely and well cared for by the parents?
- What are the criteria for 'good enough' home conditions?
- Was there good information sharing between and within agencies?
- What do we learn from this case?

Appendix 2

The Process of the Serious Case Review

The mandatory criteria for carrying out a Serious Case Review as set down in Working Together to Safeguard Children (2015), is as follows:

(a) abuse or neglect of a child is known or suspected; and

(b) either:

(i) the child has died; or
(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

The purpose of a Serious Case Review is to undertake an independent appraisal of practice, whilst also recognising the complex circumstances in which professionals are working. A review also seeks to understand the role of all agencies involved with a family, to identify improvements which are needed and to consolidate good practice. It is not about apportioning blame.

A Serious Case Review seeks to encourage:

- a culture of continuous learning and improvement across organisations that work together to safeguard and promote the welfare of children, and that
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

For the purposes of transparency all Serious Case Reviews are required by the Department of Education to be published. The Lead Reviewer is aware of the sensitivity of the information contained in this report and the distress that it may cause to family members. There has been an attempt to balance the need for agencies to learn lessons from this review and the need to manage the distress of the families concerned. All personal information has therefore been anonymised, and pseudonyms have been used to refer to key family members and those connected with the three babies.

It is expected that Southampton Safeguarding Children Partnership will translate the findings from this review into programmes of action, leading to sustainable improvements and the reduction of risk of death, serious injury or harm to children. Some agencies have already taken steps to improve practice as result of the untimely death and injury of these babies. The review acknowledges and references where this has happened.

Agency IMR Reports

The following agencies were requested to contribute to this review:

Baby Connor	Baby Ethan	Baby Danny
• Police • Local Authority Children and Families Service • GP • Hospital NHS Foundation Trust including maternity • 0-19 Services; Health Visiting, FNP • Secondary School • Local Authority Education Welfare • Ambulance Service • Local Authority Housing and Homelessness Team • Commissioned Housing Provider	• Police • Local Authority Children and Families Service • Secondary School • Hospital NHS Foundation Trust including maternity • Local Authority Housing and Homelessness Team • GP • 0-19 Services; Health Visiting, FNP, CAMHS	• Police • GP • Mental Health Services: perinatal mental health and Adult Mental Health Team • Local Authority Children and Families Service including Care Leavers Team • Local Authority Adult Social Care • Hospital NHS Foundation Trust including maternity • 0-19 Services; Health Visiting, FNP, CAMHS • Local Authority Housing • Local Authority Education • Local Authority Legal Services

The Serious Case Review Panel included members of the following agencies:

- Police
- Social Care
- Local Clinical Commissioning Group including Primary Care
- Solent NHS Trust
- Hospital NHS Foundation Trust Southampton
- Education
- Housing
- Legal Services
- Integrated Commissioning Unit

Appendix 3

The Serious Case Review Author/Lead Reviewer

Moira Murray is a social worker by training and has been the chair and author of numerous Serious Case Reviews over the past eleven years. She has also undertaken safeguarding audits for local authorities, the NHS, the Foreign & Commonwealth Office and the BBC. She was a non-executive board member of the Independent Safeguarding Authority for five years and in 2012 was appointed Safeguarding Manager for children and vulnerable adults for the London Olympic and Paralympic Games. Most recently she was the Senior Casework Manager for the Church of England National Safeguarding Team.

In the past, Moira Murray has been commissioned by Southampton Safeguarding Partnership to undertake several Serious Case Reviews. As a result, she has had previous professional contact with some of the SCR Panel Members and IMR authors involved in this review. However, she has had no involvement with any of the three cases subject to review, and had no knowledge of, or prior involvement with the babies of their families, before her appointment as the review independent author.