THEMATIC REVIEW

BABIES WHO SUSTAINED INJURIES

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Thematic Child Safeguarding Practice Review on behalf of Bradford District Child Safeguarding Partnership.
Babies who sustained injuries
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Introduction

1. The Bradford District Safeguarding Children Partnership agreed to undertake a Child Safeguarding Practice Review (CSPR) to consider the local systems and practice when a new baby is expected or born to a family where there are predisposing risks and vulnerabilities. Three different cases where babies sustained injuries that are believed to be non-accidental were looked at in detail, and then considered alongside learning identified locally in previous reviews. The aim of the review was to consider how the safeguarding partnership can ensure and embed the changes in practice and systems that are required.
2. While there are findings from the three 2022 cases, the main aim of the review was to consider and compare the learning from previous reviews and enable reflection on the impact they have had on practice and safeguarding systems in Bradford, and where progress is still required. A Serious Case Review was undertaken in 2017 (Alice) and a learning review which considered four babies with injuries was undertaken in 2019. The new cases considered in 2022 found similar themes and learning.
3. There have been a significant number of babies with serious injuries since the 2019 review that have not been the subject of a CSPR. The Partnership agreed to consider these three children in detail however, as there were known or knowable vulnerabilities in the cases which resonated due to the similarities with the previous reviews. It was thought that a thematic review of this type would identify what the continuing issues with practice and systems are in Bradford.

The previous reviews

4. The headline issues for the families considered in the previous reviews in Bradford were in the following areas:
    - Parents own vulnerabilities, including their own poor childhood experience of being parented, including abuse and neglect, victims of abuse through exploitation, mental health issues and substance abuse
    - Domestic abuse and violent behaviour

- Thresholds for neglect, including consideration of accidental injuries as a sign of neglect and understanding of cumulative harm
- The existence of previous concerns about the children and their siblings, including injuries/bruising

5. Additional specific learning for systems and practice related to:
    - Limited seeking of or consideration of the child's voice or lived experience from professionals involved in the cases
    - Underestimation of the impact of the mother's vulnerabilities on the child/ren, and overoptimism about their ability to parent and protect their child/ren
    - Little evidence of the father or non-birthing partner being considered, despite a number having significant vulnerabilities that could be a risk
    - Timing and quality of pre-birth assessment
    - Limited involvement of adult services in children's assessments and planning particularly regarding adult mental health
    - Procedures not being followed, including for the assessment of non-mobile babies with injuries, including bruises, burns and scalds
    - Gaps in required information sharing
    - Meetings being held when required, including strategy meetings
    - Drift and delay in assessments and plans
    - Lack of quality supervision that encourages professional curiosity and robust analysis
    - Gaps in key record keeping
    - Professional inconsistency due to staff turnover in key agencies and inexperience
6. The consideration of the 2022 babies shows that many of the issues continue to be a challenge in Bradford, as will be shown below. There is also evidence that, while subsequent babies have been injured, there has been some progress since Alice was injured in 2017. This review has also provided an opportunity to consider the impact of COVID-19, as the three babies were receiving services during the pandemic.

The 2022 families considered[1]

Child 1
Considered at a Rapid Review meeting in March 2022, following the identification of severe injuries on the seven-week-old baby which were reported to be 'overwhelmingly suggestive of physical abuse'. (Facial and mouth injuries, bruises, multiple rib fractures of different ages and a fractured clavicle.) Child 1's mother has older children who were not in her care at the time of the pregnancy with Child 1. Both parents have a history of domestic abuse in previous relationships and mental health issues. Child 1 is mixed parentage, white and Asian British and was receiving 'universal services' at the time of the injuries.
Child 2

[1] All of the families considered were English speaking and there was no requirement for an interpreter.

Considered at a rapid review meeting in March 2022, following the identification of injuries to the four-month-old child. (Fractured femur and torn frenulum.) Following a pre-birth assessment, Child 2 had been made subject of a child in need plan. The mother had much older children who were not in her care at the time of Child 2's birth, due to previous safeguarding concerns. Domestic abuse featured in the parents' relationship and in the past relationships of both parents, including reported incidents of violence where the mother was the alleged perpetrator. Substance misuse was a concern for both parents and alcohol abuse a concern for the mother, along with long term mental health issues. Child 2 is of mixed parentage, white and Asian British.
Child 3
Considered at a rapid review meeting in February 2022, when the 11-month-old had injuries that were thought to be non-accidental. (Bruising and healing rib fractures.) Child 3 lived with their mother and older school age sibling who had health needs. Both children were the subject of child protection plans due to emotional abuse with the risk of physical abuse highlighted. There had been an agreement that pre-proceedings work should be started under the Public Law Outline due to the extent of the concerns, which included domestic abuse from a new partner, mother's reported aggression, alcohol and cannabis use, and poor mental health. The mother also had an older child who has not been her care since birth. Child 3's father was not identified but is known to be Asian. Child 3 is of mixed parentage, white and Asian British.

The Process

7. An independent chair[2] and an independent lead reviewer were commissioned[3] to work alongside local professionals to undertake the review of the three 2022 babies and to consider what they tell us about the current state of practice and systems in Bradford, bearing in mind the learning from previous reviews. The information provided to the three Rapid Review meetings was considered and additional information was requested from individual agencies as required. The reports and plans from the historic reviews were also considered.
8. Professionals involved at the time were involved in three case specific face to face group discussions with the lead reviewer that focused on practice in the cases and the wider system. A panel of managers and safeguarding leads from partner agencies worked with the chair and lead reviewer to consider the identified learning from the 2022 cases, to reflect on the known historic concerns identified in the Alice and four baby reviews, to consider evidence of progress, and to identify where continued improvement actions are required.
9. The lead reviewer had hoped to meet with the three 2022 families, to consider whether there is any additional learning from their perspective. A meeting was held with the mother of Child 3, and her views are included in the report as relevant. The parents of Child 1 and Child 2 did not respond to attempts to meet with them.

[2] Nicki Walker-Hall is a previous Designated Nurse for Child Protection. She is an experienced safeguarding consultant who undertakes both children and adult safeguarding reviews. Nicki is entirely independent of the BSCP.
[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and is also entirely independent of the BSCP.

Consideration of the learning

10. By considering each of the three 2022 baby's, there was detailed and case specific analysis and the identification of learning. This was then considered alongside the reports produced from the Alice SCR and four babies learning review, with the aim of considering where there are continuing areas of practice or systemic concerns and whether further improvement actions are required.
11. The learning from the Alice SCR and four babies review was compared with the learning in respect of the 2022 babies, in the following areas:

    Impact of a parent's own vulnerabilities, including their poor childhood experience of being parented[4] and on-going mental health issues
12. While the three 2022 babies received significant injuries, the learning is largely in respect of practice with families with young babies where there is domestic abuse along with parental mental health concerns, and in two of the cases alcohol or substance misuse. When there are these predisposing issues in their family, these babies are more likely to be injured, which need to be considered alongside other issues such as poverty, poor housing, and the absence of support from friends and family.[5]
13. Although the 2022 children and their families were receiving services at different levels in the system, there were several similarities regarding the existence of predisposing risks; this reflected the learning from Alice and the four 2019 babies. All three 2022 cases show the need for professionals to know, consider and share historic and current issues that may have an impact on the parenting of a baby, both pre and post birth. While there were examples of information being sought and shared, there were also gaps in professional understanding of the case history both in respect of the parent's vulnerabilities and the care of the older children in the families.
14. All the mothers in the 2022 cases had older children who did not live with them. When this is the case, it is important to check agency records and ask for information across agencies, to understand the circumstances of this, and for details of the mother's care of their older children. It was only in the family of Child 3 that the mother was caring for an older child at the time of the birth of the baby and when the injuries were sustained. There were serious concerns about the neglect of that child, and he was the focus of much of the professional interventions, even after the birth of the baby.
15. Mental health problems were an issue for all the 2022 mothers. All had medications provided by their GP, but secondary mental health services were not involved at the time of the injuries to the children. Mental health concerns also featured in the histories of the men in two of the cases considered, according to the GPs of the father of Child 1, Mother 3's new partner and the father of Child 3's sibling.
16. Parental alcohol and /or substance misuse featured in the cases of both Child 2 and Child 3. There is evidence of 'historic' crack cocaine use by Child 2's mother, which was not known by those involved pre-birth with Child 2, despite her telling the nurse at her GP surgery in October 2019 that she had been using the drug recently. There was also evidence that alcohol was an issue. Again, this was not particularly known or considered by those involved at the time, and the impact of drinking on her parenting was not prioritised when Child 2 was the subject of assessments or when on a CiN plan. Child 2's father was known

[4] including abuse, neglect, and exploitation
[5] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/physical-abuse/#risk

to the police for suspected cannabis cultivation and supply. There were no other indicators that he was misusing substances, but this required consideration in an assessment.

17. There had been long term concerns about Child 3's mother's alcohol and cannabis use. In 2019 there was a report from her second child's junior school that he was bringing cannabis into school. Her new partner had a similar history and had been referred to services in respect of this on several occasions.
18. Professionals need to be trauma aware in respect of the children they are working with, but also when considering the parent's early experiences. Professionals must ask about a parent's own experience of being parented and other childhood difficulties and agency records need to be checked. This information then needs to be considered when undertaking an assessment of a child where potential parenting concerns have been identified and shared with other the professionals involved. The mother of Child 3 told the review that no professional acknowledged the experience she had in her teens of having a child with severe disabilities that she was unable to care for.
19. Little was known about the childhoods of the adults living with Child 1, 2 and 3. There was no significant children's social care involvement in their early years, but there were indicators that some of them had experiences that were potentially damaging and traumatic. Mother 1's own mother had serious mental health issues and she had become pregnant with her first child when she was 16 years old. The police shared information with the review about persistent domestic abuse in the home where Mother 2 grew up, and she had also first become a parent when still a child herself. Mother 3 was known to services as an older child due to concerns about her mental health, missing episodes, and alcohol use. It can know be seen that she was likely to have been a victim of abuse through exploitation and was first pregnant at age 15. She told the review that she was physically and emotionally abused throughout her childhood. All the mothers were victims of domestic abuse in previous intimate relationships. (Domestic abuse will be considered further below.)

Comparison with previous reviews
The impact of childhood trauma and adversity when adults enter a relationship and have children of their own is relevant and significant when working with a family in respect of their children, as are the ongoing mental health and substance misuse issues that challenge the parent's. This was also the case with Alice's mother in 2017, where were significant predisposing vulnerabilities that could be a risk to a baby, which were known to professionals but did not have an impact on their plans for Alice. Despite Alice being the subject of a child protection plan at birth, the review found that the parent's vulnerabilities and the impact on a care of a new baby were not robustly considered and that earlier opportunities to take action, prior to her injuries, were not taken.
What needs further consideration?*
The three 2022 cases show that there continues to be a need for professionals across Bradford to consistently consider and understand how a parent's vulnerabilities and experiences of trauma as a child and an adult pose a potential risk to their child/ren. Staff turnover, high workloads, and the impact of COVID-19 on ways of working, and limited access to training are likely to have had an impact. To improve practice in this area, this review suggests consideration of the following:

- Sharing the learning from these reviews as case examples during training and other development opportunities
- Professionals need to be curious about the parent's history in all cases where there are potential safeguarding concerns. This includes rigorously checking agencies records wherever possible
- Professionals to be aware of the impact of childhood experiences and trauma, and of their responsibility to seek and share information from agency records and any new assessments, while being aware of the need to avoid stigmatising parents such as those who are care experienced
- Professionals need confidence and skills and must be supported to have open and difficult conversations with families, including about the need to explore their own history of childhood trauma. This will improve their understanding of the impact of their difficult experiences on their parenting, show the need to seek and gain support to mitigate the impact, and to highlight on-going vulnerabilities such as their mental health or alcohol/substance use
- Relationship-based practice should be promoted across all relevant agencies. Relationship-based practice is founded on the notion that a practitioner's relationship with the family is the most powerful tool to facilitate change. A balance of trust, empathy, partnership, and appropriate authority can be reparative and effect timely change for children. It includes being clear about the consequences if change cannot be achieved. Child 3's mother told the review that she was unable to trust any of the professionals involved, partly due to her own childhood experiences, but also due to the high turnover of staff and her view that professionals were untrustworthy and disingenuous about their plans to remove her children. She said that she would have been more receptive to an experienced worker who spent time getting to know her.
- A partnership-wide commitment to provide targeted early help support to vulnerable families, including trauma informed parenting support
- There is a need for agencies to consider how to rectify the impact of staff turnover and the loss of experienced professionals due to retention issues
- Provision of challenging supervision of safeguarding cases when a professional is considering the impact of a parent's vulnerabilities on their child/ren to avoid over optimism, underestimation of the impact, parental avoidance and the need for effective challenge when there are concerns about the actions of other agencies and the effectiveness of a plan for a child
- Professional challenge must be seen as an essential part of an effective safeguarding system. While there is evidence of challenge and escalation at all levels across agencies, there is no one system that records when it is used, and some of the professionals involved in the cases being considered shared that they did not always escalate concerns either informally or formally when they disagreed with another professionals. Why this is the case should be explored further and other models of professional challenge should be considered, for example the Portsmouth Safeguarding Children Partnership's model 'Re-think'[6] which encourages and promotes challenge and reflection between professionals

[6] https://www.portsmouthscp.org.uk/wp-content/uploads/2021/09/7.21-Resolution-of-concerns-1.pdf

- There is a need to consider the human impact of working in safeguarding work in Bradford, including fatigue and emotional self-protection which can lead to a degree of acceptance of safeguarding issues such as neglect and domestic abuse – this needs to be acknowledged and professionals supported to reflect on this and understand the risks through reflective supervision and meetings with managers which includes tracking performance and transparent discussions about a practitioners need for support, learning and development, which may involve observations of practice in some agencies
- Improved professional awareness of the need to consider available information on fathers/partners at all stages of intervention with families and meaningfully include fathers/partners in work with families. (Also see below section)
- Consideration of children and family cases with good outcomes and where there has been positive multiagency practice in order to learn from what works well
- The need for a review of the effectiveness of the district wide ACES Trauma & Resilience Strategy, which was agreed in 2021, but has not yet been embedded. It was written as it was recognised that with a comparatively young population and high levels of deprivation, the number of young adults (and therefore parents) with ACEs was likely to be high and would have a big impact on health in the city. The strategy includes a policy and procedure for implementation and aims to have a workforce that recognises the need to be ACE and trauma aware, but is currently impacted by on-going concerns about recruitment and retention however

Domestic abuse and violent behaviour

20. One of the major issues that all three 2022 cases had in common was domestic abuse, both historic and on-going. The same was the case for Alice and the four babies in the previous review. The significance of domestic abuse in a family as a possible indicator of risk to young children, certainly of emotional harm but also potentially of a physical injury, is evident. The latter is not entirely based on evidence but the 2021 national CSPR The Myth of Invisible Men[7] states that while evidence of a link between domestic abuse and physical abuse of children is 'weaker than might be expected' this may be due to a lack of research into this issue. The report adds that despite this lack of evidence, professionals 'intuitively' hypothesise that there is likely to be a link between 'the commission of domestic abuse (against an adult) and real or potential abuse to children'. This CSPR was undertaken prior to there being clear information about how and who inflicted the injuries on the three children being considered in 2022, but the evidence of domestic abuse amongst the adults in the families considered required further analysis at the time.
21. The parents of all the 2022 children had been in abusive relationships prior to the relationships where the children were conceived. Some of them were known to have witnessed domestic abuse and suffered emotional harm in their own childhoods, and there is the potential that the others did too, although this was not known at the time. This experience in childhood will have had an impact on the parent's own emotional development and expectations of relationships. There is a view, and it is often found in safeguarding reviews, that if a child witnesses' domestic violence and abuse, they may be more likely to reproduce this

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

behaviour as adults in an 'intergenerational cycle of violence'[8] than those who grew up without this experience. Some of the parents considered by this review also had police involvement for perpetrating violence outside of an intimate relationship, including the mothers of Child 2 and Child 3.

22. The father of Child 1 lost his job as a care worker due to concerns about the use of unauthorised restraining techniques and implied issues with his anger. This happened just weeks after the baby was born and prior to the injuries being identified. This could have led to increased stress, financial concerns, and worry about the impact of the dismissal of him finding a new job. This was not known to those providing services to Child 1 and their mother at the time[9]. As well as these concerns about him at work, there were previous allegations from past partners about him being domestically abusive, and the year before the baby was born his parents (the baby's grandparents) alleged he was violent to them. As there were no children in his family at the time, this information was not shared.
23. Domestic abuse, like parental mental health, is likely to be an issue that reoccurs over time. Without evidence of challenging and effective specialist input to help both the perpetrator and victim, they will continue to be vulnerable to current or future relationships being abusive. Any plans for children need to realistically consider the likelihood of on-going or future domestic abuse. This is even when, as in the case of Child 2, the mother is convincing in her determination to separate. In that case there was a degree of professional optimism, and no robust consideration of how realistic the separation was, particularly when the baby was the partner's first child and when the mother had little other support. The decision not to have an Initial Child Protection Conference (ICPC) in respect of unborn and new-born Child 2 was taken without significant historical information being considered, without any engagement with the father/perpetrator, and despite concerns about engagement from the mother with several professionals, including domestic abuse services.
24. Professionals need to understand and consider the history of domestic abuse in the relationship and in previous intimate relationships, consider other indicators of aggression or violence, and be realistic about the likelihood of domestic abuse reoccurring. In the case of Child 1, both parents had been in abusive relationships previously. The mother had been asked several times, by routine questioning during the pregnancy, about her relationship with her new partner. She was consistently insistent that while domestic abuse had featured with her first husband, she was safe and had no concerns in her current relationship. Routine questioning is expected practice in Bradford when a woman has contact with health professionals and her partner is not present. This includes midwives, health visitors, GPs and when presenting at hospital.
25. Routine questioning about domestic abuse can give a woman permission to speak about abuse, however The Myth of Invisible Men report found that there is 'limited capacity to develop trusting relationships with parents' and that routine questioning rarely leads to a woman disclosing and to 'different service responses.' However, the Department of Health NICE guidance is quite specific about the benefits of routine enquiry into domestic abuse and the risks of relying on targeted enquiry due to stereotype and professional bias.

[8] NSPCC report Research Review: Early Childhood and the 'Intergenerational Cycle of Domestic Violence' Nov. 2019

[9] The agency where the father worked dealt with the matter internally and did not inform the safeguarding adults service. This has been taken up with the agency. There is a possibility that had this information been shared with the LADO in adult's services, this information may have been shared with children's services as the father had a young baby.

In their review into the death of Star Hobson, the national CSPR panel reinforced the importance of health routine enquiry about domestic abuse.

26. It is thought that victims may avoid reporting or disclosing domestic abuse due to the fear of CSC involvement with their children, which is something that the professionals involved with the three children in this case felt was an issue in the cases and more generally. Domestic abuse was the focus of professional interventions in respect of Child 2 and their mother. The case was referred to MARAC on several occasions because of the identified risk to her and a pattern of her disengaging with services and reconciling with her partner. The Rapid Review meeting recognised that there should have been more MARAC referrals due to the number of further high-risk assessments from police officers, that some of the assessments were wrongly graded as low or medium risk, and that not all the of incidents resulted in information sharing with CSC. There was, again, a view that Mother was willing to cooperate with police action and it appears that she was persuasive in her statements that she intended to permanently separate from the baby's father, despite her actions contradicting this. Her history of always withdrawing her support to a prosecution should have been taken into consideration on every occasion. There was a perceived understanding that she felt she was protecting herself and Child 2 by refusing to accept help, but there was a need to focus on the risk of the abuse continuing and the harm this would inflict on both mother and child, as well as the known increased risks following separation. A strategy meeting was held in January 2022, following several violent incidents and information that the couple were living together despite the mother agreeing to cooperate with domestic abuse services and the child in need plan that required her to remain separated. Again, professionals believed the mother now planned to permanently separate and agreed that the CiN plan should continue rather than an ICPC being held. This may have been a case of confirmation bias, where professionals dismiss or underplay the significance of information which does not support a plan. There were two further domestic abuse incidents known to professionals before the injuries to Child 2 on 22 February 2022.
27. Child 3's older sibling had been living in a household with both his parents where serious domestic abuse featured, and he was a victim of that abuse. The level of risk was high, and the case was the subject of a MARAC in 2020. There were long term concerns about the behaviour of Child 3's sibling, including regular aggressive and emotional outbursts that were an indicator that he had suffered and continued to suffer trauma at home. After the sibling's parents had separated, on-going neglect was an issue, linked to his mother's physical and mental health concerns and cannabis use, and there were indicators of physical abuse. At the age of seven he was recorded by the police as the suspect in several incidents, including displaying aggressive behaviour to his mother, and to children and properties in his neighbourhood. There was an understanding that he was impacted by his home situation, but there was also a degree of child-blaming which needed to be challenged by all professionals. The review has found that there was significant emotional abuse and neglect in respect of Child 3's older sibling prior to and following the birth of Child 3, that had not been sufficiently identified and assessed both in regard to the impact on the older child or the likelihood of neglect of the new baby. This will be analysed further below. There was assertive practice when Mother 3 had a new partner, and it was recognised that he may pose a risk. It was important to consider how the mother would cope with the limitations on contact imposed in respect of the new partner

however, and how this may impact on the children. Plans need to be transparent and realistic in expectations and clear about how success will be measured.

28. Domestic abuse is undoubtedly a significant issue for families and for professionals in Bradford. West Yorkshire Police had the highest rates of domestic abuse-related crimes in England and Wales in 2020 and 2021. Anecdotally there is a view that it is one of the biggest challenges for professionals who are safeguarding children in the city. This is not just a local issue, as shown in the 2022 national CSPR[10] 'Child Protection in England' which identifies 'a need for sharper specialist child protection skills and expertise, including in respect of domestic abuse.' None of the three 2020 cases considered were straightforward, with multiple parental vulnerabilities, some of which are known to increase a person's risk of experiencing domestic violence or abuse, such as 'having a long-term illness or disability, including mental health problems.[11] Expertise in responding to domestic abuse and systems that enable the issue to be addressed effectively are both required.
29. As a way of trying to deal with the high number of referrals for consideration at the MARAC[12] (multi-agency risk assessment conference) locally, there have been recent changes to the process. While the identification of high-risk cases and a wish to consider them in a multi-agency forum is positive, the significant demand has reportedly had an impact on the quality of multi-agency information sharing, reflection and plans made in the MARAC meetings. The relevant board is aware of concerns about capacity of the meetings, and the need for consistent chairing and improved outcomes/impact of MARAC meetings on the protection of victims, including children in the family. This system pressure has a related impact on victims and perpetrators in high-risk cases not always getting the services they need. The Bradford District Safeguarding Children Partnership need to be aware of the impact on safeguarding children of the systemic problems. The review that considered the death of Star Hobson, a Bradford child, recommended that domestic abuse services needed to be reviewed and commissioned that 'guide the response of practitioners and ensure there is a robust understanding of what the domestic abuse support offer is in Bradford. This should lead towards a coordinated community response by providing a bridge between services. Immediate action should be taken to provide multi-agency practitioners with guidance and/or training, supported within supervision, to enquire about domestic violence in mixed and same sex relationships, to develop safety plans for victims and their children and support perpetrator interventions.' This work is ongoing, so no further recommendations are made in respect of domestic abuse in this review.
30. The 2022 National CSPR has published a practice briefing on safeguarding children in families where there is domestic abuse. The key findings are in respect of the lack of understanding of domestic abuse evident within multiagency meetings and plans, no 'whole system' approach that safeguards children as well as adults, and an overemphasis on physical violence and lack of consideration of the dynamic of the situation. This briefing needs to be considered alongside both the learning from this review and the work being undertaken following the review into the death of Star Hobson to align any changes required.

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf
[11] Recognising and responding to domestic violence and abuse. Quick Guide. SCiE 2020
[12] A multi-agency meeting to share information on high-risk domestic abuse cases and agree co-ordinated action plans to safeguard the adult victim. Children are also considered. A CSC representative attends and the health representative shares outcomes with the relevant health visitor and/or school health nurse.

Comparison with previous reviews

The reviews completed on both Alice and the four babies included concerns about domestic abuse and violence between the parents/adults and the impact on the children and on their non-abusing parent's ability to prioritise the care of their child. There was also identification of gaps in the professional knowledge about the impact of domestic abuse and the potential risks to children. One of the cases in the four babies review included a young and vulnerable mother who was left to supervise contact between the baby and her violent ex-partner, In another, the father was known due to his violent behaviour, but this risk was not robustly considered, even when there was a prior injury to the baby.

There was some good practice identified in the 2022 cases. Routine questioning about domestic abuse was largely evident. The health visitor for Child 1 was tenacious in completing an ante-natal appointment where questions were asked about the older children and previous domestic abuse, and professionals who met the lead reviewer were clear that domestic abuse is a serious child safeguarding issue.

What needs further consideration? *

Work is being completed regarding the professional response to domestic abuse in Bradford following the national CSPR in 2022. This should include consideration of the following reflections made during this review:

- A subgroup of the Domestic Abuse and Sexual Violence Board is reviewing the current MARAC process. This should include consideration of both the whole system arrangements and the minutiae of MARAC practice in order to ensure the required improvements and impact. An update on this work should be shared with the Bradford District Safeguarding Children Partnership.
- Clear instructions are required about expected information sharing about domestic abuse incidents and MARAC plans with professionals working with all members of the family, including GPs. It is recognised that how and where this is recorded on a patient's record will provide a challenge for Primary Care, but this should not get in the way of good information sharing and improved awareness of domestic abuse in a family.
- While a better MARAC process will consider high risk cases, there is a need for a review of the domestic abuse strategy and the documents that support it, that will provide appropriate services at all levels. This should include prevention work for those identified as at risk of domestic abuse through to the high-risk cases, and early interventions for those where lower-level domestic abuse is an issue.
- Consideration should be given to the attitude of practitioners to domestic abuse in Bradford, given its prevalence, and whether this has an impact on risk assessment and children's plans.
- Child victims of domestic abuse who have lived in households where domestic abuse occurs are at increased risk of domestic abuse in their own future adult intimate relationships. The Bradford District Safeguarding Children Partnership should work with agencies to promote the need for preventative work with high-risk groups, such as care leavers and children previously subject to a child in need or child protection plan due to domestic abuse. Preventative resources including about healthy

relationships and how domestic abuse can be avoided should be targeted to these children in order to have the most impact

- Consideration should be given to how help can be provided when there are early indicators of domestic abuse in a relationship, including services providing evidence-based work with perpetrators
- Information and research about the recurring nature of domestic abuse within a relationship and the likelihood of both victims and perpetrators entering new relationships which are abusive need to be shared with parents and professionals, and requires consideration when a relationship breaks down
- When a pregnant woman shares that she has been the victim of domestic abuse in a previous relationship, midwifery and health visiting services need to consider what additional support may be required
- Multi-agency meetings such as core groups and child in need meetings need to provide the space for professionals to consider if over optimism or confirmation bias is an issue when working with families where domestic abuse occurs
- Plans for working with families where domestic abuse is an issue should be bespoke and include; an assessment of what the abuse involves, as all circumstances are different; the likely impact on the child in the family; and measurable outcomes. The review into the death of Star Hobson highlights the need for professionals to seek a thorough understanding of the relationship between the adults, including those in a same sex relationship

Thresholds for neglect, including consideration of accidental injuries as a sign of neglect and understanding of cumulative harm

31. When domestic abuse is evident in a household, there is the risk that other safeguarding concerns may be marginalised. Neglect was clearly an issue / risk for the child/ren in both family 2 and family 3. The history in respect of the siblings of Child 2 required consideration and sharing across those involved both pre and post birth, along with the consideration of what had changed to consider if there was any risk to the baby expected by Mother 3. The complexity of the case was partly due to the older children living in different parts of the country, where the mother had also lived for some years prior to her returning to Bradford in 2020. Information seeking and sharing across local authority, health and police areas can be difficult and it is therefore not always prioritised by busy professionals. As Mother 2 was not caring for any children at the time of her return to Bradford, there was no need or justification for information sharing at that time, although there was evidence that it was sought and considered during the pregnancy, which is good practice.
32. During her pregnancy with Child 2 there were concerns about domestic abuse with the child's father. This, and the previous concerns led to a social work assessment being undertaken pre-birth. A strategy meeting was then held due to concerns about her sporadic engagement with ante-natal care and domestic abuse support and her known mental health issues. Consideration was given to holding an Initial Child Protection Conference (ICPC) due to worries that the unborn baby could be 'at risk of physical harm, neglect and emotional harm' due to concerns about domestic abuse and the mother's mental health. There was some understanding of the mother's issues with alcohol, and this was discussed at the strategy meeting as there had been alcohol involved in some of the domestic abuse incidents. But there was no consideration of the recent serious substance misuse. As stated above, there was information available in the GP records that

Mother had been using crack cocaine as recently as October 2019. This information was not known so was not considered when the decision was made to work with the family on a Child in Need basis rather than holding an ICPC, and there was no exploration of how Mother had avoided the use of substances since then, if this was indeed the case.

33. The social work manager chairing the strategy meeting recognised concerns regarding the lack of meaningful cooperation from Mother 2 and recorded their view that an ICPC be considered. It was agreed that a joint visit from the social worker and the health visitor should be undertaken first. During this visit there is evidence that domestic abuse was the focus. The mother stated that she was separated from her abusive partner, and that there had not been any incidents reported for three months. This was seen as positive, and it was agreed that a CiN plan was sufficient for the baby when it arrived. The risk of neglect due to mother's issues was not the focus of the visit or the decision making about an ICPC. The fact that the mother was also voicing her willingness to engage with the CiN plan was also taken into consideration. There is little evidence that her mental health, or evidence of recent alcohol and substance misuse was considered sufficiently, with the domestic abuse seen as the prime concern. There was also no evidence of the father of the baby being seen by professionals in respect of the plan either pre or post birth. The decision was made without consideration of the other agencies who were involved in the strategy meeting, and there was no further strategy meeting held despite a change in the plan form the first.
34. There was evidence that Child 3's mother struggled to meet the needs of her school age child, and there was a need to consider the impact on that child of a new baby and a view on the likelihood of the new baby being neglected and potentially harmed due to the known issues with mother's care of her older child. Child 3 was made the subject of a child protection plan when they were six months old, due to ongoing concerns about the care the older sibling was receiving from their mother. The information shared with the review clearly identifies significant neglect of Child 3's older sibling. There had been a referral from the mother's GP during the pregnancy requesting a social work assessment pre-birth, due to an awareness of on-going concerns about the care of her older child and mother's own vulnerabilities, which included the impact of her physical health difficulties and mental health concerns. Information available in the GP records included a report written in 2019 following a referral for psychology input to improve the mother's engagement, help with pain management, and reduce admissions for her health condition. The report outlined several concerns including her difficulty in regulating emotions, particularly in relation to anger, and issues with her cognitive functioning. What it did not include was consideration of the impact of these issues on her parenting. There is no evidence that this potentially concerning information was specifically requested from the mother's GP or shared by them when she was pregnant with Child 3 or more generally when concerns were being considered in respect of the older child. The case would have benefitted from full consideration of what was known about the mother's health, mental health, and cognitive ability, along with an understanding of the medication / drugs she was taking, both prescribed and otherwise, and the impact on her parenting.

Comparison with previous reviews
In respect of Alice, there were two pre-birth assessments undertaken, both of which identified significant concerns about the mother's ability to meet her own needs and her capacity to parent. This led to a child

protection plan being made pre-birth. The mother's apparent improved engagement with the assessment led to a view that she would work with professionals and that she should be given a chance to care for the baby.

This was similar to what happened with Child 2 in the 2022 cases, where the mother's apparent willingness to cooperate with assessments and a CiN plan led to a continued pursual of this intervention even when there was evidence of poor engagement and increasing risks. Those involved explained that Mother 2 was likeable and was never avoidant, aggressive or rude to professionals. It was rightly understood that she had experienced loss and trauma. She was also reassuring regarding her separation from her partner and her relapse plan regarding alcohol.

Like for Alice and the four babies, there were issues with the timeliness and quality of prebirth assessments in respect of both Child 2 and Child 3. There was also drift and delay in respect of Child 3. There were a number of incidents of concern in respect of Child 3's older sibling in the months prior to the injuries to Child 3, including injuries to the sibling which were thought to be due to lack of supervision rather than physical abuse, although with hindsight this has been reconsidered. In this case the focus was largely on the sibling and the mother's own complex needs, rather than on Child 3, although there was good child centred practice from the health visitor, as will be outlined below. Despite information that could indicate a risk of harm to Child 3 from the time of his mother's pregnancy with him, it was not until much later that a specific assessment was completed that considered Child 3's needs and resulted in a child protection plan, which was again dominated by the concerns about the older child. There were also indicators and discussion that Child 3 needed to be subject to the Public Law Outline[13] (PLO) but this did not happen until after he was injured. (See below)

What needs further consideration? *

Dissemination of information and learning from reviews is key to communicating expected and the need for improved practice. Partner agencies should consider how they can, both together with other partners and internally, effectively disseminate this learning. This should include consideration of previous attempts with a view to understanding what the barriers have been.

There is a need for all partner agencies to consider how they can ensure that their relevant professionals are aware of:

- the threshold for neglect
- the indicators of neglect
- the existence of the neglect tool kit
- the risk to children of cumulative harm when a child is neglected over time
- the links between neglect and other forms of abuse
- the possibility of professional desensitisation when working with families where neglect is a concern

There is a need for consideration of significant harm from neglect for children where there are recurring issues with injuries, lack of supervision, and poor attendance at school and at health appointments.

[13]The PLO sets out the duty of the Local Authority pre-proceeding - when they are considering making a care application.

Professionals need to be clear about the significance of the cumulative impact over time of neglect, and avoid incident led practice.

All meetings held need to reflect the voice of the child and their lived experience as part of the meeting and this needs recording specifically. There must be effective challenge when language or discussions are child blaming.

There is also a need for relationship based and skilled social work engagement with parents to consider if they understand what neglect is and understand the impact it will have on their children.

There is a complexity to working with different communities across Bradford, and this brings a risk of making cultural assumptions. All professionals need to be helped to understand the traditional, established and emerging communities in Bradford to ensure that practice is both culturally and individual family sensitive but that safeguarding responses are consistent. In the three families the mothers were white, and the fathers were black Asian. Information is available that in all three cases there was limited, if any, support from the children's wider maternal or paternal families. The complexity of the adult relationships, including the impact of having a child who is mixed parentage in traditional communities where this is disapproved of, needs to be considered and discussed with families in order to understand the lived experience of the children and the impact on them. This will also involve professionals working with families having a safe space to consider their own values and biases.

These cases show the need for information sharing from and with the parent's GPs in assessments and when considering the potential impact on children of the parent's vulnerabilities.

Consideration of the child's lived experience

35. It is not easy to consider and understand a child's lived experience when the contact is predominantly with the parent/s and when the child is pre-verbal or guarded with professionals, as was the case for Child 3's sibling. Practice and systems need to be child centred and must consider a child's lived or likely lived experience when there are dominating adult issues. As well as understanding the parent's vulnerabilities, all professionals need to be aware of the impact of these matters on the children. When the parent's relationship includes domestic abuse, when there are mental health issues and when there is substance/alcohol misuse it is essential that professionals have a child centred approach and are able to put themselves in the child's position when considering how they experience the adult issues.
36. In the case of Child 3, there was an older sibling and there was evidence that they were safeguarding concerns in the home prior to and after the birth of Child 3. The child was at school and there were issues with his attendance that were not considered to be a sign of neglect at the time. The links between poor attendance and attainment are compelling, with consequences for a child's longer-term outcomes. The NSPCC highlight 'the failure to ensure regular school attendance that prevents the child reaching their full potential academically' as one of their six forms of neglect.[14] Children with long term health needs are more vulnerable to neglect and the impact can be more severe. Child 3's sibling had a long-term genetic health condition and had been referred for an assessment by CAMHS for ADHD and autism. As well as poor school attendance, there was a lack of consistent attendance at health appointments which the child was

[14] 'Role of Schools, academies and colleges in addressing neglect.' NSPCC 2013

required to be brought to by his carer to manage his health condition. He was also noticed to have tooth cavities and an abscess due to neglect of his dental health.

37. There are also frequent observations made from professionals on the difficult interaction between the older child and his mother. He was very vulnerable and those who knew him well were concerned about the impact on him of his experiences. It is interesting to reflect on the four child protection medicals for potential physical abuse undertaken on the sibling in the months following the birth of Child 3. The incidents leading to the medicals were an indication that when injuries were seen or when the child had said he had been harmed (for example that his mother had hit him on the head with an x-box controller) there was a hope from the professionals involved that medical **evidence** of physical abuse would be identified. It was not and there was a tendency to wait for another incident in the hope that evidence would emerge. This shows two things, that there can be an over-reliance in the system during an investigation on findings during the child protection medical that there has been a non-accidental injury (also found in the Star Hobson case) and that child protection practice in this case was incident based and did not consider the long-term evidence of neglect and emotional harm that the sibling was experiencing and that Child 3 was also likely to experience in his mother's care. Each incident or episode of concern needs to be examined with an understanding of what the child has experienced before to assess whether a multitude of factors, when considered together, constitutes significant cumulative harm[15].
38. The national Safeguarding Practice Review Panel's annual report published in May 2021[16] stated that 'the recognition of cumulative neglect and its impact continue to be a key challenge for practitioners' nationally' and this has been found in this review in the case of Child 3's brother. This a key issue for safeguarding partners, as the life-time impact on children of long-term and recurring neglect cannot be underestimated, with outcomes for these children likely to be exceptionally poor. As well as considering neglect as a standalone issue, there is evidence that other forms of abuse can co-exist with neglect, with these children more likely to experience physical harm and sexual abuse.
39. Consideration of how the arrival of a new baby would impact on the care of the older child, as well as the likely lived experience of the new baby, required consideration pre-birth in the case of Child 3. A growing family can often mean that a situation that was just good enough for a child can become more concerning and pre-birth assessments that focus on this are required. The focus on the sibling and on the many needs of Child 3's mother meant that the assessments and plans did not provide a clear understanding of what a day in the life of Child 3 involved when he was in the care of his mother. The focus of assessments and plans was on addressing the behaviour of the older child and limited consideration of the impact on the baby. The review was told that there continues to be work required in Bradford to ensure that pre-birth assessments are of a consistently good quality, with sufficient curiosity and focus on the likely experience of a baby in a family. There is a need for monitoring of compliance with the multi-agency practice guidance for pre-birth assessments.

[15] Bromfield and Higgins in Australia first introduced the terms 'cumulative risk' and 'cumulative harm' in 2005 when they point out that 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf

40. There was evidence of good practice in respect of Child 3 from the health visitor involved with the family following the child protection plan being made. When a child becomes subject to a CP plan in Bradford their allocated health visitor changes. The team working with such families are experienced child protection practitioners and the health visitor working with Child 3 received specific supervision on the case from Little Minds Matter[17]. She described to the review the power and insight gained from a session described as 'be Child 3 for two minutes.' This gave her the impetus to challenge the lack of progress in respect of the plan for the child. She contacted the child protection conference chair and lobbied for legal advice to be sought by the Local Authority. The Safer Bradford process for escalating a professional disagreement was not used.

Comparison with previous reviews
The Alice review found that the main professional focus had predominantly been on the mother rather than the baby. Yet there was still a gap in knowledge about Alice's mother's mental health and no timely assessment of her potential learning disability. This is often found in case reviews nationally and was also evident in the four cases review completed in 2019. The mothers of Child 2 and Child 3 had several significant vulnerabilities and needs, which took up a lot of professional time and focus. In neither case was the baby's voice nor lived experience captured, until later with Child 3 when there was good practice from the newly allocated health visitor during the period of child protection planning. She effectively considered and communicated the child's lived experience, the strength of this piece of work may have led to a refocused child protection plan, or care proceedings, due to the likelihood of ongoing significant neglect had the injuries not occurred when they did. The Alice review concluded that professional training and development must highlight the risks associated with fixed thinking and the need for professional inquisitiveness and challenge. For Child 3's older sibling, there had been a number of concerns over many years, none of which met the threshold for safeguarding actions. There was the opportunity to consider his lived experience. There is evidence of references to his behaviour being the problem, not the parenting he received. There was some challenge of this, but for years it did not result in a plan that addressed this.
What needs further consideration? *
Consideration should be given to the good practice in respect of the model used to understand Child 3's likely lived experience being used more generally across services to improve professional insight into a child's world. All child protection conferences, core groups and child in need meetings should have a section where those in attendance think about what they have heard through the eyes of the child/ren in the family. As considered above, there is a need for professional challenge when a plan is not progressing and there are continued or escalating concerns about a child/ren. As the current model for challenge is rarely used, there is a need to reenergise professionals in respect of this important safeguarding procedure, with consideration of a new process.

[17] Little Minds Matter is a Bradford NHS initiative that supports parents, carers and professionals to help babies get the best possible start in life. They offer direct work with families and consultation and training to professionals.

Considering men/fathers/partners

41. The household of Child 1 consisted of the baby and their mother and father. Child 1 was her father's first child. He was caring for her when medical advice was sought, and the injuries were found. The household of Child 2 consisted of the child and his mother. However, his father was known to spend time there, despite denials to professionals. Child 2's father also has no other children. Child 3 lived with his mother and a school age sibling. Mother 3 had a new partner who was thought to be a concern as he was not having contact with his own children, largely due to domestic abuse. CSC agreed with Mother that prior to a risk assessment the new partner should not have contact with the children.
42. It is common in SCRs and CSPRs to find learning regarding the need to engage with and consider the father of a child, or the partner of a mother who lives with, or spends a lot of time with, the family (including same sex partners.) This review is no exception. There are identified barriers to sharing information and seeking information about fathers and partners, and it continues to be a dilemma for professionals. Information was held about some of the men in these cases which was not known to those who had responsibility for the children, including when there was a CiN or CP plan in place.
43. There is a national issue regarding GP and other health records for the men in a family, and how these can be accessed and considered. This is particularly an issue when the men are registered at a different GP surgery to the children and their mother and has been identified as requiring further work nationally. GPs are in a unique position regarding safeguarding as they often have oversight of a person's whole life history. They receive copies of correspondence from many agencies and can provide details of historic vulnerabilities and risks, as was the case with information held on the mother of Child 2. The records held by GPs enable them to consider current information alongside this history, but only if they are asked.
44. There was good GP engagement with this review, and they were able to reflect on some of the barriers they face, particularly in relation to domestic abuse. GPs in Bradford are not always contacted when there is a section 47 investigation if they are the GP for the subject children's father. They do not routinely receive domestic abuse notifications from the police if their patient is the perpetrator, and they are not informed when the children of a male patient are made the subject of a CP plan. While health staff and those working predominantly with adults are being asked to 'Think Family' it is also important for professionals working with children to 'Think Father'. The health visitors involved in the three cases confirmed that they can have access to a mother's GP records but not the fathers or partners.
45. Professionals are right to be concerned about where they record of domestic abuse information on a patient's electronic medical record, particularly if they are a perpetrator of domestic abuse. The Royal College of General Practitioners (RCGP) guidance about this issue was updated in 2021. It acknowledges that the way information is recorded on the record of victims, perpetrators and child victims must not increase the risk of harm to victims, as perpetrators may not know that their victim has disclosed domestic abuse and may not be aware of any services being provided. The guidance acknowledges the challenges of the sometimes-limited IT systems being used but has provided helpful advice about how to ensure that practice is as safe as possible. It includes an awareness that patients can now access some of their medical records online, and the need to ensure that no safeguarding information is included in the accessible area

of the file. There is no guidance in respect of the move to full access to patient files as this is not yet law, but it something that the national CSPR panel need to be aware of.

46. While there must be consideration of the need for consent, which should be recorded, when there are or have been safeguarding issues in a family, the lack of consent should not impede information sharing. As the national panel says in the 2022 review Child Protection in England, 'time and again we see that different agencies hold pieces of the same puzzle, but no one holds all of the pieces or is seeking to put them together.' To ensure that children are appropriately safeguarded, the aim should be to encourage and support professionals to clarify what 'pieces' are known to their agency, share these 'pieces', and work together to see the 'whole picture' without fear of reprisals or breaking data protection legislation.
47. It is expected practice that midwives and health visitors enquire after the health and mood of mothers following the birth of a child, and standard tests are undertaken for post-natal depression. It is not usual practice for professionals to enquire about the father or non-birthing partner's mental health. Practice following the emergence of COVID-19 made this even less likely as a lot of contact from health professionals was by telephone with the child's mothers. Difficulties can emerge after the birth of a child for fathers (or other secondary carers) as well as for mothers. This can include relationship issues, concerns about the amount of responsibility that children bring, and a lack of confidence in the role. There is increasing evidence that fathers/non-birthing partners can suffer with a form of PND[18] and this always needs to be considered. It is particularly important where there is previous evidence of mental health difficulties in the secondary carer. The NICE guidance on antenatal and postnatal mental health does not mention fathers, and awareness of this as an issue is low[19]. This is even though the numbers of men who become depressed in the first year after becoming a father is double that of the general population. First time fathers are particularly vulnerable. Professionals need to be aware of this as a possibility, and consider it when engaging with families, particularly where there are predisposing vulnerabilities, including domestic abuse.
48. Both the fathers of Child 1 and Child 2 were first-time parents. The pregnancies and births were at a time of uncertainty and there were some limitations to services due to Covid 19. The father of Child 1 had a history of mental health problems and anger control that was not known to the professionals working with the family. He was also living with a partner with mental health challenges of her own. In the case of Child 2, there was a history of maternal mental health problems, substance and alcohol abuse, and information about the mother's care (and neglect) of her older children. Both the mother and father had been in previous relationships where domestic abuse featured, and a robust and transparent consideration of the risk that the father may pose was required. There was a delay in identifying the father which impacted on this, but even when it was established, there was little done to engage with him. The strategy meeting agreed that the couple must separate, and it was then the mother's responsibility to safeguard the baby.
49. It is not yet known how the three babies being considered in 2022 were harmed, and whether 'coping with crying' was relevant. Babies cry and parents need to be able to deal effectively with this. This is more of a challenge for those who have stresses and vulnerabilities and where there are issues in the adult

[18] Research available from the National Childbirth Trust (NCT) found that more than 1 in 3 new fathers (38%) are concerned about their mental health. The research states that one in 10 fathers have PND and appear more likely to suffer from depression three to six months after their baby is born.
[19] Community Practitioner magazine November 2018 and #HowAreYouDad? campaign

relationship, including concerns about domestic abuse. There was some evidence that 'coping with crying' was discussed in these cases. The ICON[20] ADD model is being relaunched, which should make a difference. But not always with both parents. In the case of Child 1 there was very limited contact with the father, for Child 2 there was no contact with the father, and in the case of Child 3, the identity of the baby's father was not disclosed by the mother, and she was largely worked with as a single parent.

Comparison with previous reviews
In the Alice review and the four babies review, there was little evidence of the father or non-birthing partner being considered, despite a number having significant vulnerabilities that could be a risk to a child. This was the case with the 2022 babies, particularly regarding Child 2. The father did not respond to the attempts to engage him, despite the efforts of the social worker as part of the child in need plan post birth. If fathers or other non-birthing parents are going to be treated equally, there needs to be efforts to ensure they are aware of agency expectations and any attempts to engage them need to be meaningful, even if the plan is that they will not live with the child. Any ongoing contact needs to be considered when there is a history of violence in a relationship, as it is known that even in cases where domestic abuse is a concern, there can be ongoing contact between the children and their fathers, as was the case for Child 3's sibling and his father. The mother told the review that her elder child had witnessed domestic abuse throughout his life and that this led to him being aggressive and often abusive to her. She said there was little curiosity about her injuries, and that it was hard to share the information with professionals, so no meaningful support was provided. It has been noted in the previous cases, and those being considered in 2022, that there was an absence of wider family support for these families. This issue always needs considering when working with a family at any point in the system, but certainly when there are concerns and vulnerabilities. The reasons for this should be part of any assessment, including if the choice of partner had an impact. It is noted that this can be an issue in traditional communities when the child is mixed race and needs to be explored on both a case by case and a wider basis.
What needs further consideration? *
Agencies need to consider how they can ensure that the mental health of a father or non-birthing parent is considered after the birth of a baby. The review was told that the learning from the 2020 national CSPR (The Myth of Invisible Men) has been incorporated into training. Consideration therefore needs to be given to what the barriers have been to this having an impact in its own right, but also when considering how to disseminate and incorporate the learning from this review into briefings and training. Professionals need to consider the impact on a child of experiencing domestic abuse, and the possibility that they will mirror what they have seen and be aggressive to their carer.

[20] https://iconcope.org/

The Bradford Partnership needs to consider how it can ensure that professionals consider any race or cultural aspects in families, including the impact on wider family support and the way that the child may be seen by both sides of their extended family and communities.

Assessments and planning

50. There was a verbal domestic abuse incident between Child 1's parents when she was four weeks old. The information was not shared by the police with any other agencies, including the health visitor who had recently visited the family. Two weeks later, in January 2022, the GP spoke to a parent about the child during a telephone appointment for reported concerns about Child 1's crying 'particularly when held by her father'. Over-the-counter medication was prescribed for colic and constipation, and the GP suggested contact with a health visitor to discuss feeding and latching issues. There is evidence that the family tried to speak to a health visitor the same day, but as a family receiving universal services, this was not straightforward. They had to go through the duty system and speak to a health visitor they did not know. It was recorded that a suggestion was made to return to the GP if the symptoms got worse. This was an opportunity to discuss 'coping with crying' with the family. This did not happen, but it is possible that it would have if the health visiting service was aware of the recent domestic abuse incident.
51. At the beginning of the COVID pandemic, NHS England asked all GPs to undertake remote triage. The combination of the continuing need to limit COVID infections in 2021 and 2022 and general service pressures meant that GPs did not always see a patient (including babies) face to face, although it is acknowledged that this is best practice. The Rapid Review undertaken in respect of Child 1 stated that a significant impact of the COVID pandemic has been that clinicians have had to take on more risk by managing more children remotely. It is not known however if Child 1 had received the older rib fractures at the time of the remote appointment or if this would have been identified had there been a face-to-face consultation. It is unlikely, as there are rarely external signs when ribs are fractured. However, it would have been helpful for the GP to know about and consider the domestic abuse when examining the baby.
52. Assessments need to include the reconsideration of previous information or concerns alongside any new information or incident. None of the three 2022 children had any known injuries prior to the incident that led to this CSPR. However, in Family 3 there was a clear indication that Mother required significant support in respect of her care of the older child, and not enough consideration was given to the impact on that child of a new baby and the impact on the new baby of the ongoing issues in respect of mother's parenting of their sibling, and knowable information about his aggressive behaviour.
53. When a parent has health or mental health issues, all professionals with safeguarding responsibilities for the children need to ensure that they find out and share what the known issues are, to optimise consideration of the impact on their parenting. Any specialist assessments need to be shared and considered by those responsible for the children. There is also a need to ensure whole system awareness and connectivity between services working with adults and those working with children when a safeguarding adult issue occurs which may have implications for a child.
54. Those involved in the three cases told the review that there are administrative issues with the updating and sharing of plans for children and the records of meetings, particularly strategy meeting, child in need plans and core group minutes. This hinders information sharing and ownership of a child's plan. There is a multi-

agency commitment to ensuring that plans are outcome focused and evidence improvements for children, but the administration of this remains an issue. GPs fed back to the review that they would welcome knowing if a child is on a Child in Need plan, and it is good practice to share plans with GPs, but this does not happen regularly. These are reportedly long-term issues within Bradford that are being considered by partner agencies with the aim of improving the sharing and flagging of key information to ensure that vulnerable children are identifiable to all the professionals who have contact with them.

55. The schools attended by the sibling of Child 3 reported that information sharing and timely updating across agencies needs to be improved to ensure that all those working with the family are aware of what the child's lived experience is, as this has an impact on the child's behaviour in school.

Comparison with previous reviews

The learning identified in the cases of Alice and the four babies reviewed the following year included the identification of; issues with the timing and quality of pre-birth assessments; inadequate involvement of adult services in children's assessments and planning, particularly regarding adult mental health; gaps in information sharing; underestimation of the impact of the mother's vulnerabilities on the child/ren; and overoptimism about their ability to parent and protect their child/ren. When assessments were completed following injuries in non-mobile babies, procedures were not followed. Drift and delay were also evident in assessments and plans.

These issues were less evident in the 2022 babies, however as shown above, there were opportunities to seek information from other agencies and within agency records which were not always taken, for example the GP information held on Mother 2, and the drift and delay that was apparent with Child 3.

In the Alice review there was learning identified about the use and timing of the PLO alongside child protection planning, and how it 'makes sense to professionals and parents. There is a need to ensure that agreements made in the PLO process are communicated to other agencies. Unlike child protection planning, the PLO process is effectively single agency as it is between the parents and the local authority. There are benefits to the PLO planning reflecting the CP planning process and including other professionals in the plan and expectations from the PLO process. In the case of Child 3 there had been agreement that the PLO process should be started in respect of Child 3 and the sibling, but this was delayed and had not yet begun when the injuries occurred. This was the subject of professional challenge.

In Alice's case there were gaps in the pre-birth assessments, including the absence of information from adult services, particularly mental health services and the police in respect of both parents. An extensive plan of support was put in place, but when Alice received an injury[21] at 12 weeks old, she was initially allowed to return home with her mother without a strategy meeting and S47 investigation being held. There were no concerns about the response to the injuries in the 2022 cases, with all the cases receiving an appropriate response when the initial injuries were suspected/identified.

Child 2 was on a child in need plan. This is not always as well communicated to professionals as child protection planning. The best practice in child in need planning is where it replicates the CP system in

[21] A bruise to her eye area.

respect of written plans, regular reviews of the plan with the family and professionals involved, and robust information sharing.
What needs further consideration? *
Consideration must be given to improved information sharing about a child in need plan and improved engagement across agencies, including adult services. The aims should be: - All child in need plans need to be recorded, updated and circulated to the family and relevant professionals - The relevant professionals, including the GPs of the children and the parents, must be aware of children are on a Child in Need plans. They then need to ensure that the plans are on the records of the children and the parents. Consideration of who shares this information and how this happens must be made on a case-by-case basis. For many children the health visitor may be in a good position to do this - Consideration to be given to how child in need plans can be shared with GPs when a child is over 5 years old - Professionals need to be aware that an existing or previous child in need plan indicates that there are or have been concerns about a child, and that this may indicate risk in the future Although a child has an allocated social worker when they are on a child in need or a child protection plan, there is a clear multi-agency responsibility for the child and the plan. Professionals who see the child more and know them better are essential to the process and need to ensure their voice is heard and to take responsibility within the planning.

Other issues considered

56. One of the biggest challenges in child protection work is working with families who are hard to engage, who engage sporadically, who are reluctant to accept support or who respond to professionals with anger and aggression. The level of engagement, particularly between child in need and child protection, is often based on the willingness of the family to engage. In the case of Child 2, the mother's voiced willingness to cooperate and her wish to separate from her partner determined the level of involvement and the decision to hold an ICPC was changed to a child in need plan. It had been some years since the mother had cared for children and she was given the benefit of the doubt. Later when it became apparent that she was unable to separate and that the domestic abuse was continuing, a strategy meeting again agreed that a child in need plan remained the appropriate course of action for the child, despite evidence of parental disengagement. There were also issues with the father's lack of engagement with the police which led to no action regarding his breach of bail conditions.
57. As stated in the 2022 national review Child Protection in England, 'at its heart, child protection practice requires consummate skill in blending 'care' and 'control' functions, helping families to protect children. This can only be achieved by building trusting relationships with parents and children whilst recognising that how things appear may not be the reality of a child's experience.' As stated above, the need for relationship-based practice, with children, with parents and the wider family and across agencies is essential to

improving the safeguarding of children. The focus on direct engagement will also ensure a more motivated workforce and will have a positive impact on recruitment and retention, which has been an issue locally.

58. Positive experiences of management support and supervision, both individual and group, also has an impact on staff morale and is more likely to help retain staff in areas of high need. The review that was undertaken by the national CSPR panel in 2022 following the death of Star Hobson noted that in Bradford CSC at the time of Star's death that there were 'significant problems with workforce stability and experience, at every level'. This remains a concern.

Comparison with previous reviews
The Alice SCR and the four babies review identified issues with the impact of a lack of quality supervision that encourages professional curiosity and robust analysis, issues with record keeping, and the impact of turnover of staff in key agencies and inexperience across a number of professions. There was also a concern that professionals had not felt able to challenge the plan for Alice to continue living with her mother, despite apparently not agreeing. In the case of Child 3 in 2022 there was good practice regarding professional challenge. Although there was no evidence of any impact on practice, it is noted that homelessness or a move of home was evident in the Alice review, as it was in the case of Child 2 and Child 3. It is well known that insecure housing, moves of accommodation and related professional changes/transfers can have an impact on child development and increase isolation for families. The sibling of Child 3 had a change of school when he was already struggling both socially and academically, and there were changes of health visitor for the baby.
What needs further consideration? *
The COVID-19 pandemic has apparently had an impact on training in both routine and specific safeguarding matters across partner agencies in recent years. This is relevant to both single and multiagency training. The review was told that a process of review has been undertaken in respect of Partnership training. Good quality supervision is key to effective safeguarding practice and needs to be in place. It supports and challenges staff in and across agencies, monitors practice and record keeping and encourages reflection and risk identification. Improving the recruitment and retention of key staff across the safeguarding system, such as social workers, may require a redesign of the service, and consideration of locally based service delivery through smaller teams, such as social work pods[22].

Conclusion and recommendations

59. The 2022 national CSPR Child Protection in England has recommended that Multi-Agency Child Protection Units, with integrated and co-located multi-agency teams staffed by experienced child protection professionals, are established in every local authority area. This has not yet been agreed by central government and an update is required regarding this. What the proposed system will not achieve however

[22] Social Work Pods: A Team Around the Relationship. 'An emotionally informed thinking space' providing 'organisational containment' (Ruch, 2007).

is better assessment and support before a child protection matter has been identified, which this review has found was required in the three cases considered.

60. It is not the place for a single local CSPR to recommend whole system changes, but it is clear that there is both the need and the appetite in Bradford to consider significant changes. Inter-agency and community relationships also need to be improved to better safeguard children. This is seriously impacted by the 'churn' in key staff and managers. Child 3's mother told the review she has lost count of the number of professionals involved with her family. Making the working environment in Bradford one where staff want to work and want to stay is essential. This will provide continuity to children and families and retain essential experience in the city's key agencies. There was a view from professionals that large city-wide services do not enable the development of relationships in communities and promote local knowledge. Some parts of the UK have developed decentralised services and teams working in pods and / or community hubs with experienced line managers. They report improved multi-agency relationships and staff who are more satisfied in their work, which leads to benefits to children and families in the community.
61. This CSPR has considered the learning from three cases and has identified learning that will be helpful for the wider system. The national Child Safeguarding Practice Review Panel published a briefing paper in 2021 that considered the impact on families and services of the COVID-19 outbreak to that point. The analysis shows that COVID-19 exacerbated risk due to an increase in family stressors (including an increase in domestic abuse and mental health concerns) limitations to wider family support, children not being seen as regularly, and difficulties with the requirement for ensuring safe professional practice. The children being considered in this review were born and receiving services at the later end of the pandemic, where services were still being impacted and where there remained uncertainty about what would happen. The NSPCC[23] identified that when adequate support was not available during the pandemic, 'such tensions may lead to mental and emotional health issues and the use of negative coping strategies.' The review has not specifically identified learning in respect of COVID-19 but recognises the additional strain that it put on both families and services at the time.
62. Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. There has been cooperation with this review from partner agencies, which was essential in establishing the learning from these cases.
63. It is clear from consideration of these cases that there remain a number of areas of practice that require improvements, despite the efforts of partner agencies and the Partnership to ensure that the learning from reviews is disseminated and that recommendations have been implemented. Considering why previous learning has not made an impact on practice needs further consideration and is one of the main findings from this review.
64. There is a lot of work taking place in Bradford regarding domestic abuse, and this review will not replicate recommendations.
65. The following recommendations are made however:

Recommendation 1

[23] NSPCC June 2020 Isolated and Struggling Social isolation and the risk of child maltreatment in lockdown and beyond.

That consideration is given to how to implement the suggestions included in the analysis sections of this report entitled 'what requires further consideration' (see*) in order to improve practice in and between partner agencies.

Recommendation 2

That a task group is established to explore the following issues that this report[24], along with multi-agency discussions, have highlighted:

- why the changes suggested in previous SCR/CSPRs have not had a sufficient impact?
- how the partner agencies in Bradford manage change?
- what the process needs to be for disseminating learning from CSPRs and other quality assurance activities?
- communication within and between agencies

Recommendation 3

That the Partnership asks the national Child Safeguarding Review Panel to request that the Department of Health provides clear clarification to GPs regarding how they can safely and legally record information on adult records when there has been domestic abuse in a relationship.

[24] There are other reviews being completed in Bradford at this time and there is a plan to consider this recommendation being made across the reviews.