Local Child Safeguarding Practice Review

Hallie

Review Author:

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Introduction:

1.1 The Local Child Safeguarding Practice Review was triggered by the death of a five month old baby girl, known for the purposes of this report as Hallie on 28 February 2020, which was notified to the National Child Safeguarding Practice Review Panel by Wigan Council Children's Social Care department on 3 March 2020. At that stage police investigations were continuing.

1.2 At around 05:45 on the 28 February 2020, Hallie was found in her cot not breathing and lifeless. Tragically, despite prompt medical attention Hallie could not be revived. The Sudden Unexpected Death in Childhood process commenced, and it was within this initial investigation that concerns about the material conditions in the property, and where Hallie had been sleeping were raised. This, along with the history of Hallie's family with Children's Social Care agencies, prompted the CSINs notification and pursuant Rapid Review. Coronial investigations concluded with a recording of Hallie's death having unexplained natural causes.

1.3 Hallie was the youngest daughter of her mother and father, with three slightly older siblings. All had resided together in a council rented property since 2015. The older children all attended the same local community primary School.

1.4 The review has been undertaken using a systems methodology and root cause analysis, building from the Rapid Review undertaken in March 2020 where initial learning considerations were raised. Due to the ongoing investigations at that stage both from a Police and Coronial perspective, and the impact of the Covid pandemic on all agencies it was not possible to progress with information gathering from agencies at that time and the Local Child Safeguarding Practice Review process effectively commenced in April 2021.

1.5 From the Rapid Review Key areas for further learning were identified and these were developed into themes for Terms of Reference for the report:

- What the Hallie case tells us about the response to neglect strategically and operationally in practice, and what improvements can be made?
- Whether the Thresholds of Need operating over the preceding period leading up to Hallie's death was appropriately applied, and if so if they are assistive to practitioners and preventative of harm?
- What learning can be taken from the Hallie case relating to practice within partner agencies?
- Does Hallie's case provide assurance of the quality and operation of the 'front door' (known as the Multi Agency Safeguarding Team) into services, including at early help level.

- Was the initial and subsequent support afforded to Child's family good quality, and does it present opportunities for learning?

1.6 A LCSPR Panel was formed comprising representatives of the following agencies:

Lead Reviewer
Learning and Improvement Officers, Wigan Safeguarding Partnership
Deputy Headteacher, Primary School
AD/Designated Nurse Safeguarding Children and LAC, Wigan Borough Clinical Commissioning Group.
Service Lead, Children's Social Care
Detective Constable, Greater Manchester Police
Detective Sergeant, Greater Manchester Police Case Review Unit
Specialist Safeguarding Nurses, Wrightington Wigan and Leigh NHS Foundation Trust
Deputy SENCO and Designated Safeguarding Lead, Primary School

1.7 A Practitioner Learning event took place on 9 May 2021.

1.8 An interview between the review author, the Deputy headteacher of the School, and parents took place in April 2021.

2. Summary and Brief Chronology

2.1 Hallie's mother and Father are both originally from another borough in Greater Manchester before moving to Wigan in 2013. Hallie's mother has considerable involvement with Children's Social Care in that borough prior to her becoming an adult, in terms of neglect and as an identified victim of child sexual exploitation in the period 2005-11. Hallie's mother described to the author that she used to spend a lot of time associating with older men from a particular community in that borough, and that it was Hallie's father, who is 17 years her senior, who in her words saved her from that lifestyle and helped her settle down.

2.2 Hallie's mother and father's first child, a son, was born in 2011 when Hallie's father was 17 years old, followed by another son 2 years later in 2012 and a daughter one year after in late 2013. There was then a gap of 6 years before Hallie was born.

2.3 Of note is that Hallie's siblings were subject to Child Protection Plans under the category of neglect at the time the family moved to Wigan, transferring as active cases to Wigan in July 2013. The Child Protection Plans remained open for a period of 2 months before being closed and the case stepped down to the Gateway (now Start Well) early intervention service.

Commentary: Within the limitations of access to the social care records from 2013 and staff having moved onto new roles there is little evidence to outline the reasons stepping down to a lower tier of intervention. Hallie's Mother reflected on this period in interview with the author, saying that she knew when the children were on Child Protection Plans, she needed a new start or she would lose the children, so she came to Wigan and 'got the case closed in 3 months.'

2.4 The benefit of detailing all the information transferred to Wigan from the original borough at this point some seven years later is limited. However, it is suggested that even if there was information provided about Hallie's father previous history of trauma, its use in any assessment that followed is not evident and the period in which Hallie's mother and father could have got to know services in Wigan was very short before the move to Gateway.

2.5 From the period of 2013 – 2018 there were 5 other contacts to Wigan Council Children's Social Care relating to concerns for welfare for the children, domestic abuse, neglect, and poor home conditions. None of these contacts prompted re-opening the case at a Child Protection level, with the rationale being given that the family were being supported by the Gateway level of services.

2.6 In that period the primary services that Hallie's parents and siblings were accessing health visiting services, due to the close ages of the children, and towards the latter end of that period they began to have contact with school as Hallie's older siblings entered the school.

2.7 Hallie's mother and father's interactions with school were frequent since the children commenced attending there. The school is in an area with high social deprivation and can resource a comprehensive pastoral support programme, and there was frequent contact between the family and the workers offering support. Some of this support was very 'practical' in terms of assisting with School pick up and drop off, sometimes providing food to the children via the school breakfast club.

2.8 The main interaction between school and the family was via Hallie's mother. Over the period from 2018 onwards school report that there were various occasions where their interactions with Hallie's mother led to her becoming verbally aggressive either when challenged or when she felt aggrieved that something was unfair in relation to her children. Hallie's mother has reflected on this when interviewed by the author and has stated that she 'says what she thinks' and sometimes it causes trouble.

Commentary: Against the backdrop of Hallie's mother's own experiences of abuse and neglect it is perhaps not difficult to envisage that one of the consequences of this is that she had found it difficult to develop positive verbal reasoning and communication skills, and what professionals may see as 'appropriate' behaviours to respond to what she may perceive as challenges to her abilities to parent her children. There had never, apparently, been a reflective look at Halle's mother's history and in the absence of this her behaviours were pathologized rather than being trauma-informed.

2.9 Throughout the review process, school provided evidence of their previous concerns relating to the siblings of Hallie and how they had contacted Social Care to make referrals in relation to the observed neglect of the siblings. There was (and is, under a renewed offer) an Early Help framework in place but this was not utilised by the School. In understanding the possible reason why this was not used, the School reflected in the Learning event that their experience at the time was that as they have a strong pastoral support offer they have a high threshold for looking for external support on cases, and that when they made referrals it was at a stage where they felt they had not been able to achieve progress at that initial level. The

school at the time did not hold the view that the facilitation of an Early Help process would have given them scope to deal with the issues surrounding Hallie's mother and father as they do not have access to the 'adult' agencies working with the family.

2.10 There is a lack of information or knowledge throughout the chronologies available to the Local Child Safeguarding Practice Review about Hallie's father. Typically, the information in primary health records and health visiting records, concentrates heavily on the behaviours of Hallie's mother and those of Hallie and her siblings. There are occasional recordings in relation to Hallie's father around him working and this creating childcare pressures for Hallie's mother and of him sometimes being the one bringing the children to School but there is little evidence of curiosity leading to improved richness of the information.

Commentary: This, as time goes by, creates availability bias and confirmation bias rather than focussing on finding the missing information and it becomes the accepted position that not much is really known about Hallie's mother, nor is there attempts particularly to engage him. The issue of 'hidden men' is recurrent in case reviews, and this review, along with recent research in this area[1] are cause for Wigan Safeguarding Children Partnership to further review and update the workforce development approaches that are ongoing on this issue.

2.11 Hallie was born 28th Sept 2019 spontaneously at home slightly premature at 35 weeks gestation, so she and her mother were conveyed to hospital. She made positive progress on the neonatal unit establishing feeding and temperature control and returned home with her parents within around 72 hours.

2.12 Health visiting commenced soon after Hallie's return home, and notably the Health Visitor involved (HV1) who had worked with the family almost continuously over the last 5 years was re-allocated to the case. Hallie's mother considers this as an area of great strength as she already had a trusting relationship with HV1 and that HV1 was the one consistent person who she would talk to. There was also involvement by lthe Neo Natal Outreach team from the hospital trust due to Hallie having spent time on the neonatal unit.

2.13 Records seen by the Review Panel evidence that for the following 3-4 weeks there was a good level of communication between professionals involved, albeit that at times there is a lack of analysis. There was increasing evidence of care needs not being consistently met, and this is well documented in the Neonatal Outreach record however at no point was there evidence of measures such as the Graded Care Profile being used to document neglect. The Safeguarding Team in the hospital trust have responded by facilitating mandatory neglect and Graded Care Profile Training to the children's workforce in the trust in August 2020.

2.14 Over the period covering Hallie's birth and early life there is an absence of the use of any assessment tools to scale the concern about the evident neglect. It would be expected that the Graded Care Profile would be used, but whilst there are recordings of the observed issues there is little to lift these into a more objective form where progress could be similarly measured. The lack of embedding of the Graded Care

[1] 'The Myth of Invisible Men' National CSPR, Sept 2021.

Profile Tool use across agencies that form Wigan Safeguarding Children Partnership is an ongoing concern being progressed by training and quality assurance processes.

Commentary: Whilst nappy rashes are not uncommon, there is no improvement over a 3 week period when advice on management was given. In this period there is recording by the same professional about the poor state of the home but there is no evidence of consideration of whether Hallie's physical condition was possibly being due to her not being afforded sufficient care, and a lack of analysis until the final visit on the 25 October.

2.15 The neonatal outreach team closed the case on 25 October, however as a point that evidences good practice, they contacted the duty health visitor (DHV) on the team that HV1 worked to enquire whether their concerns about home conditions on the 25 were present in the Health Visiting Record. The neonatal outreach nurse was told that there were no concerns documented, and that she should make a referral to social care if she had concerns. The DHV then later noted that there were indeed some concerns noted on earlier case records from the return home visit by HV1 but decided not to contact the neonatal outreach nurse with this update as she felt that the Neonatal Nurse should make the referral to Social Care Multi-Agency Safeguarding Team (MAST) based on her own professional judgement of the concerns she had observed.

Commentary: The primary issue here is that prioritising the safety and wellbeing of Hallie was lost in the process. Whilst the Neonatal Nurse had clearly some concern and could have contacted the MAST to discuss them and potential response, she sought to consolidate her view first by contacting her HV colleague. This was not, in effect necessary but the Local Child Safeguarding Practice Review Panel considered it reasonable to share information at this stage.

Nonetheless, on doing so she was then given incorrect information that would have lessened the concerns she held. The DHV then within a few minutes on further review noted that the information she had given was either incomplete or incorrect. The thorough review the DHV undertook was expected practice, however the decision to not then recontact the Neonatal Nurse to correct her earlier information was unsafe if we refocus the issue on Hallie's safety. The recorded reason given that the neonatal nurse should still refer based on her own concerns is irrelevant when, at that stage, the neonatal nurse did not possess the most relevant information on which to base a decision. This practice episode is not something that the Local Child Safeguarding Practice Review Panel consider to be symptomatic of a wider system, it is purely professional decision making mistakes which are best approached through the existing systems of support and supervision.

2.16 Hallie was unwell over the 5 months of her life, having repeated presentations to hospital due to respiratory problems and apnoea. In December 2019 and January 2020, she was twice resuscitated by either Ambulance staff or A+E doctors after 999 calls. On a further 3 occasions she had been presented to A+E unwell by her parents and over the course of her short life she had been admitted for observation on a

total of 5 occasions. Hallie had been seen by numerous doctors, including two consultant Paediatricians the day before she died in a clinic appointment. At the time of her death Hallie was undergoing extensive assessments in relation to metabolic problems (weight maintenance and feeding were difficult for her), genetics investigations as well as the respiratory problems.

Commentary: Hallie's health was a known factor that was both chronic and occasionally acute over her short life. As covered in 2.13 the impact of neglect on this was missed.

Section 3 Themes raised by the review into the death of Hallie:

3.1 The role of the Lead Professional, impact on Thresholds and understanding of neglect:

What can be observed in this case is that HV1 was, through no formal procedure, acting supportively in a role that would be considered as being the Lead Professional in an early help approach. However, the case was not being managed through a structured process which would have brought professionals together to review risks and progress at regular points and would have applied governance. In effect, what was occurring was those various professionals e.g., HV1, school, Outreach nursing were all trying to manage the safeguarding issues as they were presented to them rather than collaboratively. Where the concerns are around neglect, shared professional understanding is crucial as it requires objective reflection, but these opportunities were missed in this case and created a passive case management model. Resultantly, the Local Child Safeguarding Practice Review Panel's view is that opportunities to trigger the case into a Child Protection Response were missed.

The evidence for this is that despite there not being any sudden downturn in the home conditions, when Social Care intervention was triggered in January 2020 there was decisive action taken in terms of facilitating a deep clean of the property and outside area, and in replacing Hallie's bedding. However, what this also raises is that this was being facilitated by a Children's Support Worker under a tiered response and was practically focussed – it produced improvements to the material nature of the home, but there is a lack of evident oversight from a Social Worker who may have applied more of a thresholds of neglect oversight of the issues.

Learning and Recommendations:

At the time of Hallie's death work was ongoing to review and redesign the Wigan Safeguarding Children Partnership Thresholds document for professionals and following the Covid Pandemic, which started in March 2020, this was completed and rolled out across the workforce. This may have addressed the key points that Hallie's case highlights but there is a need for a recommendation in relation to this area to avoid any kind of confirmation bias (Kirkman, Melrose 2014).[2]

[2] "Clinical Judgement in Decision-Making in Children's Social Work" Kirkman and Melrose, Dept of Education 2014.

Recommendation 1
For Wigan Safeguarding Children Partnership to seek assurances by the provision of evidence from and Start Well, CSC, Health and wider partners that Graded Care Profiles are being undertaken consistently.

Recommendation 2:
For there to be clear guidance produced by Wigan Safeguarding Children Partnership on the role of the lead professional.

Recommendation 3:
For the new 2021 Thresholds framework, including lead professional role and implementation to be quality assured via a multi-agency Wigan Safeguarding Children Partnership process in early 2022, with specific audit enquiry points included in relation to this case.

3.2 Cases transferring into the area and adopting a trauma informed approach.

Hallie's case evidences the impact that vulnerable individual families or individuals moving from one area to another has on the spectrum of agency involvements there to support them and this is well understood in the context of 'Troubled families' [3]. On moving to Wigan, the long and involved history of Hallie's mother with statutory agencies through her childhood during which she had been a victim of child sexual exploitation and her mental health support needs were not relayed as she did not have active involvement at the time, and understandably she and Hallie's father wanted a new start. In context, when Hallie's mother started to have contact with agencies in Wigan she would not have perhaps considered what they did not know about her and she told the author this; she had been so familiar with having professional involvement throughout her life she thought they might know more than they evidently did.

In 2013 when Hallie's mother came to Wigan, there had not been investment in developing a trauma informed approach[4] and therefore whilst there is abundant evidence of practitioners and professionals interacting with Hallie's mother over 2013 – 2020 in a compassionate, supportive manner the professional understanding and reflection of how Hallie's mother may be presenting trauma related behaviour was less apparent.

There is similar learning regarding the impact of trans-generational parental trauma and abuse forming parts of historic case reviews in the borough[5] and the embedding of a truly trauma informed approach across agencies is a key priority for Wigan Safeguarding Children Partnership over 2021-22 and a trauma informed approach is being developed and embedded.

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[33] "Troubled families: Vulnerable families experiences of multiple service use" Blackwell, 2012
[4] "Trauma informed social work practice" Levenson, NASW Press, 2017
[5] Child T (2021 Unpublished) and Child F+G (2017, Wigan SCB).

Learning and recommendations:

Hallie's mother and Father move into the borough in 2013 is not captured in current information systems so it is not possible to comment on whether there were missed opportunities to transfer information. However, a situation arises where when Hallie's mother comes into first contact with Wigan agencies there is no evidence of attempts to build an understanding of her background. Current Greater Manchester Safeguarding Procedures detail case transfer processes which have improved greatly since 2013, however what this case shows is a little more nuanced as it was not a live case. When becoming aware of service history in another area agencies should proactively seek historic information to inform their current work.

Recommendation 4:
To raise practitioner awareness, Wigan Safeguarding Children Partnership should include this case as an example of where a trauma-informed approach could have resulted in a more asset based approach to some of the issues (e.g., the behaviour of Hallie's mother, and the issues of School attendance) in workforce development products and training.

3.3 Impact of an unwell child being born into the family:

Hallie was a baby with poor health, and an emerging picture of her needs was evolving as medical investigations took place. It was felt that Hallie would have had long term, enduring additional needs and whilst these were not diagnosed specifically by the time of her passing it is evident from the number of emergency admissions that she was very unwell and therefore vulnerable. The Local Child Safeguarding Practice Review Panel considered whether systemically we apply a strengths based, early intervention approach to situations like this; i.e. whilst health providers take the lead in those diagnostic processes do we collectively consider impact on the welfare and wellbeing of the siblings and parents in relation to assessment of the impact of any additional caring needs and supporting the family through the transition to looking after a very unwell child with emerging long term difficulties. The view was that there could be earlier identification of carer support issues and young carer support issues for the family triggered by what was known in the medical processes.

Recommendation 5:
For Wigan Safeguarding Children Partnership to consider this issue at a future executive meeting and identify any prospective improvements that can be made.

3.4 Bereavement Support:

Through this Local Child Safeguarding Practice Review both Hallie's mother and father were spoken to by the lead reviewer. Whilst not within the scope of the lines of enquiry for this review, both reflected in those sessions the disjointed way in which they had been offered support following Hallie's death. Hallie's mother had had to go via her GP to access long distance support from the bereavement team at a tertiary children's hospital, and Hallie's

father said he had never been offered any support at all. Wigan Safeguarding Children Partnership has a well-developed Bereavement Strategy and this case offered learning for a couple of key points around local professional awareness, as for example Hallie's mother did not have to access support via her GP it could have been a self-referral etc.

There is no separate recommendation for this point but the learning has been fed into the Wigan Safeguarding Children Partnership Bereavement Support Group who are undertaking a mapping exercise of referral routes into various supportive local agencies.

Section 4: Summary of Recommendations:

Recommendation 1
For Wigan Safeguarding Children Partnership to seek assurances by the provision of evidence from and Start Well, CSC, Health and wider partners that Graded Care Profiles are being undertaken consistently and that they are having an impact on the identification and reduction of neglect.

Recommendation 2:
For there to be clear guidance produced by Wigan Safeguarding Children Partnership on the role of the lead professional.

Recommendation 3:
For the new 2021 Thresholds framework, including lead professional role and implementation to be quality assured via a multi-agency Wigan Safeguarding Children Partnership process in early 2022, with specific audit enquiry points included in relation to this case.

Recommendation 4:
To raise practitioner awareness, Wigan Safeguarding Children Partnership should include this case as an example of where a trauma-informed approach could have resulted in a more asset based approach to some of the issues (e.g., the behaviour of M6, and the issues of School attendance) in workforce development products and training.

Recommendation 5:
For Wigan Safeguarding Children Partnership to consider the issue of carer support and impact of having an unwell child born into a family that already requires support as a wider partnership and develop an action plan to respond.