Child Safeguarding Practice Review (CSPR)

Skylar[1]

Contents

1 Introduction

1.1 In 2021 the PSCP agreed to undertake a Child Safeguarding Practice Review, as they recognised the potential that lessons could be learned about the way that agencies work together to safeguard children in Portsmouth by the considering a case of a young baby to be referred to as Skylar.

1.2 The professional involvement with the family of Skylar was reviewed in order to identify learning for the wider systems and for practice in cases where there are parental risk factors that may impact on the care and protection of a child. The case raised issues about the identification of risk pre-birth and the response to concerns about the future care of a baby where the parent is vulnerable due to their mental health, learning needs and a history of seeking support with suspected fictitious illnesses.

1.3 Learning was been identified regarding:

- The need to access and consider all available information on the parents when making a referral, undertaking an assessment or challenging another service in respect of an unborn baby
- Effectively giving and receiving challenge
- Recognising the potential risk to a child if a parent has a complex history with mental health issues that include a tendency to fabricate illness
- Considering and engaging the father

2 The Process

2.1 An independent lead reviewer was commissioned[2] to work alongside local professionals to undertake the review. Individual agency chronologies, including analysis, were provided to the Rapid Review. They identified important single agency learning that the wider review has built on. The agencies involved included those predominantly providing services to adults.

[1] This is a non-gender specific name chosen by the child's Mother

[2] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer of Serious Case Reviews and Child Safeguarding Practice Reviews and is entirely independent of the PSCP

2.2 Professionals who had been involved at the time were included in discussions about the case, along with agency safeguarding professionals. Due to the on-going response to Covid-19, three practitioner participation sessions[3] were held in August 2021 using video technology.

2.3 The lead reviewer spoke with Skylar's mother during the review in order to identify any learning from her perspective. Skylar's father did not respond to a request to engage with him.

3 The case considered

3.1 Skylar was born in hospital and went home to live with parents shortly afterwards. The baby was putting on weight as expected in the community and was seen regularly by midwives, the health visitor and the perinatal mental health service. When the baby was three weeks old the mother took Skylar to hospital by ambulance reporting a number of health issues. There was no evidence of any concerns following tests and professionals raised concerns about the risk to the child of the mother fabricating illness.

3.2 Skylar's mother had a very difficult childhood. She was in the care of the local authority until she was 18 where she experienced a number of placement breakdowns, including spending time in residential care where she was known to pose a risk to herself and potentially others. Both adult mental health and the learning disability service knew Skylar's mother due to her moderate learning disability and mental health issues, although she did not tend to engage with support. Over ten years after she left care she became pregnant with Skylar, her first child.

3.3 Very little was known about the father of the baby beyond his name and date of birth during the pregnancy. It is now known that he was well known to children's services in another part of the country due to the physical abuse of his older children.

4 The Learning

4.1 At the request of the PSCP this report will focus on what is considered to be the most important learning from the review. The learning points are identified below and are followed by a summary of the analysis enabled by this review of Skylar's case.

Learning point 1:

When considering if the threshold for a referral for a social work assessment is met, health professionals should review all of the information available, including the parent's history. This history and a detailed analysis of why there is a risk of significant harm should be clearly reflected in any referral sent to the MASH and all available health information should be considered in any assessment undertaken.

4.2 Considering the case of Skylar enabled those involved to reflect on the importance of ensuring that any referral, sharing of information or challenge is accompanied by details of all the information known about the family and clear and focused reflection on what risk this may hold for an unborn baby. This is not as straightforward as non-health professionals may assume, as there are numerous health systems that are not accessible to all who work with a patient. Even within one hospital there are

[3] The sessions were organised via Teams. The first focused on the early identification of risk by health professionals and the quality of referrals to CSC, the second focused on professional curiosity and the whole family approach, the last considered professional challenge. Other issues were also identified in the sessions and are included in this report

numerous IT systems, and it is difficult to find all of the known information on a patient. Skylar's mother frequently attended A&E prior to and during her pregnancy, and the maternity assessment unit while pregnant. She told the review that she found the maternity unit very helpful and supportive. The community midwives who saw her regularly and who consulted with other professionals about the case were not aware of these attendances at the time however. They shared during the review that they usually rely on the expectant woman to disclose a hospital attendance, and they will then check the systems to find out more. In this case Skylar's mother did not share this information and as there was no process in place for this information to be shared routinely with the midwives, they were not aware of this as a potential issue for unborn Skylar. The review was told that a working group is now in place to ensure that this information sharing gap is addressed in future. As the mother in this case often also attended hospitals in neighbouring areas, there needs to be professional curiosity when trying to establish the extent of any issue.

4.3 All referrals about children where professionals have a concern are sent to the MASH email address. In this case there were four referrals by health professionals in the pre-birth period due to concerns about the potential impact on the baby of mother's issues. The first went to the MASH and the next three were forwarded to the team who undertook the first assessment for management overview, as it was less than three months since the case closed. The first referral was from a midwife and contained information about the mother being care experienced and having mental health issues. As is expected and good practice, the MASH health navigator summarised much of the mother's extensive history, including stating that there were on-going concerns due to the mother's learning disability and mental health including recent overdoses, and her numerous concerning attendances for reported but not evidenced health issues. They recommended a pre-birth assessment and a S47 response to consider the extensive and complex history and the potential impact on the baby. The review established that this was a helpful piece of work which went some way to sharing the history. Although it was available on the I.T system, it was not considered by the social work team who undertook a visit to complete the children and family assessment. No checks were then undertaken with any health professionals who knew the mother during the assessment and before a decision was made to take no further action.

4.4 In a neighbouring authority the MASH has a system where the health navigator creates a case note on the social care system, which makes their work more accessible to those undertaking the assessment. The review also asks whether this helpful piece of work should also be available to other professionals working with the family, such as health visitors. The review established that this information is included on SYSTM1 which is available to a number of health agencies. There was no evidence it was accessed in this case by those who were working with Skylar, this appears to be because the case note was placed onto the mother's record as there was no record at the time for Unborn Skylar. Those making referrals, working with a family or escalating concerns about another agency's response need to ensure that they know as much as they can about the risks and vulnerabilities within a family, and this includes seeking and accessing available information on the parents. The piece of work undertaken by the health navigator in the MASH following the first referral was available to be used and built on by those assessing, by those making further referrals and those later escalating their concerns about the proposed response and the assessments made, but they were not aware of it. It

was only when this review was undertaken that the majority of those involved with Skylar were aware of it and its contents.

4.5 The MASH manager confirmed to the review that there is an expectation that when a referral is moved from the MASH for a social work assessment, that all of the information that the MASH provides needs to be considered. A lot of work has been undertaken on the quality of information seeking and sharing in the MASH. It is generally thought to be high quality and has received compliments in inspections and audits. It is therefore essential that this work, understanding and analysis are considered by those who are then going to undertake the assessment. There is also an expectation in local procedures that during a child and family assessment parental consent is sought for direct communication with the professionals who know the family, including those working with the adults. The recommendation from the MASH was for a pre-birth assessment and it was clear that there was a belief that there were enough indicators of potential harm to justify a through and robust assessment.

4.6 There is no specific pre-birth assessment tool/model in Portsmouth. The review was told that the children and families social work assessment process would be used but that there should be a focus on preparation for the birth, the potential to care for a baby and what family support was available. While Children and Family Service (CFS) professionals have stated during this review that they undertook thorough assessments, the assessment completed was based on just one-off single agency visits that largely relied on the mother's self report and did not consider the extensive history before concluding that further social work involvement was not required. The issue of pre-birth assessments was raised by the national Child Safeguarding Practice Review Panel in their September 2021 national CSPR 'The Myth of Invisible Men'. They found that improvements were required in this area and suggest that partners answer the following questions: 'Have you audited the quality of pre-birth assessments, are they undertaken as early as needed and are they informed by information and assessments on a multi-agency basis? Are the histories and backgrounds of both parents included in them routinely?' Feedback received from CFS is that it is the expectation that assessments completed on an unborn baby should include more than a one-off visit, should include historic information on both parents and require checks with those working with the family, such as midwives, adult mental health services, the parents GP, and so on. A recommendation has been made in regard to this.

4.7 The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Unborn/Newborn baby Protocol was updated and published in March 2021. It states clear multi-agency expectations when there are concerns for an unborn baby. It includes clear pathways and templates for pre and post birth plans, and a one-minute guide for health care staff who may identify pregnant women where there are existing risk factors that may impact upon the wellbeing of their unborn/ newborn baby. There was no reference to this policy in this case. Although the updated version would not have been embedded in practice at the time that concerns were emerging about Skylar, the previous protocol was in place and was also not referred to.

Learning point 2:

As stated in the PSCP Re-Think process, giving and receiving honest challenge is a crucial part of any effective safeguarding system.

4.8 In 2008 Munro et al[4] raised the importance of practitioners working in child protection being able to admit they may be wrong and to revise their views following reconsideration and/or challenge[5]. She wrote that 'assessments are fallible, and contexts constantly changing. Therefore, professionals need to keep their judgements under constant critical review'. Munro et al noted a tendency to 'stick to an initial hypothesise' even in light of challenge from other professionals or more information becoming available. There were a number of occasions during the work with Skylar and their mother where an open-minded review of what was known prior to the birth was required.

4.9 The review has seen evidence of communication by email, telephone and in meetings where requests were made that the case be allocated to a social worker and a plan made for the unborn Skylar.[6] The response to this challenge was a request from CFS for more evidence to be provided in order for the threshold to be reached, rather than an understanding that there were other and alternate views about the risks to Skylar from Mother's issues which needed to be considered more thoroughly. In the words of Munro, 'the need to constantly revisit – and if necessary revise – initial assumptions in the light of either fresh evidence or a fresh view of that existing evidence is essential if judgements are not to be rendered unsound as the premises and circumstances on which they were based change.' Although staff expressed that they were worried and voiced their belief that the unborn baby was at risk, there is no evidence of any formal use of the HIPS escalation Policy for the Resolution of Professional Disagreement.[7] This appears to be because of either a lack of knowledge of the policy, the time it was felt it would take to undertake such a challenge, and a hope that progress could be made without it. The fact that this was a pre-birth case gave professionals time to try and persuade their colleagues of the risks they felt would be present following the birth of Skylar. However while there were a number of challenges made directly to the social work team by various professionals around the time of Skylar's birth, they were largely undertaken in isolation and did not include all of the concerns and a joined up analysis of the risks.

4.10 The PSCP have devised their own model to encourage and promote challenge and reflection. 'Re-think' was launched early in 2021. Due to feedback from inspections and serious case reviews, it was acknowledged that there was a need to encourage more challenge. It was known that while some cases can get 'stuck', there was a reluctance to use the formal partnership escalation protocol. Re-think is a new option to allow professionals to pause and reflect with colleagues in an open and collaborative way. There is a hope that it will be used to discuss disagreements like those evident with Skylar. The PSCP believe it will ensure that professionals are less defensive or frustrated and will enable better safeguarding and support for the children being worked with. The review agrees that it is a positive attempt to resolve a long-term issue.

4.11 In the Re-think model an independent facilitator is used from a small pool of suitably experienced staff to find a way forward alongside the professionals involved. In the case of Skylar, the manager

[4] Fish, S., Munro, E. and Bairstow, S. (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews. Social Care Institute for Excellence
[5] 'The single most important factor in minimising errors is to admit that you might be wrong.' Munro et al 2008
[6] https://portsmouthchildcare.proceduresonline.com/p_threshold.html#
[7] https://hipsprocedures.org.uk/skyyty/safeguarding-partnerships-and-organisational-responsibilities/escalation-policy-for-the-resolution-of-professional-disagreement

who had been involved in the initial decision making was asked to review the conclusion of the assessment. To ask the same professionals who have made decisions to then review them without any further scrutiny from someone who was not involved is unlikely to lead to a change in the plan. Particularly when they may understandably feel resentful about the challenge to their own or their team's practice, leading to a defensive rather than open minded review of the case. A model where an independent facilitator is used is a good one to avoid this dynamic.

4.12 The Re-think process was launched in February 2021 and was available around the time that concerns about the response to unborn Skylar were being discussed by various professionals. There was no consideration of using the process, probably because it was very new and not yet embedded. At least one of the professionals involved in the case was not aware of the Re-think process at the time of the sessions held for this review (August 2021) so it appears that further work is required to ensure that it becomes as helpful as is hoped. The review was informed that due to the demands on services from COVID-19, the launch was a 'soft' one and that further work is to be undertaken during 2021 to promote and embed the process.

4.13 Other options were also available at the time, including involving more senior managers in discussions about this case. While this happened to a certain extent in the health agencies and CFS, it had little impact. The involvement of safeguarding leads within health would have been a helpful response that was not used at the time. There was also the potential in the child protection procedures for any professional to call an Initial Child Protection Conference. This rarely, if ever, happens. A number of the health staff involved in this case were not aware this was possible, so the safeguarding leads across health agencies agreed that they will ensure that they put a process in place for future use should this be required. They will also communicate this option across their agencies when and if the need arises.

4.14 The idea of escalating a disagreement is not one that is well understood in a lot of health settings. The concept of asking for a second opinion is more common and is readily used by doctors in particular. Those involved in the review shared that when promoting the 'Re-think' and HIPS escalation policy with health professionals, to compare it to the idea that a second opinion is being sought might be helpful to ensure it is used more readily across health agencies.

Learning point 3:

All professionals need to be aware of the potential risk to a child of a parent who has a complex history with mental health issues that include a tendency to fabricate illness, and of the need to seek advice in such cases.

4.15 As well as her learning disability and the complex and potentially significant mental health issues that the mother had to manage, the impact of her own experiences as a child and her time in care also required robust consideration by the professionals involved in respect of unborn Skylar. Research into Adverse Childhood Experiences (ACEs) shows that when a person experiences numerous types of abuse or neglect as a child, and the longer they experience them for, the worse their physical, mental and social outcomes are likely to be. This includes the possibility that their children will be known to safeguarding services, and that they will require support in the future with their longer-term mental

health. In Skylar's mother's case, she was very well known to partner agencies as a child due to abuse and neglect, and then as a child in care. At one point she was the subject of a child protection plan under three categories at once (neglect, emotional harm and physical abuse.) These experiences were likely to have an impact when she became a parent, particularly as there was little evidence of any services managing to provide the on-going and significant support in her adulthood that she was likely to need in order to recover from her past.

4.16 The 2016 triennial review[8] of serious case reviews stated that abuse and neglect experiences in the parents' own childhood are often found to have posed a risk to their children. Skylar's mother's history made her extremely vulnerable in her own right and means she required support individually and as a parent. Getting her to accept support was likely to require skilled intervention. A survey of over 2000 children in care 'Our Lives Our Care' by Coram Voice and the University of Bristol (2018) found a widespread mistrust of professionals amongst those spoken to. Although Skylar's mother's experience of care had been some years before, she continued to be wary of professionals and she told the lead reviewer that she was very concerned that her child would be taken away. This was likely to have had an impact on her level of candour with professionals, on whether she would accept her need for support, and on her meaningful engagement with professionals. This complication needed to be considered by those involved, particularly those who were assessing her ability to parent, the level of risk to a baby, and the chance of her agreeing to the long term support she was likely to require. She told the review she has found the support more recently very helpful and would have appreciated more support prior to the bay's birth.

4.17 Those who met Skylar's mother stated that she does not admit to having any learning issues other than dyslexia and does not present as having a learning disability. The lead reviewer also noted this when she spoke with her as part of the review. Skylar's mother appears confident and proficient when speaking to professionals, and they were almost exclusively reassured by her presentation. The police noted that they do not have a flag for a learning disability on their system for the mother, which may also be because of assumptions being made about the way that she presents. This can often be the case with adults who are care experienced. The ability to engage with and reassure professionals can be learned and can provide a false sense of security to professionals who are not alert to this possibility. This appears to have been the case with Skylar's mother. Professionals need to ensure that they are balanced in their consideration of the history reported by professionals and by parents, to ensure that all views are given appropriate credence. While it is important to consider the views and history provided by the parent, they should not be the sole voice in an assessment. It is important to include any history and information from adult based services when planning for a child, so that parental self-reporting alone is not relied upon. There was a lot of information available about Skylar's mother that needed to be considered, including reports of her extensive and recent overdoses, her seeking of medication and treatments for conditions including epilepsy, diabetes and a stroke when there is no proof that she had these conditions, and the impact of her low IQ.[9] The fact that she was

[8] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 (May 2016) Sidebotham et al
[9] Said to be around 65, which significantly limits intellectual functioning

open to the hospital high intensity user group as recently as 2020 due to the excessive number of A&E attendances needed to be shared and explored.

4.18 The detail of the mother's time in the care of the Local Authority was largely unknown to those involved prior to the care proceedings starting on Skylar. This was reportedly due to in depth information not being carried over to the new system when Social Care records were migrated in 2019/20. During the meetings with front line professionals, the review was told that historic records need to be requested and this does not tend to occur pre-birth unless significant concerns are identified. When this was questioned with senior managers, it was confirmed historic records are readily available and it is the expectation is that they are accessed when an assessment is being undertaken. The review was told that there are people working for Portsmouth City Council who remember the mother from her time in care and as a care leaver who could have provided helpful background information had they been asked. Professionals need to remember to consult those who have worked in agencies for a significant amount of time. This might include managers, IROs and conference chairs.

4.19 The mental health of a parent should be considered in the context of the impact on the care provided or likely to be provided to a child. This review found that there was insufficient consideration or overly optimistic consideration of this impact during the social work assessments and when the health visitor agreed that early help support via ECHO[10] was likely to be sufficient following the birth of the baby. While ECHO is a positive programme that provides helpful support to those who most require it, there was a concern shared during the review that the limitations of the programme may not be fully understood across agencies. The concerns that were shared by professionals about Skylar's mother's needs prior to and following the baby's birth led to the health visiting service recognising that ECHO alone would not be sufficient to safeguard Skylar and stating this to CFS who had determined this was the most appropriate course of action for Skylar's mother.

4.20 Those with concerns were not entirely clear about the potential risk to a baby from a mother who has a history of fabricating issues about her own health, until the hospital attendance that led to the referral for this review. There was a clear view that Skylar's mother sought attention from health professionals and that there was rarely any real substance to what she reported about her own ailments. Until Skylar's second attendance at A&E when three weeks old, no professional had stated that there was a clear and present risk to the baby of the mother using the child to continue to gain support and attention, and that this could potentially lead to an acceleration of the mother's behaviour. During this attendance she reported that she had called an ambulance as Skylar had gone floppy and was bringing up green bile at home. There was no evidence of any illness following medical investigations, including some invasive procedures to establish whether Skylar was suffering from a twisted gut. The attendance led to a high level of concern from hospital staff given Mother's history, some noted evidence of neglect of the baby and her observed care and handling of the baby while in A&E. There was assertive and positive practice from the senior paediatrician who refused to allow the child to be discharged due to concerns about what could happen to the baby in their mother's care.

[10] Enhanced health visiting offer for families who require additional support due to parental risks/ concerns

4.21 The report of Skylar's condition from the mother in the context of fabricated or induced illness in a young baby is deeply concerning as such episodes can be induced through suffocation or strangulation and parents can escalate behaviours if they don't receive the response they are looking for. The Royal College of Paediatrics and Child Health (RCPCH) published a report 'Perplexing Presentations[11] (PP) and Fabricated or Induced Illness in Children' in March 2021, around a month before Skylar's presentation at hospital. It provides best practice advice for paediatricians in the medical management of PP and FII cases to obtain better outcomes for children, and has led to earlier recognition of possible FII, which may not amount to likely or actual significant harm at the time. The case of Skylar highlights some of the difficulties with this approach as the **risk** of FII may not meet the threshold for safeguarding procedures prior to a serious incident. The guidance is very helpful however when considering this issue, as it 'aims to provide a framework for earlier intervention to explore the concerns of children, families and professionals in order to try, if this is possible, to address the issue of a perplexing presentation well before significant harm has come to the child or young person whilst also outlining when immediate action may be required.' Safeguarding procedures need to be reviewed to ensure that they allow good preventative practice in this area. They already allow for action due to a 'risk' of significant harm, and Skylar needed to be considered as at risk of FII prior to their birth.

4.22 While there is a lot of information available about identifying a child where a PP or FII has happened, there is little research available about the future risk to a child expected by an adult who has a personal history of FII. The research available[12] states that, as in this case, perpetrators of FII are high users of obstetric services and that they tend to require interventions in the delivery, such as inducement of labour or caesarean sections, and that these women require monitoring during pregnancy due to the risk associated with the condition. A high proportion of mothers involved in FII in respect of their children have been found to have a personality disorder - the diagnosis previously given to Skylar's mother. The key signs include 'emotional instability, disturbed thinking, impulsive behaviour, and intense but unstable relationships with others. It is thought that some mothers who carry out FII find the situation of their child being under medical care rewarding.' [13] When there is any concern that a parent's mental health condition may pose a serious risk to a child, specialist advice should be sought in order to understand the condition, the risks and what might help. All professionals need to have open discussions with each other that recognise each other's area of expertise and to ensure that assessments are holistic and based on multi-agency knowledge and experience.

4.23 There was good practice in regard to individual professionals sharing information and their concerns about the mother of Skylar becoming a parent. For example, the GP and the consultant gynaecologist wrote to each other and shared information about the inconsistencies in the medical history that the mother was reporting to professionals. There was evidence of information sharing between adult mental health and the perinatal mental health service and between the midwifery service and the

[11] The RCPCH Child Protection Companion 2013 extended the definition of FII in 2013 by introducing the term Perplexing Presentations with new suggestions for management
[12] The perpetrators of medical child abuse - A systematic review of 796 cases (2017) Gregory Yatesa and Christopher Bass
[13] https://www.nhs.uk/mental-health/conditions/fabricated-or-induced-illness/causes/

health visitor. What was lacking was all of the information and expert opinions being considered together.

4.24 There was no consideration of whether the mother met the criteria for involving the adult safeguarding team or if a referral should be made to the adult MASH in regard to the mother in her own right as a vulnerable adult, despite how well known she was, particularly in the hospital setting. In Portsmouth, there is a commitment to promoting the 'family safeguarding approach'. This should include raising awareness of the criteria for referring to the Adult MASH or taking advice from the Adult Safeguarding Team among professionals in both adult and children's services. A recommendation has been made to encourage and support this.

Learning point 4:

Even where a family report that the unborn baby's father is not likely to be involved in its care, it is important to ensure there is information sharing and consideration of the father.

4.25 Research[14] shows that professionals do not always engage with fathers, that they have limited expectations of them, and that when plans are made to support or protect children it is often assumed by professionals, and the parents themselves, that 'parent' really means 'mother'. When seeking or sharing information and when undertaking any assessment, the father of a child, including of an unborn baby, should not be missed or an after-thought. They should be an integral part of any plan for a child, including considering if they are a risk or a protective factor. When considering what support may be available to a family, paternal families should also be routinely considered. All professionals have a responsibility to engage with fathers and to question any apparent lack of engagement with the father from other agencies.

4.26 When the first referral was made to the MASH early in the pregnancy, checks were undertaken by the police including on the Police National Database (PND) when nothing came up locally. The PND system was down on the day however and checks were not completed later when the glitch was fixed. Further checks were completed following the baby's second presentation at hospital, and again nothing was identified due to the incorrect spelling of the father's name. It was during the Rapid Review process that details of Skylar's father's concerning history were found. Skylar's mother told the review that she was honest with staff at the time about his heavy drinking and verbal abuse. If this is the case, it was not reflected in records or assessments.

4.27 For health professionals there are systems issues that can hinder the meaningful engagement with a child's father. The System 1 templates do not clearly request a father's information, and consent of the father to include him is not easily sought and gained when they are working or not present during appointments. Before a baby is born the records tend to be the mother's and it is not thought to be appropriate to include much information pertaining to the father unless a record is opened for him, which is a possibility if consent is gained. Good practice suggests that a child's Health Visitor should meet with a father or mother's partner, but this does not happen in every case, due to capacity and pragmatic limitations if a father works out of the home.

[14] Family Rights Group, Fatherhood Institute, Daryl Dugdale (Bristol university), Professor Brigid Featherstone (Open University) 2012

4.28 In the case of Skylar, the mother reported that she was in the process of separating from the baby's father and that he would soon be leaving the family home. This was accepted and there is little evidence of any meaningful engagement with him by any agency that was considering the support that Skylar's mother was likely to require when the baby was born. Her word was taken that he would not be involved. This was not checked with him or discussed with them as a couple in order to see if any support could be available in the short to medium term following the baby's birth, and to seek background information on his experience of parenting. The HIPS unborn/new born baby protocol states that 'it is important that all agencies involved in pre and post birth assessment and support *fully* consider the significant role of fathers, partners, wider family members or other significant adults in the care of the baby even if the parents are not living together and where possible involve them in any assessment.'

4.29 There needs to be a whole system focus on the need to engage with a child's father (or other secondary carer) whenever services are being provided to a family. In the 2015 NSPCC report, Hidden Men - Learning from Serious Case Reviews[15]. It is pointed out that men can be 'ignored by professionals who sometimes focus almost exclusively on the quality-of-care children receive from their mother and/or female carer.' Individual practitioners should be encouraged to always to ensure that they 'think father/think man' when working with families. As this review was drawing to a close, the third national CSPR[16] was published. It focuses on the circumstances of babies under one who have been harmed or killed by their father or other males in a caring role. One of the specific questions that the review considers is 'how can the safeguarding system be more effective at engaging, assessing and planning for and with men in the protection of their children (or those for whom they have parenting responsibility)?' A recommendation for the PSCP has been made in regard to this issue.

5 Conclusion and recommendations

5.1 Prior to the birth of Skylar, the referrals, assessments and attempts at professional challenge largely lacked the required detail in both content and analysis. Once the baby born and then when it was presented at the hospital for the second time, there was a good response with clear statements of risk and escalation to ensure the baby was protected, despite a number of professional disagreements. It was not until the baby had been presented at hospital and subject to unnecessary procedures that a child protection response was implemented, and it was then that the extent of mother's own history of fabricating illness was established and the father's concerning history was identified. There had been indicators of concern about the couple's relationship, including the large age gap between them and allegations of verbal domestic abuse made then withdrawn by the mother during the pregnancy, but limited professional curiosity about him.

5.2 It is incredibly hard to predict significant harm in the future in the case of a first time parent where their ability to parent a baby has not yet been tested. The GP described their dilemma as 'my gut feeling was concern, but it was incredibly hard to put the extent of these concerns onto paper, as it was a perceived risk for the future and there was little hard evidence that could be put forward.' The health

[15] https://learning.nspcc.org.uk/media/1341/learning-from-case-reviews_hidden-men.pdf
[16] https://www.gov.uk/government/publications/safeguarding-children-under-1-year-old-from-non-accidental-injury

care professionals who knew the mother wanted her to have the chance to prove herself, but felt she needed to do so with safeguards in place for the baby.

5.3 The review has found the need for a number of recommendations in order to ensure that the learning from this review has a positive impact on practice and systems. They were devised in collaboration with the PSCP Learning from Cases Committee who are responsible for the action plan.

Recommendation 1:

The PSCP to ask all partner agencies to consider the questions included in the National CSPR published in 2021 in order to ensure that services are more effective at engaging, assessing and planning for and with men in the protection of children

Recommendation 2:

The PSCP executive to request a progress report on the embedding of the Re-think model

Recommendation 3:

The PSCP to seek assurance from partner agencies regarding professionals having access to both the historic and current information that is required to make decisions in safeguarding work. This should include consideration being given to health professionals working with children having access to information compiled in the MASH regarding the parents

Recommendation 4:

That the PSCP seeks assurance from Children and Families Service that

- All of the information compiled in the MASH and held by other professionals is sought and considered by social workers undertaking assessments
- Social work assessments completed on an unborn baby include more than a one-off visit, historic information on both parents and checks with all professionals working with the family
- All social work staff are aware of the expectation that historic information (pre-Mosaic) is available and must be accessed when completing assessments

Recommendation 5:

That the PSCP considers the RCPCH report ‘Perplexing Presentations and Fabricated or Induced Illness in Children’ and requests that the HIPS procedures are reviewed to ensure they reflect best practice in this area of safeguarding

Recommendation 6:

The PSCP to work with the Portsmouth Safeguarding Adults Board to plan for raising awareness about making adult safeguarding referrals when required