FINAL REPORT OF THE CHILD SAFEGUARDING PRACTICE REVIEW REGARDING

Leo

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CONTENTS

1. THE CRITICAL INCIDENT THAT TRIGGERED THE REVIEW:

1.1 In October 2021, an ambulance was called to the home address. Leo, aged 4 months, was found by paramedics in cardiac arrest and he was unresponsive. Paramedics reported that there was evidence of cannabis use in the parent's bedroom. Leo was taken to hospital and his sibling went to stay with a family member. He died a few days later in hospital, when his life support was turned off.

1.2 Medical examinations subsequently showed that Leo had a bleed to the brain, a torn frenulum[1] and bleeding behind his eyes. He also had rib fractures that occurred roughly two weeks earlier[2].

2. THE REVIEW PROCESS

2.1 The Terms of Reference to the Review are shown Appendix 1. The analysis and findings in this review were drawn from:

- A combined chronology of all the agency's involvement.
- Individual agency reports answering the questions raised in the terms of reference.
- A practitioner event where those working directly with the family were able to provide a context and understanding as to why events or tasks had or hadn't happened.
- A staff survey.
- Individual meetings with practitioners where further information was needed.
- A follow-up practitioner event to share the findings and recommendations.
- A meeting with care experienced parents from Cumbria.

2.2 The review focussed on the period between the 1st of July 2019 and 15th of October 2021. Relevant information falling outside of this period is included in this report to provide context.

2.3 A draft of this report was shared with the Review Panel and later accepted by the Cumbria Safeguarding Children Partnership.

3. Key themes arising from this review include:

The need to involve and assess fathers and identify any strengths or risks they bring to parenting
The importance of the effective provision of early help services
Recognising parental misuse of prescription and non-prescription drugs
Assessing fathers and male care givers
Feeding difficulties as a trigger to harm
The importance of following 'was not brought' procedures
The need to identify and meet the needs of care experienced parents

[1] A frenulum is a soft piece of tissue that appears as a thin line between the gums and lips. The breaking of this piece of skin in non-ambulant children is often associated with force feeding or a direct blow to the mouth.
[2] Based on approximations by experts in the care proceedings

3. FAMILY COMPOSITION

	Age at time of death	Ethnic Origin
Mother	Not relevant	White British
Father	Not relevant	White British
Leo	4 months	White British
Sibling	20 months	White British

4. BACKGROUND HISTORY

4.1 Leo's mother was care experienced[3]. The mother had experienced neglect and trauma as a child. Later in her teenage years in 2015 there were some indicators that she was being exposed to exploitative behaviour from older males. One of those 'older males' was the father of Leo. The mother was under 16 years of age and the father was 8 years older than her. The risks to the mother were not well understood in 2015 and when professionals were told it was not an intimate relationship by the mother, no further action was taken, a rather naïve response[4]. It is recognised that since this time a new exploitation risk assessment and multi-agency strategy has been introduced by the Partnership and two Local Government Association evaluations of the response to young people at risk of exploitation have been undertaken, one in 2019 and one in 2022. The 2022 review found that since 2019, Cumbria Safeguarding Partnership (CSCP) have made substantial progress and had addressed the recommendations made in the 2019 review. There is a strategic group in place that meets regularly in relation to missing, exploited and trafficked children. This group undertakes regular quality assurance activity in respect of children that are identified as being vulnerable, for example multi-agency audits.

4.2 The mother did not have a known history of drug taking or entrenched problematic alcohol use.

4.3 The father had a history of experiencing abuse and poor mental health. He first sought help for agoraphobia and anxiety when he was 16 years old. His mental health remained poor through his late teenage years and he attempted to take his own life on three occasions in 2009, 2011 and 2015. He was reported to have been addicted to analgesics'[5] since 2016. He told his GP in June 2019 that he was self-medicating using Pregabalin[6], Gabapetine[7] and Quetiapine[8] and had been misusing drugs for some time.

4.4 The police records show they responded to both parents as both victims and perpetrators of domestic abuse in their previous relationships.

4.5 The mother's family support from her own family was limited to her birth father, who sadly passed away in early 2021. The couple also received some support from the paternal grandmother and paternal great grandmother, but professional's views about the consistency of this support were unclear.

[3] Had lived in local authority care during her childhood

[4] Contextual Safeguarding was evolving as a concept from 2011 but had not been fully recognised until the later works of Firmin in 2017[4].

[5] GP record from 2016

[6] Is an anticonvulsant, analgesic and anxiolytic medication used to treat epilepsy, pain opioid withdrawal and generalised anxiety disorder.

[7] Gabapentin is used to treat epilepsy. It's also taken for nerve pain. Nerve pain can be caused by different illnesses, including diabetes and shingles, or it can happen after an injury. Occasionally, gabapentin is used to treat migraine headaches. Gabapentin is available on prescription. It comes as capsules, tablets, and a liquid that you drink.

[8] A antipsychotic medication used for schizophrenia, bipolar disorder and major depressive disorder.

4.6 Leo's father had ongoing support from his mother and his sister, who were in frequent contact with the family and offered the mother employment prior to and shortly after Leo's birth.

4.7 The couple began living together in June 2019. The mother fell pregnant shortly before this.

5. THE LIVED EXPERIENCE OF THE CHILD

5.1 Leo was meeting all of his developmental milestones before he died. He was able to control his head and had mastered sitting up. His weight was as expected. He would give cues to his parents and began to smile when he was 2 weeks old. He was described as a happy baby who was very bright.

5.2 It is reported that Leo looked like his father.

5.3 Leo suffered from feeding difficulties since shortly after his birth. This would lead to him suffering discomfort and he would be "screaming in pain". He would often be sick after feeds and suffered from sickness and diarrhoea. He was tried on various different milks by the health visitor and the parents leading up to August 2021 when he was taken to Accident and Emergency (A&E) as a result of the parent's frustration that his feeding difficulties weren't being resolved quickly enough. He was prescribed omeprazole by treating medics in A&E. This appears to have alleviated his discomfort and he was described by his health visitor as being 'happier in himself'.[9]

5.4 Police investigations show that Leo suffered rib fractures in early October 2021. Tests carried out following his admission to hospital showed that he also had a bleed to the brain, behind his eyes and a torn frenulum. He died in October 2021, as a result of the catastrophic injuries he sustained.

6. THE VIEWS OF THE PARENTS

6.1 Leo's father was convicted of murder and two accounts of child cruelty in relation to his death. The mother was convicted of two counts of child cruelty. As part of the review process Leo's parents were invited to engage with this review following the outcome of the criminal trial, but we were unable to secure their engagement.

7. THE VIEWS OF OTHER CARE EXPERIENCED PARENTS IN CUMBRIA

7.1 The parents that met with the author were open, honest and engaging and gave valuable insights into their experiences. They were keen to share their views and ideas about how services could be improved and shared messages that professionals can sometimes lose sight of.

7.2 They shared how they felt 'prejudged' due to having been in care, they felt they are judged more harshly due to their history. All the parents that met with the author had been referred to children's services during their first pregnancy. This gave the impression of an inflexible historical approach[10] to the needs of care experienced parents. Especially, where one parent described that she was working in a residential children's home when she fell pregnant, but that a referral to children's services was made about her and her child in any case.

7.3 This feeling of being prejudged and treated differently meant that they didn't want to access support that was available as they were scared this would be seen as a weakness. This leads to a vicious circle of new parents needing support but not accessing it due to a worry that this will lead to them 'losing their child'. This is even

[9] Combined chronology entry 06.09.21
[10] In the last 5 years

more problematic when considering the support networks available to these parents can be more limited due to their history. One parent described:

> *'we don't get any breaks, we don't have anyone safe to ask to baby sit …. For a break, and if 'they' are having a bad day or feeling tired there is no break - unlike other parents'*[11]

7.4 So, in addition to fearing the repercussions of asking for help due to their worry that they would be seen as not coping, these parents do not have access to the natural respite that other parents do, which would usually arise from grandparents and wider family.

7.5 The parents that the author spoke to were able to recite occasions when they were able to forge positive, supportive relationships. This included a residential worker that stayed in touch after she (the mother) had left the children's home. This worker was there for her:

> 'like a family member'

7.6 Another example given was where:

> 'an early help worker that stayed in touch long after early help involvement ended'

7.7 A very clear message from these parents was that trusted relationships were very important to them.

7.8 Workers that were open and honest with the parents made it possible for them to be open and honest too.

7.9 Some parents described there being only one early help service on offer, which entailed a course with a local provider. *(A view that also was shared by professionals in the practitioner event.)* One parent had accessed this. Another parent had declined the support provided by that particular service provider and there wasn't another option available for her to access.

7.10 One parent suggested a WhatsApp group for parents who are care experienced to provide an additional support mechanism. However, after discussion, it was agreed that this would need to be monitored, as it would be too much responsibility to ask one of the parents to take on a monitoring this role and hold the responsibility for ensuring that no safeguarding issues were missed. This suggestion is included later in the recommendations to the Cumbria Safeguarding Children Partnership.

7.11 The parents also suggested a creative and responsive service for care leavers who are parents, to replicate the support of a safe wider family. For example, contract residential or foster carers who have previously cared for the young person to act as sessional workers (by the hour) to be corporate grandparents. This could involve taking calls when the parent needs reassurance or to let off steam or offering to care for the baby/children when the parent needs a break. This would give financial recognition for the additional work of members of

[11] Not a verbatum quote

staff and also permission for them to keep in contact and support the young person. The parents I spoke to were happy to be a part of exploring how this could be set up locally.

7.12 They felt it would be beneficial to raise awareness of the need for an occasional break from parenting when assessing or developing pathway plans for care leavers that are new parents.

8 THEMATIC ANALYSIS AND LEARNING

8.1 INFORMATION SHARING - 1ST PREGNANCY

8.2 The first pregnancy was known about by health and social care professionals in late 2019. Records leading up to the birth suggest that neither the midwife nor pathways worker[12] had concerns about the mother's capacity to parent and that the parent's relationship was considered to be 'healthy' and 'stable'. The father always presented to the pathways worker as engaged and would speak to the pathways worker. There were no signs of substance misuse and the parents reported having good support from the paternal wider family.

8.3 The pathways worker described having a good relationship with the mother. The worker had known the mother for some years but when she was allocated to him, although there was a chronology on file, it was not a comprehensive chronology. This impacted upon the understanding of the full impact of the mother's adverse childhood experiences and the previous concern that she had been exploited by the father of Leo in 2015.

8.4 The histories of the care experienced parents that met with the author show they were all referred for a pre-birth assessment. It is the view of the National Panel that pre-birth assessments "should be a routine response for any care leaver who is to become a parent"[13]. This view was not shared by the local care experienced parents that have contributed to this review. The example of the care experienced mother who was also employed by children's services at the time of the referral for a pre-birth assessment, raises an important question about the appropriateness of employing standard practice for expectant care experienced adults. Some children leave care having developed secure and strong bonds with their carers, can show great resilience and become good parents.

8.5 However, in the case of this mother she had experienced neglect and abuse, had recently left an abusive relationship and fallen pregnant by the father, where there had previously been concerns that she had been exploited by him. In addition, the father had a history of mental ill health and misuse of drugs including tramadol, pregabalin, gabapentin, quetiapine, cannabis and alcohol. This family was a family that would have met the threshold for a prebirth assessment if all of the available information had been pieced together.

8.6 **THE SAFEGUARDING HUB**: During the first pregnancy the midwife asked the mother if there was any domestic abuse, substance misuse or parental mental health difficulties in the parent's histories. She was assured by the mother that no such factors were present. Although the father's name was known and the midwife made an informal telephone call to the Safeguarding Hub. She didn't make a formal contact as set out in the local procedures. The safeguarding hub had no record of the phone call. [14] If a formal contact had been submitted to the safeguarding hub, information about the father's mental health and substance misuse issues could have been highlighted. This affected the midwife's assessment of risk and a prebirth assessment was not triggered.

8.7 One social care practitioner who was part of the review, felt that there continues to be a practice issue where professionals may request information from the Hub, but not be clear about the reason for asking for

[12] It is the role of the Pathways worker to work alongside the care experienced person and jointly identify any needs for support they have.

[13] Safeguarding children under 1 from non accidental injury (2021) p.45

[14] The front door of children's services which has a key function of sharing information and assessing risk

information. This can make it difficult for professionals in the Hub to decide what information should be shared as they don't understand the context. For example:

a) Request for information on Mr X a request for an unspecified reason
   Versus
b) A request for information on Mr X to assess potential risks/strengths for a pre-birth maternity assessment.

8.9 Although this is not good practice for professionals to seek information without a clear purpose it should not have precluded the Safeguarding Hub from disclosing all of the known risk factors in relation to the father, namely his poor family relationships, mental ill health and substance misuse[15].

8.10 **SHARING OF INFORMATION BETWEEN THE GP AND HEALTH VISITOR:** The GP's notes on the father did contain information highlighting risks in respect of the father. If the GP surgery had linked the father and mother together as expectant parents, the following information would have been accessible:

- The father had tried three times to take his own life and had enduring poor mental health.
- Within days of the pregnancy being confirmed the father self-reported to his GP that he was smoking up to 25 joints of cannabis a day and was misusing substances.
- In July 2019 the father told a psychiatrist that he was self-medicating by using pregabalin, gabapentin, quetiapine and codeine and was referred to psychotherapy.

8.11 The GP did not flag the concerns regarding the father to the midwife, after the mother booked her first pregnancy with the GP. The parents were registered with the GP at different addresses and it is likely that the Locum GP who registered the pregnancy, did not marry up the pregnancy of Leo's sibling with the birth father. There were significant staffing issues in the surgery which meant it was short staffed. At that time midwives did not have access to GP records which is why this information wasn't detected as part of routine enquiries made by the midwife.

8.12 The father's medical history coupled with the knowledge that the mother had been in care and experienced adverse childhood experiences, would have provided sufficient information to trigger a pre-birth assessment.

8.13 The absence of a children's services pre-birth assessment meant that health professionals were not fully alert to the risks in the family and resulted in the pathways worker having limited knowledge of the risk factors in the family. The Pathway worker's lack of knowledge of the father's background became especially significant when the anonymous allegation was made about the family in September 2020.

Learning points:

- Comprehensive chronologies are essential for professionals working to support care experienced young people to enable them to contribute to the assessment of risk and understand the young person's needs.
- Effective information sharing between key agencies such as GPs, midwifery and the Safeguarding Hub is crucial to ensure that pre-birth assessments are triggered where there are known risk factors such as adult mental health issues, substance misuse and adverse childhood experiences.
- Where agencies get in contact with the Safeguarding Hub to request information, they need to be clear about the purpose of the request for information and follow the local procedures using the agreed 'Requests for information' form, found on the Partnership website via the following link: https://www.cumbriasafeguardingchildren.co.uk/professionals/concernsaboutachild.asp
- GP surgeries need to establish the name and dob of fathers and ensure that family compositions are understood.

[15] Cited from the Children Services IMR

- It is essential that midwives gather information from GP records in respect of both mothers and fathers when assessing family's needs, in addition to seeking information from the Safeguarding Hub, if concerns or risk factors exist.

8.14 INFORMATION SHARING - 2nd PREGNANCY

8.15 The mother conceived Leo in August 2020. The mother did disclose that she had experienced adverse childhood experiences and told the health visitor that her father had been murdered. The information about the birth father's history remained unknown to the midwifery and health visiting services, despite a pregnancy booking sheet having been shared with the GP surgery which identified both the mother and the father. The booking sheet offered an opportunity for the parents to be linked on the GP records. At this point and given that the family appeared to have managed well with the first baby, the assumption was made that the family had no additional needs and they were initially assessed as requiring 'universal'[16] standard of service.

8.16 In line with good practice the mother was allocated the same midwife and health visitor as she had in her first pregnancy.

8.17 Eight months before Leo was born, in September 2020, an anonymous referral was made about the father. It was reported that he had been using and selling heroin, was seen driving a car whilst intoxicated with a child in the car and was reported to have mental health issues. The Safeguarding Hub did contact the pathways worker whose role it was to support the mother. He shared that to his knowledge the father did not have access to a car or have a driving licence. The father's previous history, which was available to the Safeguarding Hub, was again not shared with the pathways worker. No checks were made with the GP to establish if the father had mental health issues and as a result, the referral was considered to be malicious, and no further action was taken. This meant that the information known to the GP that the father misused substances was not shared to inform the response to this referral and the GP was not made aware that such a referral had been made.

8.18 The response or lack of response to referrals made by the public and wider family, was key learning arising from the National Review into the murders of Arthur Labinjo-Hughes and Star Hobson (2022).[17] The CSCP has driven work across the partnership to embed the key learning from this National Review, particularly that referrals should no longer be categorised as malicious and can only be judged to be "not proven" after a robust investigation. Assurance has been provided to the CSCP that this has been embedded within all agencies at all stages of involvement with children and their families.

Learning points:

- When safeguarding concerns are reported it is essential that all aspects of the referral are investigated and checked with the relevant agencies including mental health services and the family GP.

THE EFFECTIVENESS OF THE EARLY HELP SYSTEM

8.18 The midwife made a referral to Barnardos during the first pregnancy, for 1:1 work to support the mother. Although the midwife was not fully aware of the risks cited above, she did feel that the new family might benefit from the support, as not a lot was known about the father and they had limited wider family support. The midwife referred the mother for 1:1 sessions rather than group meetings, as the mother was shy. This referral was accepted but got lost when the contract transitioned between Barnardo's and Family Action.

[16] Universal, plus and partnership plus services are three levels of support that can be offered linked to need, Universal services is for families were there are no assessed additional needs.

[17] National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson accessed at National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk) on 26.06.2023

There did not appear to be effective tracking systems in place to ensure that all families that had been referred were offered a service. On receipt of this report the Partnership have subsequently reflected that an early help assessment should have been triggered at this point.

8.19 Further consideration was made for some early help for the family in February 2020 by the health visitor, but when she discussed the possibility of receiving extra support, the parents felt they didn't need this. The provision of early help is based on consent and parents are at liberty to decline this form of support.

8.20 Care experienced parents that contributed to this review described how, in their experiences the early help services were restricted to one provider and one offer. Practitioners in the review felt that early help support looks different dependent on where families live in Cumbria. It is important that there is a range of early intervention services to meet the diverse needs that are experienced by children and families and these services are offered consistently across all areas in Cumbria, and that professionals and families including care experienced are clear on what early help is and what the offer is. It is acknowledged that considerable work is now being undertaken to develop the Early Help offer and services to support parents locally.

Learning points:

- It is important that all referrals to early help are tracked to ensure that families that are identified as being in need of support are offered services.
- It is important that early help offers a diverse range of services that meet local need to prevent families' difficulties from escalating.
- It is important that when a practitioner assess that a family may need additional help that an early help assessment is initiated by that practitioner and completed with the family. A plan should also be made in how agencies and the family would work together to meet the children's needs.

8.21 RECOGNISING PARENTAL SUBSTANCE MISUSE

8.22 Following Leo's death evidence gathered as part of the police investigation showed that the parents were using a cocktail of substances which rendered them at times unable to meet the children's basic needs including feeding, supervising them and responding to their distress.

8.23 Professionals undertook multiple announced and unannounced visits to the family home between the day that Leo was born in May 2021 and the day he was taken to hospital in October 2021. On no occasions were signs of substance misuse observed. There was no evidence of drug use that would be considered to be more commonly known. For example, needles, wraps or bongs. There were no observations of substance misuse in the parent's presentation. For example, slurred speech, drowsiness, hyperactivity or being unusually energetic.

8.24 The father was open to his GP about his substance misuse in 2019. The mother however, misled professionals by stating that there were no issues for the parents about substance misuse and that her experience of witnessing her parents misuse substances made her determined not to expose her children to this.

8.25 Misuse of prescription drugs such as pregabalin, gabapentin, quetiapine and tramadol can be difficult to detect, especially when traditional substance misuse training usually focuses on the more prevalent forms of misuse such as heroin, cannabis and alcohol. Frontline practitioners that contributed to the review were reflective about the complexities in the detection of misuse of prescription drugs. They felt that if they had not been part of this review, they would not be alert to the impact of the misuse of prescription drugs. A recommendation has been made to review the local training offer and evaluate how it provides practitioners with the skills to understand the prevalence of misuse of prescription drugs, and to be able to identify and respond to parental misuse of prescription drugs.

Learning point:

- It is important that frontline practitioners working with parents understand the prevalence of misuse of prescription drugs and are able to identify and respond to parental misuse of prescription drugs.

8.26 ASSESSING RISKS AND STRENGTHS IN MALE CARE GIVERS

8.27 The mother returned to full-time employment when Leo's older sibling was 10 months old and she returned to part-time work shortly after Leo's birth. She was open about her intent to return to work with professionals that were working with her. When the mother was at work the father had sole care of Leo's 15 month old sibling and a Leo as a new born baby. The father was described by those that observed him with the children as taking an active role in caring for the children. He was able to dress, wash and feed the children and never presented as anxious or sought support from the health visitor about day to day care of the children. There were no concerns about the home conditions that were observed or evidence of drug paraphernalia seen in the home, on announced or unannounced visits.

8.28 The absence of knowledge about the father's poor mental health, history of trauma and substance misuse resulted in him being seen as an able 'stay at home' father rather than a parent whose vulnerabilities could impact on his parenting. [18] The father's role as a main carer did not prompt professional curiosity about his capacity to care, full time for two children under 2 years of age.

8.29 The initial health visiting assessment completed over the telephone in May 2021, was a missed opportunity to exercise professional curiosity about the father as an equal partner in terms of the care giving role and at times the sole carer. This assessment was completed with the mother and did not include the father. Although it is noteworthy that Leo's feeding difficulties had not developed at the time of the health assessment.

8.30 Practitioners fed back that identifying care givers is not generally explored in the midwifery booking or primary visits. In addition, the primary visit fell in the period when Covid 19 restricted home visits and it was conducted over the telephone with the mother.

8.31 Following this, the father was present on most occasions that the health visitor visited. He was talkative and shared some details of the abuse he experienced in his childhood and talked about the pain he was experiencing with his back.

8.32 Practitioners fed back that any assessments after the initial assessments tend to focus on the progress the child is making rather than the parenting. This is an important gap given the research about the impact of day to day care in parenting and especially that of fathers.

8.33 Research indicates that children under the age of one year old are the most vulnerable cohort of children. Baby boys outnumber girls in the likelihood of harm by their father[19] and day to day care such as crying, babies being unwell and not sleeping[20] are triggers to harm, which in most cases is caused by the father of the child. Leo at that time had feeding difficulties resulting in him crying, 'screaming with pain' and having vomiting and diarrhoea following feeds and not sleeping. These factors would have acted as additional stressors for both parents.

8.34 In this case, the father was not 'invisible' or 'hard to engage' and there is no evidence that he misled professionals when asked about his use of substances, for example, his disclosure to the GP in July 2019. He

[18] Safeguarding children under 1 from non-accidental injury (2021)
[19] The Myth of Invisible Men Safeguarding children under 1 from non accidental injury 2021 p18
[20] The Myth of Invisible Men Safeguarding children under 1 from non accidental injury 2021 p25

started to share information about his childhood trauma, without prompting, from the health visitor. Given his openness and his availability to professionals it is highly likely that had he been engaged in either a children's services pre-birth assessment or a holistic health assessment, that the risks he posed would have been identified.

8.35 There was a lot of contact with the father, but he as a parent, he was never assessed.

Learning points:

- Fathers and other male care givers need to be included in any assessment of parenting.
- Risks to infants (children under 2 years old) and identified complicating factors identified in research should be considered when assessing need and risk.

8.36 RESPONDING TO FEEDING DIFFICULTIES

8.37 Leo's feeding difficulties started when he was a few weeks old in mid-June 2021. He continued to experience discomfort, pain, distress and vomiting and diarrhoea and his weight was observed to have dropped slightly on the 17th of August, when weighed by the health visitor. The health visitor described her frustration at trying to get help for Leo's feeding difficulties. She made multiple planned and unplanned home visits and recommended a change in milk. The advice she gave didn't resolve the feeding issues and her multiple attempts to secure support from the GP were unsuccessful. Referrals to paediatric services can only be made via the GP and not from health visitors.

8.38 In the end, the health visitor advised the mother to take Leo to the local Accident and Emergency department due to their shared frustration in getting access to a GP. The mother did take Leo to the hospital in August 2021, shortly after Leo's drop in weight was noticed. This is not in line with expected practice. It is not unusual for feeding difficulties to take some time to resolve as a range of different types of milk and exclusions need to be tested out. However, the combination of 5 GP surgeries into 1 large surgery, the staff shortages at the time and the lack of access to a named GP meant that the responsiveness to Leo's feeding difficulties fell below expected standards. It is highly likely that the feeding difficulties, Leo's restlessness and discomfort would have been contributory factors in him sustaining the catastrophic injuries that were discovered in October 2021. In recognition of the impact of feeding difficulties in children a Pathway has been created to guide decision making by general health practitioners in response to unsettled infants. There is also a planned awareness raising campaign by the Partnership in relation to ICON in September 2023 which coincides with ICON week. ICON was developed to raise awareness that:

- **I**nfant crying is normal
- **C**omforting methods can help
- It's **O**k to walk away
- **N**ever shake a baby

Learning point:

- Staff must be aware of the potential impact of feeding difficulties on safety in families where there are predisposing factors which heighten risk and especially for care experienced parents, where there is no opportunity to take a break utilising safe wider family members for support.

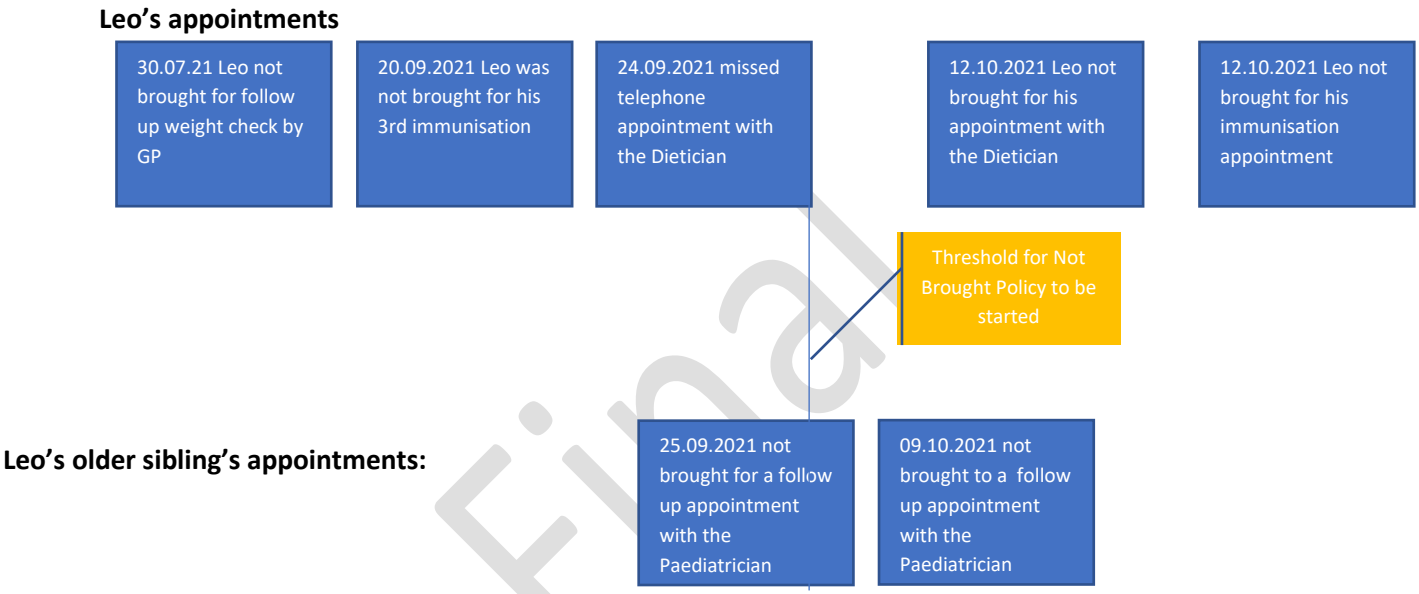
8.39 BABIES NOT BROUGHT TO APPOINTMENTS

8.40 Missed appointments are known indicators of risk and as a result midwives, health visitors, GPs, Paediatricians and other health staff are expected to follow 'not brought' policies. A 'not brought policy' sets out what staff

should do if children are not brought to appointments. Ordinarily, there is an expectation that a review is carried out when a child is not brought to 3 appointments.

8.41 There were opportunities for Leo and his sibling to be discussed at the GP surgery regular safeguarding meetings due to missed appointments between July 2021 and Leo's death. Leo was not brought to 3 appointments leading up to the 24th of September 2021. However, there were missed appointments that were knowable[21] in the safeguarding system about each of the children. Leo's sibling had also not been brought for health appointments around that time. The missed appointments coincide with the likely date of Leo's rib fractures. See Fig 1.

Fig 1.



8.42 The two missed appointments with the dietician (one telephone and one face to face) are particularly perplexing given the mother had so proactively sought advice about Leo's feeding difficulties. This was a missed opportunity for professional curiosity to be exercised. Practitioners that contributed to the review shared that appointments that are offered by a medic outside of the surgery e.g. dietician, are not notified to the GP surgery and Health visitor in a timely manner. This meant that the third missed appointment was not identified in September or October 2021.

8.43 There was however an opportunity to have identified three missed appointments that were offered within the GP surgery. The third missed appointment was the missed immunisation appointment on the 12th of October 2021, three days before Leo was found unresponsive and taken to hospital.

8.44 However, had this pattern of missed appointments been brought to the GP Safeguarding meeting or placed on the Safeguarding register for regular discussion it would have provided the opportunity to pull together information from the GP and Health Visitor notes which would have shown the father's significant history of mental ill health and substance misuse, the mother's exposure to harm and neglect as a child, the additional stressor in the young family of feeding difficulties and the missed appointments. Of note, Covid restrictions

[21] Knowable – defined as able to be observed, understood, or ascertained

were in place at the time and the focus of the surgery was to ensure that all patients were vaccinated. This meant that the GP safeguarding meetings either didn't happen or were held virtually.

8.45 IDENTIFYING AND MEETING THE NEEDS OF CARE EXPERIENCED PARENTS

8.46 The mother had an allocated pathways worker who saw her regularly at both planned and unplanned visits. He feels he had a good relationship with her and she engaged well with him. All the expected Pathways planning and reviewing was undertaken in line with procedures and signed off as expected by a team manager.

8.47 The Leaving Care Act 2000 came into effect on the 1st of October 2000. The main aims of this legislation were:

- to delay young people's discharge from care until they are prepared and ready to leave;
- to improve the assessment, preparation and planning for leaving care;
- to provide better personal support for young people after leaving care;
- to improve the financial arrangements for care leavers.

8.48 Where a young person is considered as 'eligible[22]', the Local Authority has a duty to carry out an assessment of the young person's needs for advice, assistance and support to provide and prepare a pathway plan. Assessments and planning for the mother's needs focussed on her health needs, education, training or employment, her identity, family and social relationships and her emotional and behavioural development. There was evidence of exploration with the mother about smoking, substance misuse and alcohol linked to her pregnancy. The mother denied any use of drugs.

8.49 There is evidence that the impact of the arrival of each of the children was considered in assessments and plans, but this was very limited. The Pathway Plans were focused on the mother's needs as a care leaver and did not include consideration of her needs as a mother. This is particularly pertinent given that at the age of 21, she was expecting her second child and her experience of neglect and abuse as a child meant she did not have a positive 'blue print' of parenting to base her own parenting upon.

8.50 Frontline practitioners that contributed to the review felt that Pathway plans proformas are quite restrictive and do not lend themselves to thinking about the wider needs of young people who are to become parents. One practitioner acknowledged that recent changes have been made to improve the forms that are used but further changes could be considered to ensure that care experienced young people are also seen as parents and that planning and support extend to cover these needs also. Feedback from other care experienced parents would indicate that it may be beneficial to include consideration as to how the young parent can be offered a break or a rest when needed.

Learning point:

- The needs of care experienced young people who are expecting a child or are caring for children, need to be taken into Pathway planning to ensure that these young people are being offered all available support services to promote positive, safe parenting.

9. IDENTIFIED GOOD PRACTICE

9.1 Midwives in Cumbria now have access to the GP notes and can review them to gather information on families when assessing levels of need.

[22] Eligible children are those in care aged **16 and 17** who have been looked after for a period to be prescribed. The age at which spells in care start to count towards eligibility will also be prescribed. Relevant children are those aged 16 and 17 who meet the criteria for eligible children but who leave care.

9.2 The GP has now employed additional administrative capacity to marry up family members so that records are appropriately linked.

9.3 The mother was offered continuity of care by having access to the same midwife and health visitor through both pregnancies.

9.4 Both the pathways worker and the health visitor visited the family on a planned and unplanned basis. Both services felt that they were able to be responsive to the family's needs by offering practical support and advocacy.

9.5 The family's need for alternative housing due to the birth of the second child was responded to promptly and the family were offered practical support in terms of a new cooker and carpets following Leo's birth.

9.6 Feedback from professionals in the hospital showed good professional curiosity. When Leo was taken to hospital in August 2021 for reflux issues a health professional requested a review of Leo by the paediatric consultant. This was prompted by Leo letting out a 'cry' indicating pain when his hand was lifted to wipe away vomit. This was viewed as an indicator of concern and a review was undertaken by a paediatrician, no injuries were identified. This was an example of good professional curiosity and an alertness to the potential for safeguarding issues in non-verbal infants.

10. CONCLUSIONS AND RECOMMENDATIONS

10.1 The purpose of a Local Safeguarding Child Practice Review is to identify good practice and learning in respect of single or multi-agency safeguarding practice. It is important to distinguish what was 'knowable' and what was not 'knowable' in this review.

10.2 There was information in the safeguarding system which meant that the risks arising from the father's parental mental health, historical substance misuse and adverse childhood experiences were 'knowable'. The father was in plain sight, he attended antenatal checks with the mother and was present and engaging when professionals went to the home and was at times open about his substance misuse, issues with anger and his mental ill health. The mother's history was known and she was described as being "easily led" and wanted to be loved.

10.3 There were a number of missed opportunities where all of the risks could have been identified. These opportunities arose at:

- The first and second antenatal assessments
- The GP appointment in June 2019
- The anonymous referral in September 2020
- The appointments that Leo was not brought to in September and October 2021.

10.4 The reason these opportunities were missed were threefold. Firstly, there was poor information sharing between the Safeguarding Hub and midwifery. The Safeguarding Hub held a case history for the father which included mental health issues and substance misuse issues. Secondly, the parent's records were not linked by the GP surgery. Thirdly, a historical lack of access to GP records by midwifery staff. As a result, the initial assessment of need was flawed. The Safeguarding Hub did not disclose the risk factors that the father brought into the family, namely his history of mental health issues, self-harm and substance misuse. Had the risk

factors in this family been fully understood this could have resulted in the risks to Leo being better mediated and understood.

Linked recommendation 1:
For the Partnership to seek assurance that where information is requested by health and midwifery services, this is completed in line with the agreed protocols, and results in the relevant disclosure of information held on expectant mothers and fathers.

Linked recommendation 2:
For the Partnership to be provided with assurance that:

a) the investment and changes to ensure that midwifery staff have access to GP notes and information has had an impact for all midwifery across the County.
b) that the positive practices to ensure GP records marry up the names of mothers, father and children have had the desired impact across the County.

10.5 The anonymous referral made in September 2020 did not receive a robust response and not all agencies were contacted to discount the concerns raised. This limited the professional curiosity about the referral and left practitioners with false assurances. There has been significant learning from the national review into the murders of Arthur Labinjo-Hughes and Star Hobson[23] about the importance of robust responses to anonymous referrals and concerns raised by family members. It is important that the Cumbria Children's Safeguarding Partnership are provided with assurance that referrals are being responded to robustly.

Linked recommendation 3:
For Cumbria Children's services to give assurance about the rigour of responses to anonymous referrals made to the Safeguarding Hub.

10.6 The GP did not link the father with the pregnancy in June 2019, which was largely due to disruption from combining 5 GP surgeries into 1 and significant staffing issues. Local practice has shifted since this time and now administrative support has been secured to ensure that households are identified.

10.7 The expected procedures about children not being brought to their appointments were not followed in respect of Leo, who had not been brought to appointments in the community and the hospital. It is important that information is shared in a timely manner between health providers to ensure that risks and unmet needs can be identified and responded to.

Linked recommendation 4:
For the North East and North Cumbria ICB and Lancashire and South Cumbria ICB to provide assurance to the Cumbria Safeguarding Children Partnership that children who are not brought to appointments within setting (the GP surgery) and across settings (GP and hospital) are alerted and responded to in a timely manner.

[23] The Child Safeguarding Practice Review Panel: Child Protection in England (2022)

10.8 In addition to factors such as parental substance misuse, mental ill health and the stress of looking after two children under 2 years of age, Leo's feeding difficulties were an additional stressor to his carers. It is important that feeding difficulties are recognised as a potential safeguarding risk and are responded to promptly.

Linked recommendation 5:
Health visitors and GP training pathways to raise awareness of the impact of feeding difficulties and being unsettled on child safety and provide Cumbria Children's Safeguarding Partnership with assurances that feeding difficulties and unsettled infants are recognised as potential triggers to harm and responses to feeding difficulties are responded to in a timely manner by health professionals.

10.9 The family's lack of access to early help and wider family support was recognised by professionals working with the family. Isolation is a known factor to increase the stress of day to day parenting. Local care experienced parents stressed the impact of not being able to have a break, like parents where safe grandparents or wider family are on hand to offer some respite. The staff survey showed that professionals were not fully aware of what services care experienced parents can access for support and the role of the Pathways team.

Linked recommendation 6:

For the Partnership to receive assurance that all agencies are clear on their roles and responsibilities in relation to the assessment of early help needs and the provision of early help services.

10.10 Support for young people that have been in the care of the Local Authority is key to ensuring that they are able to be the best parents they can be, recognising that their experience of being parented has not left them with good examples and strategies to employ, when parenting their own children. The role of the pathways team is to identify the needs of care experienced young people and support them in achieving their aspirations. The current pathways plan and assessment tools do not invite the worker to think about the care experienced parent's needs and therefore don't fully recognise this as an exciting but also stressful transition in their lives.

Linked recommendation 7:
For Children's Services to consider adjusting the current pathways proforma or creating a pathways plan and assessment proforma for care experienced parents or expectant parents with the local care experienced parent group.

10.11 Local care experienced parents should be offered the highest standard of services in a way that is accessible and does not prejudge them. Local Authorities are charged with ensuring that care experienced young people are aware of their entitlements. It may be helpful if the multi-agency 'offer' to care experienced parents is published to ensure that all avenues of support are explored to offer wrap around corporate grandparent/wider family like services.

Linked recommendation 8:

Cumbria Corporate Parenting Services to work with the care experienced parent group to consider the following:

- A scheme where professionals that have developed positive relationships with young people are able to continue to support them when their original roles cease. E.g. previous residential workers, foster carers, or early help workers
- Cumbria Corporate Parenting Services to work with the care experienced parent group to consider developing a WhatsApp group for parents which is formally monitored by experienced professionals to ensure that any safeguarding issues are identified.
- Cumbria Children's Services to consider publishing a care experienced parent guide or a description of a potential multi-agency 'offer' setting out what support they are potentially entitled to, in a similar way that other entitlements are published. This could then raise awareness among parents, expectant parents and other professionals supporting care experienced young people.

10.12 Finally, the part of this review that was not 'knowable' was the extent to which the parents were misusing prescription substances. The parents were skilled in hiding their substance misuse from professionals that visited the home in both planned and unplanned visits. Given the lack of changes in presentation by the parents and no evidence of misuse in the home – the extent of their substance misuse was not 'knowable'. One practitioner that contributed to the review was open and reflective about the parent's substance misuse and felt that had (they) not been involved in this review they would not be alerted to seeing blister packs of medication as a potential safeguarding issue. Given the expediential rise in deaths in London due to misuse of Gabapentoids and the local intelligence that Cumbria has an established problem with tablets such as Diazepan, Zanax and Pregablin, it will be important going forward that the workforce is sufficiently skilled in recognising and responding to parental misuse of prescription drugs.

Linked recommendation 9:

The Cumbria Safeguarding Children Partnership to seek assurance that local training offers for professionals enable them to understand the prevalence of the misuse of prescription drugs and they can recognise and respond when parents are misusing prescription and non-prescription substances.