**COVENTRY SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW**

Independent overview report of the Serious Case Review concerning the death of Baby C

Date of report: January 2016

Agreed by Coventry Safeguarding Children Board: 17th February 2016

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## 1. SUMMARY OF THE CASE

1.1 This review was commissioned by Coventry City Local Safeguarding Children Board (LSCB). The subject of this serious case review (SCR) is Baby C, who died at the age of 11 months in April 2014 after being left unsupervised in the bath with Sibling 1, aged two years.

1.2 The LSCB met and agreed that the baby's death met the threshold for a serious case review in accordance with the Local Safeguarding Children Boards Regulations 2006 (Regulation 5).

1.3 A serious case review is undertaken where the abuse or neglect of a child is known or suspected and the child has died. This review, however, was not able to establish the reason for the circumstances that led to the death of Baby C and concluded that the sad death of Baby C could not have been predicted or prevented by the professionals involved.

## 2. METHODOLOGY

2.1 Two independent overview authors were commissioned and the methodology agreed, as set out in Appendix 1. The methodology is compliant with the requirements of Working Together 2013 and 2015.

2.2 The government has introduced arrangements for the publication in full of overview reports from serious case reviews. Accordingly, this report has been appropriately anonymised.

2.3 A lengthy and detailed report was initially developed by Jane Wiffin and Nicki Walker-Hall. The LSCB commissioned a briefer report more proportionate to the case. In addition, some minor re-adjustments were made to the terms of reference. Daryl Agnew an independent author was commissioned to undertake this work.

## 3. THE SCR PROCESS AND TERMS OF REFERENCE

3.1 The LSCB commissioned a multi-agency panel of senior managers to oversee the review (Appendix 2). The panel agreed the terms of reference (Contents page 2) which provided the framework for analysis for the single agency reports, i.e. the Individual Management Reviews (IMRs). The agency report authors reviewed local records, policies and procedures relating to this family and included interviews with the professionals directly involved in the case.

3.2 It was agreed that the scope of this review would be the 22 month period from when Sibling 1 was brought for the 6 week check to the date of the critical incident involving Baby C in April 2014.

3.3 The panel met on a number of occasions to review the single agency reports and the analysis of the content included in the draft reports provided by the overview authors. In addition, two practitioner events were held to ensure that the information was accurate and the analysis and conclusions of the report were reflective of the experiences of the professionals involved.

## 4. FAMILY OVERVIEW

4.1 Table 1 includes the family members who had contact with the professionals during the review period.

**Table 1: the family**

| **Baby C** | Died age 11 months | Dual heritage (white & white/black Caribbean) |
|---|---|---|
| **Relationship to child subject within the review** | **Age at start of the review** | **Ethnicity** |
| Mother | 22 | Dual heritage (white/black Caribbean) |
| Father | 28 | White British |
| Sibling 1 | 2 | Dual heritage (white & white/black Caribbean) |
| Ex-Partner of Father | Not Known | White British |
| Half sibling 1 | 7 | White British |
| Half sibling 2 | 3 | White British |
| Maternal grandmother | 48 | White British |

## 5. INVOLVEMENT OF THE FAMILY

5.1 The mother and father of Baby C both agreed to be interviewed as part of the review process. The interviews were undertaken by the overview authors and facilitated by the current allocated social worker. Each parent was interviewed separately and then interviewed together. Their views have been incorporated within the relevant sections of the report.

## 6. CHRONOLOGY OF PROFESSIONAL INVOLVEMENT WITH THE FAMILY

6.1 The scoped period of the review covers the 22 month period of professional involvement with Baby C and the family from the birth of Sibling 1 until the date of the critical incident. The antenatal and postnatal records for Sibling 1 indicated that there were no early concerns.

6.2 This section does not provide any comment, analysis or conclusions as these are covered in the subsequent sections of this report.

6.3 Both parents attended the GP appointment for the routine 6 week check when Sibling 1 was assessed as developing appropriately. The GP encouraged the mother to see the health visitor and offered some counselling for her 'low mood', reported by the father. This consultation was not shared directly with the health visitor and a subsequent GP visit two months later did not record any further concerns.

6.4 Six months later when the mother was 18 weeks pregnant with Baby C, she attended the community midwifery clinic, accompanied by the father although they were not living together at that time. This first appointment was six weeks later than normal. The mother was aware she had delayed seeking professional involvement and reported that she had 'tried to ignore the problem'. Coincidentally, she saw the same community midwife from her previous pregnancy who recalled that the mother had reported good family support from her own mother. (Sibling 1 was with maternal grandmother during this midwifery appointment.) Mother reported smoking, drinking alcohol occasionally but not the use of any drugs.

6.5 The mother's contact with midwifery was routine for the remainder of the pregnancy. All missed appointments by the mother were promptly followed up. The father accompanied her to most appointments. No concerns were noted and the mother was referred for Healthy Start support, a government initiative for low income families which provides food vouchers.

6.6 Following a referral by the midwifery service, a stop smoking adviser SSA visited the mother when she was around 20 weeks pregnant. The mother presented as a single parent and the SSA was concerned she was isolated, depressed and had minimal support. The SSA suggested she contact her GP for advice, attend the Sure Start programme and make contact with the health visitor for support. The SSA's concerns were shared with the midwifery service who agreed to contact the mother's health visitor. Intermittent contact continued until three weeks after this initial visit when the SSA contacted the health visiting service directly to express her concerns about the mother's isolation and social circumstances. She was told there would be an assessment of need undertaken.

6.7 On the same day, a nursery nurse undertook the routine 8-12 month assessment for Sibling 1 who was assessed as meeting all appropriate milestones. Mother provided similar information to the nursery nurse about her personal circumstances and reported that the SSA was 'supporting her'. The nursery nurse offered advice and relevant information and subsequently updated the health visitor about this visit.

6.8 Three weeks later, the father's ex-partner told a professional from the Children and Family First Team (CFF) that she was concerned because her children had said on return from a visit with their father (also father of Baby C and Sibling 1) that there had been a lot of shouting and arguing and the mother had hit Sibling 1.She also reported

previous concerns about Sibling 1 being hungry and the parents spending money on 'weed' (cannabis).

6.9 All concerns were shared verbally with Children's Services with the exception of the allegation of cannabis use. This piece of information did not appear in the contact or referral to social care made on that day.

6.10 It was agreed to undertake an initial assessment. A social worker and social work assistant undertook a home visit to the family two weeks after the referral was made. The allegations of hitting Sibling 1 were vehemently denied by the parents. The child was checked for bruising and none were found although this is not surprising given that three weeks had elapsed since the alleged incident. The social worker had no concerns about the interaction observed between Sibling 1 and the parents. The parents were not told the source of this referral. The father's children who made the original allegation were not seen and no contact was made with the father's ex-partner.

6.11 The health visiting service and the GP were informed about the nature of these reported allegations. Neither reported concerns arising from their work with the family. However, no contact was made with the midwifery service.

6.12 The mother's claim during the Initial Assessment visit that she was attending the Children's Centre was checked subsequently by the social worker and found not to be true. The parents were offered parenting support via a voluntary assessment of early support (the Common Assessment Framework (CAF)) which they declined.

6.13 Mother gave birth to Baby C eight weeks later and her midwives saw her routinely after the birth.

6.14 Two weeks after the birth, a health visitor completed a new birth visit and the Family Health Assessment. She had no information about Sibling 1 or mother's previous contact with professionals. The family circumstances had changed: mother had moved into new accommodation, was no longer in a relationship with the father but said they remained friends. She was asked about domestic violence and abuse but made no disclosure. She reported that she and the father smoked tobacco and cannabis. The health visitor developed a plan of support to be provided by the nursery nurse.

6.15 At the routine 6 week assessment by the health visitor, Baby C was assessed as developing appropriately. The home was clean and tidy and Sibling 1 appropriately dressed and reported to be sleeping better. Mother was reported to be coping well and interacting appropriately with both children. Support was offered from the nursery nurse because they were a young family with a new baby and an older child with sleep problems.

6.16 When the nursery nurse visited two weeks later, the parents were at home but both children were staying with the maternal grandmother. The parents at that time

reported the children to be well. A visit was re-arranged but the nursery nurse would not see the family for another five months.

6.17 When Baby C was 10 weeks old, a family support worker (FSW) from the voluntary service supporting the father's ex-partner, contacted the Family First Team to report concerns about the level of arguments witnessed by the siblings when they had contact with their father. The team reported they had already raised the same concerns with Children's Social Care who were now involved. The FSW telephoned Children's Services directly and was told that an assessment had been completed five months earlier, the allegations not substantiated and the case had been closed.

6.18 Over the next three months, there were three incidents involving the police as a result of disputes between the mother and the maternal grandmother. When Baby C was 12 weeks old, the police were called to the maternal grandmother's address where she made various allegations about Baby C's mother, including a threat by her to 'smash up' the house. There was no mention of the children and no information was shared with any other agency.

6.19 Further incidents between mother and the grandmother, including an abusive text sent by the mother, involved the police and were assessed (using the DASH) as a standard risk. A referral to the multi-agency screening process assessed this to be Level 1.The Domestic Abuse notification was viewed by the health visitor but no further action was taken because it was graded Level 1, involved the two adults and there was no indication that the children were present. Children's Social Care only became aware of this incident two months later when it was agreed there would be no further action.

6.20 Five months after her initial visit, the nursery nurse made two subsequent visits. All the family were present on both occasions and the children were observed to be developing well. On the first occasion, mother reported feeling low and lacking support from the father. Offers from the nursery nurse of a referral to a voluntary service or a CAF were declined but the nursery nurse said she would discuss these concerns with the mother's health visitor. At the second visit, two weeks later, mother reported that she had arranged a GP appointment for two weeks' time. Discussions with both parents included how the father could support the mother as she was still feeling low. Following discussions with the health visitor, it was agreed the nursery nurse would contact the GP to get an earlier appointment for the mother, which she did. The GP agreed to telephone the mother in three days' time.

6.21 On the day of the planned telephone consultation, mother attended the surgery because Baby C had a cut and swollen hand, and was advised to go to A&E as the wound looked infected. Mother told the A&E doctor that the father had dropped a glass dish on the floor which broke. Later, when crawling, Baby C cut his hand on a piece of glass causing a small cut. Baby C was discharged following treatment.

6.22 A planned visit by the health visitor took place the following week when mother disclosed that she had been physically, emotionally and financially abused by the father for the last 18 months and the incidents were becoming worse. An appointment was made for her with the domestic violence service for the following week. (She did not attend.) The health visitor advised her to contact the police as necessary and to keep the planned GP appointment. Another visit the following day reported that the children were 'well cared for' but mother reported she had not eaten for two days. The health visitor agreed to issue a food voucher and completed the domestic abuse risk assessment tool (DASH) with her.

6.23 The following day, the health visitor made a referral to Children's Services regarding the domestic abuse, the mother's low mood and her allegation that the father took money from her for cannabis and alcohol. This telephone referral was followed by a written referral faxed through to the Referral & Assessment Service (RAS) which included information about these concerns. The health visitor also reported that the mother had tried to separate from him but was scared he might abduct the children.

6.24 In the following days, food vouchers were provided. The mother did not attend either the planned GP appointment or the domestic abuse appointment.

6.25 The health visitor's referral to Children's Services (6.23) was viewed by a Team Manager and it was agreed that a Child and Family Assessment should be undertaken around risk and need. The health visiting service received a fax and telephone message to this effect.

6.26 Four working days after the referral, the allocated social worker telephoned the health visitor office to ask about any concerns regarding the health and development of the children. It was reported that there were no concerns about the children but that food vouchers had been requested by the mother. Information was also provided about the nursery nurse's work with the mother, including play and parenting support and concerns about the mother's low mood at times. It was agreed that children's social care would be in contact after the assessment was completed.

6.27 The social worker visited the family the following day. Mother reported that she and the father had ended their relationship and gave detailed information about the risk she felt he posed but also how she planned to keep her and the children safe.

6.28 The Child and Family Assessment was completed six weeks later. Social care made no further contact with the family or health professionals. The nursery nurse and health visitor continued to visit and provide support.

6.29 Two weeks after the social worker visited, the health visitor completed Baby C's 8-12 month review and assessed baby as progressing satisfactorily. Mother reported she was struggling financially and the health visitor provided food parcels and advice about debt management. The mother was again encouraged to see her GP regarding her low mood. Mother reported she was no longer in a relationship with the father and there had been no further incidents of domestic abuse. Mother said that

she would not engage in an early voluntary assessment for support (a CAF) and was reluctant to attend the local Children's Centre. At this point, the health visitor changed the care pathway from 1 to 2.

6.30 Five days later, the police received a 999 call with no one on the line and swearing in the background. A call back reached an answer machine. Mother then called the police and said that a child was playing with the phone and officers were not needed. A police check of records identified three similar incidents four months earlier where children had reportedly been playing on the phone.

6.31 Two subsequent visits to the family home by the health visitor assessed both children as well and a positive attachment with the mother was recorded. Mother reported that the father had been to the home to see the children but they continued to be separated.

6.32 Six weeks after the initial referral, the Child and Family Assessment was completed, in line with the local timescales. Mother provided a significant amount of information during the assessment including her involvement with Children's Social Care historically. The conclusion was that 'although at present there are no child protection concerns and care of the children is good, this would degenerate should parents resume their relationship again.'

6.33 The assessment concluded that the children's needs met the criteria for support through the Children and Family First Team at level 3 which indicated there were complex needs. (There are 4 levels of need, with level 4 the highest.)

6.34 Ten days after this decision about support, a decision was made by Children's Social Care that the case would be held at early help which is level 2 CAF, with a recommendation that the health visitor hold the case. It is not clear if this recommendation was acted on by Social Care.

6.35 During this time, Sibling 1 was brought to hospital following a fall resulting in a laceration to the head and Baby C as his finger was shut in a door by Sibling 1.Both incidents were dealt with routinely and the health visiting service informed.

6.36 Baby C was brought to the children's emergency department by ambulance following an emergency call from the mother. She had found Baby C submerged and lifeless in the bath with two-year-old Sibling 1. Mother had left the bathroom for a reported period of between 5 and 10 minutes while both children were left unsupervised in the bath. Baby C was taken to hospital and spent a period of 4 days on a life support system. Following consultation with the family, the life support was withdrawn as Baby C had suffered significant neurological injury not compatible with life. Baby C subsequently died.

## 7. ANALYSIS

7.1 This section considers the questions as agreed within the terms of reference for the review (Contents page 2) to determine the extent to which they have a bearing on the death of Baby C.

**Referral and assessment**

7.2 Referral and assessment practice across all agencies indicated a need for improvement.

7.3 The Referral and Assessment Team were under extreme pressure at the time with high caseloads and high referral rates being the norm. Nonetheless, in principle, all referrals, including those that appear to be replicating a previous referral, should be investigated to ensure that a systemic pattern of behaviour or abuse is not occurring.

7.4 The point of referral is vital as a starting point for assessment. It is therefore essential that written referrals are made that fully accord with the verbal information that is shared, and include the details of all those professionals known to have had direct contact with the family. This should lead to a full assessment of all the relevant issues.

7.5 Overall, the appropriate referrals were made. In the main, the responses to them were also appropriate but they fell short on the investigation of the repeat referral due to the workload pressures at that time. There is no evidence to suggest that this shortfall made any difference to the outcome for Baby C.

7.6 While there were some examples of comprehensive assessment, individual practitioners missed the opportunity to improve the family's access to support by not sharing the assessment outcome information with the relevant agencies. Pertinent information was often not communicated and shared with all the agencies involved.

7.7 On occasions, professionals failed to recognise or address in their assessments the impact of the parents' behaviour and lifestyle choices on their children.

7.8 An assessment of the mother's wellbeing occurred when she visited her GP for Sibling 1's 6 week screening test. The disclosure of her low mood triggered the appropriate referral to the health visitor who subsequently facilitated an assessment that did not reveal any postnatal depression. There is no evidence to suggest that her low mood had an impact on her ability to care for her family. In fact the evidence presented indicated that the children were well cared for.

7.9 An Initial Assessment was completed in response to the first referral regarding physical abuse and parental arguments. These allegations were 'vehemently' denied by the parents and the social worker observed Sibling 1 to have no bruising. However, as three weeks had elapsed since the incident there was unlikely to be any bruising. Although the father's ex-partner made the allegation, no one from her family was spoken to as part of the assessment. The conclusion that the concerns were unsubstantiated was therefore over-reliant on the parent's own report that it did not

happen. Overall, these issues meant that the Initial Assessment was overly superficial and relied too heavily on 'parental self-report'.

7.10 During assessments, positive relationships were observed between Sibling 1 and both parents but the allegations of adult arguments should have led to an exploration of the parents' willingness to put the needs of the children above their own. Support for the family through the Common Assessment process was offered and declined on more than one occasion but alternative solutions for support were not explored and the parents' decisions were not sufficiently challenged by professionals.

7.11 There were several incidents where the parents were found to be knowingly misleading professionals by providing inaccurate information. This was not challenged by the professionals and the case was closed without further assessments.

7.12 There was evidence of some positive communication across agencies. However, this did not extend to the midwifery service. Despite mother being seven months pregnant, opportunities were missed to monitor the impact on mother and the unborn child.

7.13 The Family Health Assessment was undertaken by the health visitor in a timely way when Baby C was born. Mother was asked routinely about domestic violence and abuse, and she confirmed her use of cannabis and smoking. The health visitor was not aware of earlier concerns about possible depression or the recent involvement of Children's Services as she did not have access to the records of the siblings. Based on the information available to her, the health visitor formulated a plan of support for a young family with a child with sleeping difficulties to be carried out by the nursery nurse. This support however was delayed by five months due to a lack of capacity within the health visiting team. Since these events, Coventry has now recruited a significant number of additional health visitors to the team.

7.14 A Child and Family Assessment regarding concerns about domestic abuse failed to include the father as part of the process. As a result, opportunities were not taken to explore why he was not claiming benefits and was relying on the mother for financial support. The concerns about domestic abuse were described in the assessment but were not sufficiently analysed. Information was not sought from the police so the disputes between mother and the maternal grandmother were not known and the impact on the children not considered. This was a family struggling with the co-existence of domestic abuse, substance misuse and poor mental wellbeing. The impact of living in these circumstances on these young children was not fully assessed or addressed.

7.15 The mother's willingness and her capacity to engage were not sufficiently analysed. She made it clear in assessments that she did not feel able to attend the GP appointment or the support services. This was a recurring pattern which appears to

contradict the social worker's opinion that she was willing to engage with support through the common assessment process.

7.16 The plan to provide support via the Child and Family Support service was appropriate, and at this point the case should have been transferred to the Children and Family First team. A transfer summary was completed but the planned handover visit did not take place. The decision was then made that the case would be held at early help (level 2 CAF) with the recommendation that the health visitor hold the case. There is no clear rationale for this decision, nor was the health visitor informed.

7.17 Assessments should rarely be done in isolation. It is essential that all assessments are informed by contact between the key agencies and individuals. Information known to any professional should be shared with all those with an ongoing involvement with the family; in this case, with the GP, health visitor, nursery nurse and midwifery when relevant.

7.18 Assessments were done at key points but were not always sufficiently comprehensive and relied heavily on parental self-reporting. Action was not taken in line with the decisions made. There is, however, no evidence that this contributed to the outcome for Baby C.

7.19 All social work assessments that conclude there is ongoing work required by partner agencies, should be shared with those charged with taking the issues forward. This should be a standard inclusion in discussions with parents so that they are clear that permission is being sought from them to approach other agencies at the beginning of the assessment process.

**Early Help**

7.20 The mother went to see her community midwife at 18 weeks pregnant and was aware that she had delayed seeking midwifery support. This is unusual as more than 85% of women in Coventry book before the 12th week of pregnancy. This delay is an important risk factor for maternal and foetal complications. Possible uncertainty in pregnancy should be explored. Current practice in Coventry is that mothers who book late and are ambivalent about their pregnancy are prioritised and their mental health is also considered.

**Children's experiences**

7.21 Sibling 1 and Baby C were both less than two years old during the period under review. Overall, there is evidence that professionals considered the children in their work with the family. Attention was paid to their development by health professionals and the positive interaction between parents and children were commented on by all the professionals. What was lacking however was any one professional asking the mother or father to reflect on their actions in the context of the needs of the two young children.

7.22 The father had two older children, half siblings of Baby C and Sibling 1.They raised concerns about adult arguments and made an allegation about the physical abuse of Sibling 1. It is often very difficult for children to articulate when the behaviours of their parents are placing them at risk or impacting on them negatively. It is therefore essential that those concerns are both acknowledged and acted upon.

7.23 All professional referrals made as a result of a child's disclosure should trigger a response between the assessing social worker and the child. In cases where there are barriers to communication this may be done through established alternative communication techniques by professionals who know the children or through an advocate for the child.

7.24 Overall, the evidence from professionals is that both Sibling 1 and Baby C were well cared for in spite of the issues in the lives of their parents. There was a failure to respond to the half-siblings about the issues they had raised and the parents were not challenged to consider the impact of their lifestyle on their children. There is no evidence however, that these matters had any bearing on the outcome for Baby C.

**Domestic violence and abuse**

7.25 There were a number of verbal altercations between mother and the maternal grandmother, one of which was referred to the Coventry domestic violence and abuse joint screening process. No further action was taken as the case did not meet the thresholds for intervention at that time. The health visitors were informed – and children's services were made aware. However, there was some delay in receiving this information. It is not clear why.

7.26 There were a number of missed opportunities to explore possible indications of domestic violence and abuse. These included: at the initial assessment; at the Child and Family Assessment when there was no reference to the DASH assessment, or to mother's low mood; and the failure to contact the police. The assessments should have been more comprehensive. However, there is no evidence that this would have had an impact on the outcome for Baby C.

**Parental emotional wellbeing**

7.27 A number of professionals had concerns that the mother may have been low in mood. She was reported to be emotionally well so these concerns were not substantiated by any formal assessments. The potential impact of maternal mental wellbeing on the mother's ability to care for her children was not fully explored. Health professionals should routinely consider the impact of maternal low mood on the welfare of children.

7.28 The slightly fragmented response from health agencies meant that although the early worries about the mother's emotional wellbeing were shared, the long standing pattern of poor emotional wellbeing and a reluctance to seek help regarding this were not. It was acknowledged that the mother was struggling, finding it difficult to go out or attend appointments, but drew no conclusions regarding her ability to engage with support services. The assessment did not sufficiently reflect on the possible

implications this had for these young children. Since the review, the 'Acting Early Pilot' has been established which has resulted in significant improvement in inter-agency communication. Similar cases are now discussed at regular monthly multi-disciplinary meetings, enabling early interventions to be put in place.

7.29 Some agencies held information about the parents' use of cannabis but this was not always shared and consequently not seen as an area of significant concern at the time. The extent of their cannabis use was not recorded. The link between cannabis use and low mood/depression was not recognised or assessed as a possible contributory factor by professionals. Some analysis of the parents' drug use and the impact on family life and their parenting should have been undertaken.

7.30 As part of the SCR process, the parents talked about the impact of their cannabis use on their responsiveness to their children, and their relationship. They suggested that professionals did not highlight this as an issue and that it was only during their involvement in the child protection process that they both recognised this was a critical issue with regard to their parenting. Since this review, the city drug strategy has been developed which encourages professionals to examine the impact of substance misuse on the ability to parent positively.

**Information sharing and multi-agency working**

7.31 Despite all professionals recognising that both parents needed help and support with their daily life, when offered it was consistently declined. This failed to trigger any alternative remedial actions for the family. There is evidence that inter-agency communication was poor and as a result, comprehensive assessment opportunities were missed. A multi-agency approach could have provided more positive support for the family.

## 8. CONCLUSIONS

8.1 The overall findings from this review are that Baby C's death could not have been predicted or prevented by the professionals involved with the family. This review has identified some shortcomings in practice and some learning points but there is no evidence to suggest any causal link between these shortcomings and the death of Baby C.

8.2 In the main, when professionals visited the family home they observed a mother, and, at times, a father who provided appropriate care and attention for their children, despite significant difficulties and disadvantages.

8.3 This review has not been able to establish the reason for the circumstances that led to the death of Baby C. What has emerged is a concerning but familiar picture of the early stages of poor parental mental health, issues of domestic abuse and cannabis misuse. This has been recognised as a common theme in reviews locally and nationally.

8.4 There is evidence that the right referrals were being made and by the right people but the information was sometimes lost, incomplete or not acted upon. The failure to explore maternal wellbeing meant the impact on the family and relationships was not well understood. This, together with a lack of assessment of the couple's cannabis use and limited reporting of the domestic abuse meant that the level of risk was not recognised. A poor referral and assessment process hindered the identification of the potential risks and needs of both the children and adults.

## 9. RECOMMENDATIONS

### 9.1 Recommendation 1

**Social Care**

When a social care decision is made for a case to be transferred to a higher or lower level of priority, the decision and rationale for this must be clearly communicated across all partner agencies involved with the family.

### 9.2 Recommendation 2

**a) Social Care**

All professional referrals made in response to a child's disclosure must result in the assessing social worker contacting the individual young people who have raised the allegation. Where there are known barriers to communication, the professionals involved should seek alternative methods of intervention to support the communication process which may also include advocacy support.

**b) All agencies**

When a young person is sharing a safeguarding concern with professionals about themselves or another young person, all necessary support should be given to allow that disclosure to be made including advocacy support.

### 9.3 Recommendation 3

**NHS England (as commissioners of primary care), Public Health (as commissioners of the health visiting service) and the Clinical Commissioning Group (as commissioners of maternity services) all GP Providers, Coventry and Rugby GP alliance, Coventry and Warwickshire Partnership Trust (CWPT) and University Hospitals Coventry and Warwickshire NHS Trust (UHCW).**

It is recommended that general practice managers with the primary care team facilitate regular meetings between all health professionals involved in the delivery of care for the 0-5 age group. This will provide a more structured opportunity for regular and ongoing discussion about vulnerable families and will enable a coordinated approach to the provision of health care and support, including signposting and referral, where appropriate.

### 9.4 Recommendation 4

**LSCB**

The LSCB should continue to monitor individual agency progress on responses to domestic violence.

## 10. APPENDICES

### Appendix 1: Methodology

For this SCR, we propose to use a systems based methodology underpinned by the principles in Working Together 2013. We are using a defined data collection process which includes a review of agencies' records, interviews with the professionals involved, agency analysis and appraisal of practice followed by a practitioner event to understand further the human factors at play. Cross referencing of this data, with agency and Local Safeguarding Children Board policies and procedures, will add to the review of the systems in place. The critical incidents in this review will be drawn out for the expert panel, who will in turn draw out the lessons and thus the learning for the future.

### Appendix 2: Multi Agency Panel Members

| I D | Agency Representation |
|---|---|
| RS | West Midlands Police Force |
| KM | University Hospital Coventry &Warwickshire NHS Trust |
| JP | Coventry & Rugby Clinical Commissioning Group |
| PG | Coventry & Warwickshire Partnership Trust |
| DC | Coventry City Council Social Care |