Walsall Local Safeguarding Children Board

Serious Case Review

‘Miles’

Review report

Independent Reviewer: Kevin Ball

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1. Introduction

1.1. This Serious Case Review examines the involvement of agencies and professionals with a child who, for the purpose of this review will be known as Miles. Miles died at 18 months old and had been in foster care for the previous eight months with his mother whilst assessments, as part of Court proceedings, were taking place. Miles had considerable additional health needs which required care and attention on a daily basis.

1.2. A Serious Case Review was commissioned due to the fact that Miles died whilst being a looked after child, he had experienced abuse/neglect during his life and the initial review of information identified issues about the quality of the foster placement which may have left him exposed to ongoing risk. He became looked after due to concerns about the mother's ability to meet his needs, and there had been concerns that he had experienced abuse or neglect whilst in his mother's care despite a number of agencies being involved in his life.

1.3. A full and thorough Police investigation was completed, including the involvement of expert witnesses. This concluded with an unascertained cause of death and no further action being taken by the Police.

2. Process for conducting the review

2.1. The decision to initiate a Serious Case Review was taken in May 2019 by the Independent Chair of the Local Safeguarding Children Board (LSCB) following a Rapid Review of agency contact with the child. The Board commissioned Kevin Ball as the Independent Reviewer[1]. Following the appointment of the Independent Reviewer an initial scoping meeting was held at the end of July 2019. At this point the following steps were taken:

- Single agency reports[2] and chronologies were requested and submitted in September 2019, which in turn generated a combined chronology of agency involvement. This process provided each agency with the opportunity to reflect on their involvement with the child and parents. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice early in the process.
- A facilitated multi-agency workshop was convened in October 2019 involving practitioners who had come into contact with the child and parents. This was then followed up with a second workshop in February 2020 to test out the learning and seek practitioner input into recommendations. The reason for the delay between the two workshops was that an outcome from the post-mortem and Police investigations had been anticipated and it had been hoped to share this, along with the findings of the case review, with practitioners; the outcome from the post mortem and Police was however delayed.
- Due to the delays caused by the post mortem and Police investigations it was not possible for the Independent Reviewer to offer to meet with Miles's mother or father, to gain their perspective, nor the foster carers until March 2023.

2.2. The approach taken with this review has complied with the expectations as set out in statutory guidance[3] and has provided a way of looking at and analysing frontline practice as well as organisational structures and learning. A Soft

[1] Kevin Ball is an independent and experienced safeguarding consultant, with specific experience of chairing and authoring case reviews.

[2] Single agency reports were submitted from the following agencies;

- Walsall Health Care NHS Trust
- Walsall Children's Social Care
- Sandwell & West Birmingham Clinical Commissioning Group
- West Midlands Ambulance Service
- Black Country Partnership Foundation Trust
- Birmingham Women's & Children's Hospital NHS Foundation Trust
- Walsall Clinical Commissioning Group
- West Midlands Police
- Sandwell & West Birmingham NHS Hospital Trust
- Dudley & Walsall Mental Health Partnership Trust
- Independent Fostering Agency
- Cafcass

[3] Working together to safeguard children, 2015, HM Government.

Systems Methodology[4] has been adopted allowing system thinking ideas to be applied, enabling the review to identify and capture opportunities for professionals and organisations to learn and improve safeguarding practices from a whole safeguarding system perspective.

2.3. The timeframe under review was from August 2018 to April 2019. Relevant information prior to this period has been included as necessary.

3. Family structure & contribution to the review

3.1. For the purpose of conducting this review the following individuals are relevant:

Subject	Identified as	Subject	Identified as
Miles	Miles	Father	Father
Mother	Mother	Foster carers	Foster carers

3.2. Seeking the contribution of family members has been an important consideration. As stated above, there were delays in the Independent Reviewer being able to meet with the mother due to the Police investigations. In practice this meant that there was a gap of over 3½ years between Miles's death and the parents and foster carers being offered the opportunity to contribute to the review in March 2023.

3.3. Miles's mother spoke about feeling blamed by professionals in the early weeks and months of Miles's life about his lack of weight gain, and feeling like her parenting was inadequate up until a diagnosis was given. She spoke about having a good relationship with the foster carers, and finding them very supportive and helpful. She also spoke about the first Social Worker being very helpful, but then changes of worker being unhelpful; she then felt let down following the conclusion of the Police investigation and decision of the Crown Prosecution Service was made, and then having no workers involved with her. The stress and emotion of having to live with the uncertainty of the lengthy delays with the Police investigation and post mortem were very difficult for her, especially as this delayed being able to hold a funeral.

3.4. Despite good efforts, it was not possible to locate Miles's father; he has therefore not contributed to the review.

3.5. The foster carers were asked if they wished to contribute once the Police investigation had concluded. They chose not to contribute.

4. Synopsis of relevant case history

4.1. Agency records highlight that the mother, and her siblings, had been known to services since 2003 due to concerns about them being neglected as very young children – following an initial assessment by Children's Services no further action was taken. Later concerns about physical abuse, domestic abuse and sexual assault within the family emerged. Information submitted about the father identified very limited involvement with child mental health services in 2012.

4.2. The mother's pregnancy with Miles was unplanned and there are differing accounts recorded in agency records about maternal ambivalence towards the pregnancy and becoming a parent. When Miles was born, Miles's mother was aged 16 years and his father 17 years. Miles was born with a cleft palate[5]. Shortly after Miles's birth, concerns were raised about his weight gain and the parent's commitment to caring for and feeding a young baby. These

[4] i) Soft Systems Methodology by Checkland, P., & Poulter, J., in Systems Approaches to Managing Change: A Practical Guide, Reynolds, M., & Holwell, S., Open University, 2010, and ii) Soft systems methodology in action, Checkland, P., & Scholes, J., 2003, Wiley.

[5] A cleft palate is an oral malformation that occurs during pregnancy.

concerns were referred to Walsall MASH[6]. This resulted in Miles becoming subject to a Child in Need[7] plan and a Child & Family Assessment being undertaken.

4.3. In January 2018, at four months old, Miles was taken to hospital due to continuing concerns about failure to gain, or maintain, weight. This resulted in a Strategy discussion[8] taking place alongside the mother stating that she was worried about her capacity to care for Miles. No specific medical cause could be identified about Miles's failure to gain weight however he was diagnosed with a genetic disorder that affects the immune system, but which can also include other health complications, and feeding problems.

4.4. During this time the mother and father, with Miles, had no settled accommodation. The quality of the relationship between the mother and father was erratic; fluctuating with them being together or separated.

4.5. In June 2018 Miles was admitted into hospital a second time due to pulling out a feeding tube but also being ill, unresponsive and a mirror reportedly being dropped on his head causing a bruise. This resulted in a Strategy discussion and a request for legal advice to consider what safeguards might be needed. At the end of June both parents agreed for Miles to be accommodated under section 20[9] as a Looked after Child (LAC)[10]. This was formalised in a legal planning meeting in early July following the earlier request for legal advice in June. Alongside this, given the consensual nature of the section 20 arrangements an Initial Child Protection Conference[11] was convened, at which point Miles became subject of a Child Protection Plan under the category of neglect for a short period of time, as well as being a Looked after Child (LAC). Miles was discharged from hospital into a foster care placement for both Miles and the mother. At this point, the appointed Independent Reviewing Officer (IRO) highlighted the mother's own vulnerability as a child herself and that she should have her own allocated Social Worker.

4.6. Over the following months Miles and the mother remained in the foster placement whilst assessments directed by the Court progressed. Concerns about Miles's weight and feeding regime fluctuated, with positive progress being noted alongside difficulties with the feeding tube being used and supplies for the equipment being problematic.

4.7. In August 2018, aged 11 months, bruises were noted on Miles's arm during a routine LAC medical; this prompted a Child Protection Medical which concluded that non-accidental injury could not be ruled out.

4.8. In September 2018 Miles was reported as having difficulty weight bearing on one foot; this resulted in a full medical examination at a Walk in Clinic however no concerns were raised. In October Miles had two separate bruises; a bruise below his eye, which was unexplained but was examined at an Emergency Department; and later, a bruise on his forehead, again unexplained but which was examined in the same Walk in Clinic as before. There was no further

[6] MASH – Multi-agency safeguarding hub, which provides a single point of contact for anyone to share concerns about the welfare of a child.

[7] Child in Need - Section 17 of the Children Act 1989 imposes a general duty on the Local Authority to safeguard and promote the welfare of children who are 'in need' and to promote the upbringing of children in need by their families by providing a range and level of services to meet those children's needs. A child in need is defined as a child: i) who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services; ii) or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services; iii) or a child who is disabled.

[8] A strategy discussion is held under Section 47 of the Children Act 1989 which provides the local authority with a duty to make enquiries as considered necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

[9] Section 20 - Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of (a) there being no person who has parental responsibility for him; (b) his being lost or having been abandoned; or (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

[10] A Looked after Child is cared for by a local authority.

[11] Child Protection Conferences - Regional Child Protection Procedures for West Midlands

action taken in respect of either of these bruises. The parenting assessments of both mother and father were completed in October but negative in terms of their ongoing capacity to care for Miles.

4.9. In January 2019 Miles had scheduled surgery and was discharged back to the foster carers. Shortly after the discharge Miles was taken to a Walk in Clinic with a fever. An infection was diagnosed and treated accordingly. In February the Mother approached her GP to discuss the need for counselling having been advised to do so by her Social Worker. In March a scratch on Miles's leg was noticed prompting a Child Protection Medical; no further action was taken and no concerns were raised about this scratch.

4.10. Towards the end of April Miles was taken to a Walk in Clinic by the Mother, reporting a two week history of a chesty cough; this was diagnosed as a chest infection. Two days later Miles died, aged 19 months old.

5. Findings & analysis

1. Having mapped the professional and agency contact with Miles over the timeframe under review there are a number of features that stand out that help us understand what happened, and why events might have occurred as they did. These features are relevant from a multi-agency safeguarding system and practice perspective and, as such, provide us with the greatest insight into the quality and effectiveness of the response to Miles at the time. Where possible, an explanation of why events occurred as they did, has been provided. Learning points for use by all professionals and trainers have been emphasised. The following areas are explored;

- Multi-agency practice that was timely & effective: what worked well?
- Quality of placement
- Medical examinations from a child protection perspective
- The effectiveness of joint working in regard to safety planning and risk management
- The quality & effectiveness of information sharing across the professional network and whether this impacted on assessment, decision making and safety planning

5.1. Multi-agency practice that was timely & effective: what worked well?

5.1.1. There are a number of features to this case where professional practice was timely and effective. It is important for this review to capture any aspects of good practice in order to assist professionals and agencies understand what worked well. The following aspects are noted;

- The triple track planning for Miles at an early stage in order to secure his future stability and care.
- The consistency provided for the mother and Miles by the Child Protection Chair becoming the Independent Reviewing Officer.
- Although it could have happened earlier the fact that the Independent Reviewing Officer and Team Manager identified and confirmed that the mother should have her own Social Worker due to her age, is a positive decision.
- The matching process between Walsall Children's Services and the Independent Fostering Agency for the suitability of the placement.
- The child focused and personalised way in which the record of LAC reviews are written is outstanding. Although Miles was a very young child and developmentally, unable to read or write, the way in which the actions and progress is expressed would have provided a plain, yet sensitive account for Miles to read when older.
- The effective communication of information by Walsall Healthcare NHS Trust to other relevant professionals.

5.2. Quality of placement

5.2.1. Given the fact that Miles died whilst in the care of the local authority and in an approved placement it is appropriate for this review to examine the quality of those arrangement, and whether there are any lessons to be learnt.

5.2.2. Statutory guidance[12] states that *' … when arrangements are made by the local authority for a parent and child to live together with foster carers, for example to enable a parenting assessment to be undertaken, the responsible authority must take particular care to clarify the nature of the arrangement. If both the parent (under the age of 18) and child are looked after children, both will be foster placements, but it is also possible that looked after status will only apply to either the child or the parent. In whichever circumstance, it will be necessary to clarify the respective roles of the foster care and the parent in relation to the child …'*.

5.2.3. Walsall Children's Services have reported that due process was followed in terms of matching Miles's needs with the skills, experience and competence of the foster carers he was placed with. Information submitted from the local authority indicates that all relevant background information about the mother and Miles was provided to the Independent Fostering Agency (IFA) that was responsible for the management of the placement, which included details about Miles's health needs, the young ages of both of the parents, missed appointments and concerns about the parents' ability to work with Children's Services.

5.2.4. The IFA have confirmed that the foster carers had considerable experience having managed over 50 placements in their fostering career, of which five were parent and child placements since 2015. The foster carers had maintained regular attendance and compliance with training requirements. Records indicate that the foster carers had monthly supervision visits from the IFA supervising Social Worker (plus telephone contact) during the time Miles and the mother were placed with them. The local authority also maintained an appropriate visiting and monitoring pattern to see Miles and the mother in the placement. The visiting pattern of both the local authority and IFA complies with expectations as set out in statutory guidance[13] and National Minimum Standards[14]. Assessment of other children in placement at the time was also weighed against the demands of having a mother and baby in placement, and were not judged as undermining the ability of the carers to care for the mother and Miles. It is however worth recognising and stating the obvious that having a full quota of placements (based on approval for the usual fostering limit[15]) will inevitably increase the time commitment of any foster carers. Nevertheless, based on the knowledge, skills and experience of the foster carers this appeared to be an ideal match and information examined across both the local authority and the IFA triangulates in terms of matching, decision making and practice being compliant.

5.2.5. From the point that Miles and the mother were placed with the foster carers in July 2018 statutory expectations in respect of formal review points, via Looked after Children Reviews[16] were complied with and reviews were held within appropriate time frames (August, October and November 2018 and April 2019) or when a change in circumstances warranted a review, for example the negative outcome of parenting assessments and change to the planning pathways. Of note, the third and fourth reviews were held sooner than required under statutory guidance. Due to Miles's young age and the parallel Court proceedings running alongside to determine his future, this is considered good practice. The first LAC Review identifies a need for triple track planning; i) a full return of Miles back

[12] The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services, p. 13, 2011, HM Government.

[13] The Children Act 1989 Guidance and Regulations Volume 2: Care planning, placement & case review, p.100, June 2015, HM Government.

[14] Fostering Services, National Minimum Standards, Standard 21, 2011, HM Government.

[15] The usual fostering limit is set at 3, The Children Act 1989: Guidance & Regulations Volume 4: Fostering Services, 2011, HM Government.

[16] The Children Act 1989 Guidance and Regulations Volume 2: Care planning, placement & case review, p.113, June 2015, HM Government, & IRO Handbook, Statutory guidance for Independent Reviewing Officers and local authorities on their functions in relation to case management and review for looked after children, 2010, HM Government.

into his parent's care, ii) a placement with a connected person, or iii) adoption. The consideration of these different pathways at an early stage is also good practice. Goals and objectives are clearly articulated. There is consistency with the same IRO chairing all reviews, and attendance by relevant professionals is good. The tone and focus on Miles, as the subject of the review in the review documents, is outstanding; the reports are written in a child centred way.

5.2.6. From a procedural point of view it is clear that practice was compliant however the review has captured information that does offer learning.

5.2.7. There is a potential mismatch in understanding about what was expected of the placement. Walsall Children's Services have noted that *'… the foster carer is not asked to undertake any assessment of [the mother's] ability to care for Miles; she is asked to ensure that Miles's care, as provided by the mother, is supervised and to support the contact arrangements by transporting the mother and Miles to contact …'*[17] where-as the IFA have noted that *' … this was a placement in which the carers were contributing to a parenting assessment being undertaken by the local authority and as such the carers needed to allow the mother to demonstrate her parenting abilities while ensuring Miles was safe and secure … monitoring and reporting on … mother/Miles's interactions … the overall health and well-being of Miles … to offer help and advice to the mother in her parenting … but being mindful of not undermining the parenting assessment that was being undertaken … concerns or positive factors … the mother's care of Miles overnight while he was in her room …'*[18]. The differences in the above accounts may be subtle however are worth noting.

5.2.8. Whilst the IFA have demonstrated that the foster carers were provided with regular contact and visits from a supervising Social Worker, they have reflected that that quality of this was not to the standard they expect. This was due to staffing issues which resulted in disruption, inconsistency and poor record keeping. The quality of management oversight was lacking and there was no challenge to some of the aspects of practice identified as a result of this review, but which could have been noticed at the time.

5.2.9. The lack of high-quality supervision and management oversight at around September and October 2018, and then again in January 2019 help us begin to understand why Walsall Children's Services began to lose confidence in the quality and effectiveness of the placement. During one incident the foster carers are reported as forgetting about a pre-arranged contact session, and during a second, the foster carers did not notify other professionals about the bruise to Miles's eye, and a third incident where the foster carers cancelled a scheduled contact session as they *'… had lost track of time …'*[19]. Other examples include the carer stating that the mother could *'… stay for as long as she likes …'* and the carers wishing to make representation at Court in support of the mother which would have resulted in them working against the Local Authority care plan. This reflects a level of optimism by the foster carers about the mother's parenting abilities. This is further confirmed in January 2019 when discussions are held between Miles's Social Worker, the IRO and the Court appointed Guardian, querying some aspects of the foster carers involvement and knowledge about the mother's activities.

5.2.10. The concerns which began to emerge centred on the quality and tone of the relationship between the mother and foster carers. This had led to suggestions that elements of a collusive relationship between the foster carers and the mother had formed and that this was undermining the quality and effectiveness of the placement.

5.2.11. It is important to explore this emergent relationship dynamic in context in order to better understand why, and how, such a relationship may have formed. The fostering task can be challenging and one of the key features which complicates any relationship dynamic is the need to define, create, and maintain, relational boundaries. In this

[17] Walsall Children's Services, submission to the review.

[18] Independent Fostering Agency, submission to the review.

[19] Walsall Children's Services, submission to the review.

case the foster carers were required to create, and maintain, boundaries around their relationship with the mother who was young and vulnerable in her own right, but also a young baby with multiple health needs. These boundaries needed to be managed within a warm, nurturing home and family environment – thereby adding a layer of complexity. Given the nature of the environment but also the type of relationship required the potential for boundaries to become blurred is all too apparent irrespective of the length of experience the foster carers may have had. The opposing environmental circumstances and relationship would likely be experienced as clinical, regimented and not conducive to assessing the true quality of a parent – child relationship.

5.2.12. The blurring of boundaries in such situations creates risk; risk that boundaries will become confused, shift or crossed and that biases will form. It is at these points that collusive practices might emerge from a healthy and professional relationship and unwittingly becoming dysfunctional. There are a number of factors which might contribute to such a dynamic emerging and include; identifying with the experiences or personality of the person requiring care, strength of feelings about a particular issue, tiredness or stress, personality traits in the person requiring care that lead us to like or dislike them or be attracted to them in some way, manipulation, and being in an environment that does not easily lead to boundaries being maintained i.e. a home environment and not an office or more clinical setting[20]. Factors that appear to have contributed to this happening in this case include the quality and consistency of supervision and support by the IFA and supervising Social Worker, a lack of clarity around role and task for the foster carers, but also the placement being extended from the original plan to 34 weeks to allow further assessment as part of the Court proceedings. This extension was supported by the Children's Guardian from Cafcass and the Court. This extension inevitably encouraged a greater attachment to form, and in the absence of high-quality reflective supervision, scrutiny and challenge by those professionals most closely involved it strengthened the alliance that had formed between the carers and the mother. Whilst this had no direct impact on Miles's safety it does highlight the inherent challenges for professionals when working with complex and intimate relational dynamics and being reliant on what is being reported.

5.2.13. From a system thinking perspective emergence[21] is a key property of complex systems – of which the relational dynamics within a foster caring situation and working with multiple professionals is one example. The strength of a complex placement dynamic can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted or easily managed. The need for foster carers to remain professional within their own home, whilst offering appropriate levels of support and guidance but not interfering would have been a core feature of this placement. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners or carers. By simply focusing on what may be perceived as the errors of individuals it distracts attention away from the more complicated story of what may have happened; as noted in research[22] *'… underneath every simple, obvious story about error, there is a deeper, more complex story …'*. Information gathered from all perspectives confirms that the emergent features of the mother-baby foster care placement contributed to quality and effectiveness of the placement being compromised as time passed.

Learning point: Regular high quality and reflective supervision for foster carers is critical to avoid bias forming.

Learning point: Bias can lead to collusion and optimism. Ensuring all professionals involved with a child remain alert to such biases being formed is important to remaining child focused.

[20] Cooper, F., Professional boundaries in social work and social care: A practical guide to understanding, maintaining and managing your professional boundaries, 2012, Jessica Kingsley.

[21] Seel, R., Emergence in organisations, 2006.

[22] Dekker, S., The field guide to understanding human error, p. 3, 2006, Ashgate.

5.3. Medical examinations from a child protection perspective

5.3.1. Miles was seen on five separate occasions between August 2018 and March 2019 due to minor injuries, each time prompting an examination. Records indicate that two of these were completed on the basis of a formal Child Protection Medical, and the other three were as medical examinations. On two occasions (August 2018 and March 2019) a formal Strategy discussion was convened. In amongst these examinations' other practitioners, such as the Health Visiting Service, Community Paediatric Service following check-ups but also LAC health assessments, GP, Dietician, and Community Children's Nurse, had regular and frequent interaction with Miles as part of his routine health care. Unpicking these episodes provides learning;

5.3.2. In August 2018 Miles had a Child Protection Medical following soft tissue damage to the forearm being noted during a routine LAC medical. The report from the examination did not provide a clear steer about whether Miles was non-mobile or able to roll from side-to-side. It was also noted that Miles needed to have a feeding tube inserted into his nose which required his arm to be held to facilitate this. The Paediatrician concluded that non-accidental injury could not be ruled out but accidental injury may have also been a possibility. A concern raised only by the mother was that the bruises could be bite marks. One hypothesis being put forward by the mother was that these had occurred following Miles having contact with his father and paternal grandparents however the reality was that there could be numerous other potential perpetrators given the age of the bruising. The concerns did prompt a Strategy discussion but not until after the Child Protection Medical. Based on the inconclusive and conflicting findings of the medical examination it was not deemed proportionate to interview all the people potentially involved in the family gathering. The outcome of the Strategy discussion was that the Police recommended a single agency investigation by Walsall Children's Services. Miles returned to the foster carers and no further action was taken in respect of the bruising other than the foster carers should increase their vigilance and that Miles could resume sleeping in the mother's bedroom rather than being in the foster carers bedroom.

5.3.3. Closer review of this episode has highlighted that there were discrepancies in the language used by Children's Services when discussing the episode with the Police i.e. non-accidental versus unexplained, but also that some elements of information from the Paediatrician, via the Strategy discussion, were not fully conveyed to the Police. Although unlikely to have altered their decision making, especially given the need for strong and decisive medical evidence, the need for Strategy discussions to be conducted effectively is highlighted further below as a learning point. Whilst the evidential threshold for a criminal investigation may not have been reached and the likelihood of gaining certainty about the origins of the bruising were very limited, there remained unanswered questions about the cause of the bruising. The decision to conduct a single agency investigation could have been challenged by Children's Services but was not.

5.3.4. In September 2018 Miles had a medical examination at a Walk in Clinic due to having difficulty weight bearing on one foot; the explanation given by the mother for this was that Miles had slept awkwardly and that he had caught his foot in the cot rails. Examination showed nothing abnormal and his foot appeared normal. The examining Nurse sought advice from the Hospital and an x-ray was recommended, however the mother did not follow this through. She did see a GP the following day with Miles and nothing abnormal was noted by the GP. As no concerns were noted by the GP, Children's Services were not informed of the attendance. The flagging system on the GP Practice database did alert the GP to the fact that Miles was a Looked after Child.

5.3.5. In October 2018 Miles had two separate examinations by health practitioners following two separate bruises being noticed. On this first occasion, a member of Miles's extended family had noticed a bruise below one of his eye's which had been treated by the foster carer. The family member contacted Children's Services who advised that medical advice should be sought. The injury was examined at an Emergency Department and the cause of the bruise was unexplained but judged not significant. Requesting a thorough medical examination would have been a better pathway to follow. The A&E department informed the Social Care Emergency Duty Team (EDT) yet there was no

consideration about holding a Strategy discussion. The foster carer had not been worried by the bruise because of its small size but did follow the advice given. Miles was also identified as a LAC during this attendance. No further action was judged as necessary as Miles was fit and well and it was followed up by an attendance at the GP two days after presenting to the A&E department. Records indicate that information about this bruise was not shared directly with Miles's Social Worker because the electronic recording system was not working, but was shared with the EDT. On the second occasion, two days after attending the GP for a follow-up appointment for the first bruise, a bruise on Miles's forehead was examined at a Walk in Clinic. The explanation for this was that he had hit his head on the tray whilst sitting in the highchair. No treatment was needed and, on this occasion, information was shared with the Social Worker. These two incidents were not linked and as such, no Strategy discussion was considered. The lack of Strategy discussions around this time was not challenged by the Children's Guardian.

Learning point: When information about a child's safety or welfare comes from an unexpected source, in this case the child's extended family member, it is important that the lead professional i.e. in this case the child's Social Worker, has access to all relevant information and is able to maintain a chronological overview of what has happened, who has been involved, and what the implications might be for the child.

Learning point: Expectations between professionals needs to be clearly articulated; if not, it potentially leads to frustrations, delays and misunderstandings. In this case, information from the A&E attendance was not shared resulting in the Social Worker only knowing about the second bruise.

5.3.6. In March 2019 Miles had a Child Protection Medical following a scratch on his leg being noticed. The explanation given was that this happened whilst changing a nappy and the scratch was caused by finger nails. Records indicate a series of exchanges between the mother, foster carer, Social Worker and Team Manager, paternal grandparent and the Police during the course of one single day, which conclude with a telephone Strategy discussion between Children's Services and the Police resulting in no further action. Again, the Child Protection Medical took place before the Strategy discussion.

5.3.7. Review of the Walsall on-line safeguarding procedures has highlighted that there is clear guidance about when a medical assessment might be required, and that this should be considered following a Strategy discussion and form part of any ongoing section 47 enquiries. On two other occasions, no health professional was invited to contribute, which not only fails to comply with procedural guidance but is surprising given the number of health professionals that could have been contacted to contribute who knew of Miles. No explanation can be given for this oversight. The Children's Guardian was also not invited. The on-line procedures do not however have any information or reference to children who are not mobile and who might have sustained injuries. Another recent case review conducted by Sandwell LSCB highlighted the absence of such guidance. Regional guidance on children that are non-mobile and who might have sustained injuries is currently being developed and it is anticipated that this will be published soon.

Learning point: Strategy discussions are multi-agency meetings to discuss the safety of children. Conducting them as a single agency, or in the absence of information from other sources defeats the objective and undermines the collective effort to safeguard children. The process for conducting them on open cases, already known to Children's Services, as well as new cases which are referred via the MASH, should be no different.

5.3.8. Importantly, Miles was subject to an Interim Care Order during this period, in foster care and therefore his care arrangements would have been subject to much scrutiny. Taken in isolation, each incident may not have heightened concern. The final incident occurred four weeks before Miles's death. When all of the incidents are viewed from a chronological perspective there is no obvious emergence of any concerning pattern, given the variations and explanations provided – however, with the benefit of hindsight there is, nonetheless, a pattern that does emerge regarding bruising of a non-mobile child. The professional response, from a health, social care and medical perspective at the time, might therefore be judged as proportionate and timely but does reflect the importance of all agencies and professionals exercising healthy scepticism and referring information about such incidents to allocated Social Workers,

who act as the lead professional for such cases. As well as being curious, it does also highlight the importance of professionals challenging decision making – in this case around the use Strategy discussions. Questions have been raised about whether the response to each, or all, of these incidents would have been different had Miles not been in foster care i.e. were false assurances and bias applied because of a perceived level of safety around Miles given his status? Information submitted and discussions with practitioners suggest not, with no obvious bias being applied due to Miles's status or care arrangements.

Learning point: Local procedures[23] state; *'Strategy meetings should be multi-agency as far as possible and should involve all key professionals known to, or involved with, the child and family. Local authority children's social care, health and the police should always attend. Where the child is in hospital, the appropriate clinician should also be included … A strategy meeting/discussion is an opportunity to share as much of the available information as possible between participants to inform the next steps. In addition to sharing information, the meeting/discussion should be used to … plan how the section 47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose, agree what action is required immediately to safeguard and promote the welfare of the child …'.*

5.3.9. The above accounts have highlighted that the contributions to, and timing of, Strategy discussions is crucial for a strong and effective multi-agency response; this is especially do when it concerns very young children who are additionally vulnerable. Alongside this, where injuries may not appear to reach a threshold for more robust intervention it remains important to share all information in a timely manner allowing a chronological narrative to be formed, which may identify patterns or repeated (but lower level) concerns.

5.4. The quality & effectiveness of information sharing across the professional network & whether this impacted on assessment, decision making & safety planning

5.4.1. Statutory guidance[24] states *' … practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care …*'. During the timeframe under review the following professionals were regularly and actively involved, or had contact with, Miles and his mother; Walsall Children's Social Care Social Workers, the IRO, GP, the IFA Social Workers, Community Nursery Nurses and Health Visitors, Paediatrics (acute & community), specialist nurses, dieticians, A&E services, and Walk in Clinic staff.

5.4.2. Records and discussions confirm that there was good information sharing between Walsall Children's Services and the IFA to help make decisions about placement matching. The IFA and foster carers were provided with the placement Plan, Care Plan, ICPC record, Child & Family Assessment, social worker report to the LAC review, CYP LAC review record of meeting – which is very positive.

5.4.3. Walsall HealthCare NHS Trust were involved in Miles's life a number of times prior to the timeframe under review. Information submitted and triangulated demonstrates that information sharing by the Trust was timely and effective.

5.4.4. The above episodes demonstrate effective information sharing practice across health professionals and agencies involved with Miles. Given the range of professionals involved this is a positive finding.

5.4.5. Walsall HealthCare NHS Trust's more recent contact was through the LAC process by providing a LAC health assessment in July 2018 (at the point Miles became a LAC). Paediatric reviews by the Trust took place in October and

[23] Regional child protection procedures for West Midlands, Strategy meetings/discussion.

[24] Working together to safeguard children, 2018, p. 18, HM Government.

November 2018 with a further appointment scheduled for May 2019. These were scheduled around the time of the LAC reviews and documentation confirms that health related information was appropriately fed into the reviews. There is one exception to this; that being a LAC health assessment scheduled for February 2019 which did not happen due to it being cancelled three times by the foster carer because Miles either needed surgery or was reported as unwell. These accounts correlate with other information provided to the review. The current Walsall HealthCare NHS Trust policy[25] for children that miss appointments has been examined for this review and is due for revision; this will provide an opportunity to strengthen it where-upon it will become a 'was not brought' policy. Attempts were made to reschedule this assessment between January and March 2019 however these were not successful and as such, Miles's LAC health assessment was not completed prior to his death. It is impossible to comment on whether this health assessment would have revealed any underlying health issues which might have needed further investigations or treatment. Notwithstanding this, Miles was seen by other health professionals before his death including the Health Visitor, a Consultant at Birmingham Children's Hospital plus the Specialist Nursing Service (cleft palate). No information has come to light to indicate anything untoward.

5.4.6. The Dietician last met with Miles in January 2019. Whilst the Dietician maintained regular contact with professionals up until this point the next scheduled follow up appointment was not until after Miles died.

Learning point: When children have complex health needs that require the involvement of multiple professionals it is important for the named lead professional (in this case, the Social Worker but also the Named LAC Nurse) to maintain some oversight of missed appointments. A chronological record of missed appointments should be kept and viewed from a safeguarding lens. This is especially important when children access services that cross geographical boundaries and serve a region rather than just one local authority area.

5.4.7. From the perspective of the GP that Miles was registered with whilst in foster care, records indicate that they were not notified about Miles becoming a LAC or notes from the Child Protection Conference process. Whilst information exists on the GP record from other health professionals involved with Miles, there is an absence of formal information from Walsall Children's Services, which should be routinely shared with a GP. This indicates a potential need to review notification systems and processes by Walsall Children's Services. Further to this, the GP Practice has highlighted that it would have been useful to have had contact from the mother's own Social Worker in November 2018 to discuss the mother's circumstances given that the mother was advised to see the GP for advice. The mother duly met the GP however the GP was operating in an information vacuum given the lack of formal notification about Miles's status but also the reasons why the Social Worker might have thought it sensible for the mother to consult with a GP. This would have provided an opportunity to remind the GP of the mother still being a child herself.

Learning point: Notification systems and processes are an important and necessary feature for busy professionals working with large numbers of people, across complex organisational and service boundaries; they provide a quick way of ensuring systems and professionals are informed about information. Ensuring they are effective and reach the right people at the right time is an important factor to remain alert to. Regular reviews of such processes are necessary.

Learning point: When one professional recommends the involvement of another professional to a parent, it may be helpful to gain consent from the parent to discuss the reasons why additional professional input might be needed.

5.4.8. Some professionals involved with Miles, the foster carers and the mother have reflected on the complexity of the local health architecture and that, in wanting to ensure all professionals remained up to date with case tracking and monitoring, it created information sharing hurdles. One example being that the Sandwell & West Birmingham Community Children's Nursing Service contacted the Walsall Hospital to inform them that they were aware of Miles being an in-patient in August 2018, but then not receiving any records relating to his discharge plan as requested.

[25] Did not attend, No Access and Multiple Cancellations' guidance issued by Walsall Healthcare Trust.

5.4.9. Further examples include as a LAC, Miles was placed in foster care in a neighbouring local authority area. Miles was under the care of a Hospital Paediatric Service and Dietician Service in Walsall. He was under the care of a Specialist Nursing Service (cleft palate) in Birmingham Children's Hospital. Sandwell & West Birmingham NHS Trust were responsible for the Health Visiting Service and Community Children's Nursing Service and they were notified about Miles becoming a LAC in July 2018. The Sandwell & West Birmingham Health Visiting Service made contact with the Walsall Health Visiting Service and the foster carers, and in turn, contact with Miles's Social Worker; information was shared about the case throughout between those professionals. The Sandwell & West Birmingham NHS Trust Health Visitor attended the first LAC Review but also completed a 'new to the area' home visit, as per expected standards. The service offer was at Universal Plus given his LAC status. Further visits were achieved later in August 2018 but also in September, October and December 2018 plus January, February, March and April 2019. The April visit included contributing to the fourth LAC Review. The Health Visiting Service raised no concerns about the quality of the foster placement with the mother and foster carers being receptive to all advice given.

5.4.10. The reflections from practitioners about navigating the complexity of local health services and structures may be justified however the information submitted to the review, on the whole, fails to support a view that it hampered effective information sharing. Records demonstrate good and relatively tight information sharing practice in respect of communicating concerns, updates and activities. There is no evidence which indicates significant failure to share information which had an impact on assessment, decision making and safety planning. Nevertheless, it is worth reminding all leaders and commissioners that when practitioners work across geographical and organisational boundaries and where there is a need to transfer information it can create risk; especially so when families transition across those boundaries.

Learning point: Case transfers, handovers and organisational boundaries can generate vulnerability in system processes - introducing new workers, differences in thresholds and procedures, have resourcing implications, and differing safety net mechanisms. When coupled with situations in which children might be at risk of harm these transfer points can create fertile ground for miscommunication and failures to occur. These are unintentional but are a key feature for professionals to be alert to when working across multi-agency partnership arrangements and for those responsible for commissioning services across geographical boundaries.

5.5. The effectiveness of joint working in regard to safety planning & risk management

5.5.1. Statutory guidance[26] refers to the need for professionals to identify, assess and intervene in children's lives in a timely and child focused way in order to be effective in safeguarding a child's welfare. It is evident that these stages were successfully achieved by statutory agencies in this case given the incremental step-up of involvement from Miles's birth through to becoming subject to Court protection in June 2018. It is also clear that the pathway taken by Walsall Children's Services from June 2018 onwards, overall was a pathway that was affording Miles greater safeguards and with an eventual plan which may have led to adoption. In this respect the management of risk and safety planning was effective and being reviewed on a regular basis within a formal and appropriate framework.

5.5.2. There is an argument that more focused and robust assessments could have been actively undertaken during the mother's pregnancy with Miles, in the shape of a formal pre-birth assessment with a potential view to being subject to a Child Protection Plan at birth – especially given the mother's known history and vulnerabilities; these included the mother and father's young age and inexperience at parenting, a history of witnessing domestic abuse, maternal mental health and stated ambivalence about the pregnancy, paternal mental health, and limited support networks. The view that earlier and more robust intervention was warranted has to be balanced with information that appeared to demonstrate the mother managing Miles as a new born, the mother feeling like she had sufficient support around her and concerns about weight gain not emerging until some weeks after the birth. For example, the mother and father

[26] Working together to safeguard children, 2015 & 2018, HM Government.

were both offered support through parenting programmes. The father did not attend any sessions and the mother completed one programme aimed at 0 – 5 years instead of the Mellow Parenting programme[27] which she had been offered but not attended. On balance, the review finds the response of professionals and agencies effective and proportionate to the circumstances and information available at the time.

5.5.3. Once Miles became a LAC and was accommodated with his mother in foster care it is possible to see examples of effective multi-agency working. These include;

- Multi-professional contributions to the regular LAC Reviews.
- Information sharing between Walsall HealthCare NHS Trust and other professionals.
- Information sharing between Sandwell & West Birmingham Health Visiting Service and Walsall Health Visiting Service but also the foster carers and Miles's Social Worker.
- Information sharing and matching process by Walsall Children's Services and the Independent Fostering Agency.

5.5.4. As noted above, there are examples where multi-agency working could have been more effective. These include;

- The failure to include a health representative in two Strategy discussions (August 2018 & March 2019); seeking the input from health professionals was simply not considered by those responsible for convening the discussions. The Police did not challenge this practice failure either.
- The decision by the Police not to undertaken further enquiries about potential perpetrators of the bruising on Miles in August 2018, resulting in Children's Services and the foster carers being left with having to manage any future contact with family members and a degree of uncertainty and concern about potential future harm.
- Although the Birmingham Women's & Children's Hospital NHS Foundation Trust's Specialist Nursing Service (cleft palate) provided continuity of care for Miles there was no recognition of issues which might impact on his care and safety from a safeguarding perspective; this is despite knowledge about some of the parent's difficulties and other risk factors. As these factors were not viewed as risks, practitioners did not see the need to seek any advice or support via, for example the Safeguarding Team. Instead, practitioners based their assessments and judgements on the reports from other professionals involved with Miles. This issue has prompted the Trust to develop a plan of action to reduce the likelihood of this happening again.
- The electronic record keeping system used by the GP Practice highlights information shared by allied health professionals yet there is no evidence of any scanned documentations on Miles's notes from Walsall Children's Services. This further highlights a potential gap in the notification systems or day to day practice from Walsall Children's Services in sharing information with GPs

5.5.5. Notwithstanding the omissions highlighted above, it seems unlikely and improbable that these would have altered the outcome for Miles, given the unascertained results of the post mortem and the outcome of the Police investigation.

6. Conclusion

6.1. This Serious Case Review has examined agency and professional contact with a 19 month old child that died whilst in foster care with his mother. The review has benefitted from documentary information submitted by all the agencies involved and also the contributions of professionals working with the child and his parents. Miles's mother contributed to the review at the end of the process, his father and the foster carers did not contribute.

6.2. Whilst the child had increased needs, these were not life limiting. The outcome of the post mortem is an unascertained cause of death, resulting in the Police taking no further action.

[27] Mellow Parenting Programme

6.3. The review has captured learning points for use by practitioners, managers and trainers. As a result of this review agencies that have contributed have been able to identify learning that can be taken forward internally. Action plans have been provided by each agency involved, and where relevant and appropriate to do so, improvements have been initiated. It is the role and responsibility of the Safeguarding Partnership to monitor, scrutinise and challenge progress against single agency action plans. The report concludes with a number of recommendations for Walsall Safeguarding Partnership which may strengthen practice.

7. Recommendations

7.1. In addition to the single agency actions plans that have been submitted, the following recommendations are for Walsall Safeguarding Partnership;

1. To ensure the learning from this review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek assurance that the actions identified by each partner agency, as a result of this review, have been managed, implemented and embedded in a timely manner.

3. Walsall Children's Social Care to review their notification systems to health partners, particularly GP, when children become subject to Child Protection Plan and/or Looked after Children, ensuring they are effective and robust.

4. Seek assurance, through a focused audit exercise, about the process for ensuring all relevant professionals, especially health practitioners, are invited to Strategy discussions on cases that are already open and have a lead Social Worker. Where deficits are identified, action should be taken to rectify issues.

5. Ensure the revised regional guidance available through the on-line Safeguarding Procedures about the recognition, response and management of bruising and injuries to non-mobile infants is disseminated to all relevant professionals.

6. Consideration should be given to providing training about bruising and injuries to non-mobile infants and issuing a reminder to all relevant practitioners about the importance of completing chronologies to track and monitor patterns.

7. When the current Walsall Healthcare NHS Trust policy/guidance 'Did not attend, No Access and Multiple Cancellations' is revised to a 'Was not brought' version it should include children that are looked after, as well as those that are subject to a Child in Need Plan or children subject to a Child Protection. The new guidance should be disseminated to all relevant practitioners in the Trust and also Walsall Children's Services, given their role and responsibilities as the lead professional for such cases.