Child Safeguarding Practice Review

Learning identified from considering Ted

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1 Introduction

1.1 The Southampton Safeguarding Children Partnership (SSCP) agreed to undertake a Child Safeguarding Practice Review (CSPR) to identify learning, by considering the engagement of professionals with the family of a child to be known as Ted.

1.2 When Ted was a year old, he had a leg fracture (femur) which is thought to be a non-accidental injury **(To be updated after criminal investigation/finding of fact).** Ted was identified with significant emerging health needs prior to the injury[1]. He is developmentally delayed and was described as 'non-mobile'. His father has recognised vulnerabilities including care experience, mental and physical health issues and is a regular cannabis user. He was a single, young male carer at the time of the incident leading to this review. Ted had not had contact with his mother for over six months.

1.3 Learning has been identified in the following areas:

- The importance of knowing and understanding the impact of a parent's vulnerabilities and history on their parenting
- Parental substance misuse, mental health, and prescribed pain medication
- Working with homeless families
- Exploring and understanding a disabled child's likely and actual lived experience
- Considering absent parents, even when domestic abuse is alleged

[1] Evolving cerebral palsy. Ted will have long-term health issues with delayed motor milestones

- Considering what support is required to ensure a lone, non-birthing parent acquires 'Parental Responsibility'[2]
- Flexibility in providing on-going support when a family moves temporarily (including across local authority borders) or the case steps up from early help
- Referring/ transferring a child in need plan across local authority borders
- Emotional support for parents of children with complex and lifelong conditions
- The need to consider if the parent requires an assessment or support due to their own needs or as a care leaver

2 The Process

2.1 An independent lead reviewer[3] was commissioned to work alongside local professionals to undertake the review. The detailed information provided during the Rapid Review process was considered. It provided a focus for the review and formed the basis for the terms of reference.

2.2 A face-to-face multi-agency meeting with professionals involved in Southampton at the time was held for discussions about the case and the wider system. A panel with an independent chair from within the Partnership worked with the lead reviewer to identify the overall learning and recommendations included in this report. The panel also took responsibility for considering the single agency learning and improvement actions required. Discussions were also held with safeguarding partners in Hampshire.

2.3 The lead reviewer hoped to meet with both parents to identify any learning from their perspective. Ted's father was spoken to by a professional working with him closely at the time of the review and he was clear he did not wish to engage. He is aware that if he changes his mind, contact will be facilitated. Ted's mother agreed to meet with the lead reviewer and a plan was made on two occasions, however she did not attend. She will be contacted again prior to publication.

3 Learning identified

3.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed and case specific analysis.

Consideration needs to be given to a parent's vulnerabilities and history when deciding if an assessment is required, when undertaking assessments and making plans for children, to understand if there is or is likely to be an impact on their parenting

3.2 There was little doubt that Ted's father loved him and was committed to his care. All of those who knew them and worked with them noted a close bond and professionals were committed to helping Father to be a good parent to Ted. There was an understandable view that he was doing his best in a very difficult situation. The responsible community paediatrician told the review that Ted is going

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[2] Parental Responsibility is defined in the Children Act 1989 as being "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". In practical terms it means the power to make important decisions in relation to a child.

[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the SSCP.

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to need complex medical support for the rest of his life, and that 'his father tried his utmost despite his own vulnerabilities, mental health issues and having been in care himself as a child'.

3.3 Father had predisposing vulnerabilities that had an impact and were exacerbated by the pressure of caring full time for a young child with emerging special needs, in insecure housing and with complex relationships with his family who he was relying on to support him. Father had apparently been in care in another part of the country from age 14 -18. His lived experience within the care system was not known to those working with him in respect of Ted, although it was thought that Father had been in care due to a breakdown in his relationship with his parents and concerns about physical and domestic abuse. His own childhood records were not readily available to professionals in Southampton or before that Hampshire, where the pre-birth assessment was undertaken. Father was not receiving care leavers support from the local authority where he had been in care or from Hampshire where he lived as a young adult, and no consideration was given to providing him with support in his own right as a care leaver living in Southampton. The law states that care leavers can be supported up until they are 25 years old. Father was 23 when he moved to Southampton with Ted. There is no evidence that his care leaver status was confirmed or considered in respect of any support he may require. In Southampton, extensive support is available for care leavers but only to those who were in the care of Southampton City Council, not those who were in care in other areas. Father was the responsibility of the local authority where he lived as a child for care leaver support. Health agencies have some responsibility for care leavers but this tends to just involve issuing a health passport.[4]

3.4 There was the possibility that a Care Act 2014 assessment[5] could have been requested due to Father's own vulnerabilities. While it is possible that he would not have met the requirements for support under the Care Act, there is no evidence that this was considered at the time. This may have been more of an issue if he had been childless and had then requested support and housing in his own right in Southampton, as the requirement to support Ted under the Children Act 1989 met the family's needs at the time.

3.5 It is known that adverse childhood experiences have an impact on a person's physical and mental health and on their social outcomes. This includes the likelihood that their own children will be known to safeguarding services. The longer-term negative impact on the mental health of a person who has experienced adversity in their childhood is also well acknowledged. In this case, Father was involved with CAMHS as a child due to a suicide attempt, and he told professionals in Southampton that he had a history of anxiety and depression. Father was spoken to by a worker in the early help hub shortly after he came to Southampton in March 2021 and self-referred to children's services for help with housing. He was honest about his history. He informed them that Ted was on a child in need plan in Hampshire, that he did not have Parental Responsibility, that he

[4] An electronic system that stores health information (appointments, health history, immunisations, prescribed medication etc) in one secure place.
[5] A Care Act 2014 assessment is how a local authority decides whether a person needs care and support to help them live their day-to-day life.

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had a history of drug use and fluctuating mental health, that he had CSC involvement during his own childhood, that he had been struggling with family bereavements, and that he was on probation for assaulting and racism to a police officer and for possession of cannabis. He described recent difficulties in co-parenting with Ted's mother and that there had been a lot of arguments resulting in the relationship breakdown. The early help hub worker noted that there were indicators of domestic abuse and the recording from the hub management oversight recorded that it needed to go to locality for a worker within Sure Start to contact the family and discuss the groups available to them, with the expectation that Ted would remain allocated to the social worker in Hampshire. The recording of management oversight states that a referral should be made to the MASH if the family remained in the area. It was not clear at the time that they would stay in Southampton.

3.6 There were clear vulnerabilities for Ted at this point. He was just 13 weeks old, was living with his father as a sole carer without Parental Responsibility, the family were living with family members short-term, and Father had shared his own vulnerabilities that could be a risk to Ted. Southampton MASH received the referral from Hampshire in May 2021. A decision was made in the Southampton MASH that a new social work assessment was not required, and that early help was the appropriate plan for Ted, with an expectation that, should the situation deteriorate, a re-referral would be made to the MASH in the usual way by the early help service. This was not challenged by any professionals in Hampshire or Southampton and there was no record of a request for a threshold review. There is no evidence that Hampshire provided copies of the pre-birth assessment and child in need information, or that they were requested by the Southampton MASH, who did not undertake their own agency checks. Consideration was not given to what information from Hampshire needed to be shared with early help to enable them to better understand the vulnerabilities and risks. This was because Father had engaged with the early help service and appeared to be managing well. The review was told that there have been issues with case transfers when a family moves areas across the wider HIPS area, and this may be reflected in what happened in this case. Practice when a transfer is required needs to be child and vulnerable family centred. A recommendation is made in respect of this.

3.7 A social work assessment on Ted had been completed in Hampshire pre-birth due to Mother's mental health and learning disability, and Father's drug use and social care history. They were also homeless at the time and had financial difficulties. Repeated learning from case reviews shows that assessments are often mother focused. The 2021 national CSPR, The Myth of Invisible Men[6], states that 'service design and practice tends to render fathers invisible and generally 'out of sight' and that there are 'deeply engrained roles, stereotypes and expectations about men, women and parenthood in our society.' This is an issue nationally that needs to be considered and challenged. CSC in Hampshire understandably did not consider at the time how the father would manage as a

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

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single carer, what support he would require and whether there were potential risks to Ted if this were the case.

3.8 There is evidence on the CSC case record in Hampshire that when Ted and his father moved to Southampton there were conversations between the allocated social worker and the Southampton MASH, homeless team and health visitors. This record states that a referral had been made to the Southampton MASH with a request that an assessment was undertaken as Father was living with Ted on his own when they moved. The referral was in writing and stated that the transfer was required for support. At the time Father had been caring for Ted alone for around two months and it is recorded on the Southampton MASH record that he was 'proving to be able to provide for Ted appropriately with the support of his family,' and that he had been 'engaging with early help'. Although at the time the early help worker's focus was on rehousing rather than parenting support. A decision was made by the Southampton MASH that no further assessment was required and that the on-going provision of early help was the appropriate response. The case was also then closed to children's social care in Hampshire.

3.9 A further referral to the Southampton MASH was made later in June 2021, as part of a hospital discharge planning meeting that was attended by the hospital paediatrician and coordinated by the safeguarding clinical nurse specialist. The referral shared some low-level concerns about Ted's care and concerns about Father's social circumstances and vulnerabilities. The paediatrician requested and offered immediate support with housing, highlighting the inappropriateness of the family sofa-surfing or being in B&B accommodation with Ted's emerging health needs. At the time Father was working with the early help worker and the MASH felt this was sufficient.

3.10 Early help professionals in Southampton were aware that Ted's father smoked cannabis and he admitted that he had used cocaine and had 'an unhealthy relationship with alcohol' in the past. He was adamant that he only smoked cannabis after Ted was in bed however and that he would go outside and take a baby monitor so that he was able to respond if his son needed him. This was a concern which was discussed with Father by the early help worker but was accepted as it was acknowledged that this alone would not meet the threshold for a safeguarding intervention. The early help worker told the review that they had never smelt cannabis or saw any evidence of cannabis in the property. The health visiting service was not aware of the cannabis use until a child in need meeting was held in Southampton on 1 October 2021. The early help worker told the review that she had hoped to organise an early help meeting of professionals involved with Ted prior to this, which would have included information sharing, but had not been able to achieve this. There was evidence of discussion between the early help worker, housing and the health visiting service, but a date suitable for all was apparently not found.

3.11 As well as his mental health issues, Father had physical health issues with back pain following a historic road accident. He was prescribed pain killers that could also have had an impact on his parenting. The early help service was conscious of this potential risk as they had been told by Father's new girlfriend that Father would be 'knocked out' after taking the medication and he

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admitted it made him drowsy. The risk was believed to be heightened because a child with complex needs can wake more readily and often in the night, and there was a concern that Father would not wake. The social work assessment which started in August 2021 recognised that Father suffers from 'acute and significant pain' and that this is difficult for him to manage. Father reported that he regularly delayed taking his medication because of the side effects and his wish to be alert when looking after Ted. The assessment acknowledged that the resulting pain could impact on his 'regulation' however. This was a significant issue as he was known to have issues with managing his frustration and that this could lead to him being angry and abusive to professionals. The review was told that there was a flag on the police system from 2019 that said that anyone dealing with him 'should be aware that he can suddenly become very violent without much warning and will spit.' This information was not widely known by professionals in Southampton and lone visits were often undertaken, for example, by the therapists working with Ted. Father was also involved with probation at the time of his move with Ted to Southampton, having received an 18-month community order in January 2020 for offences against a stranger when he had been drinking alcohol that included common assault and battery, racist abuse, and possession of cannabis. (While the police have a record of a 12-month order, the probation service has confirmed it was 18-months).

3.12 When Ted was on a child protection plan it was clear that Father struggled to contain his temper and to regulate his behaviour with professionals who he experienced as critical of his parenting. Those who have experienced historic trauma are known to find it difficult to regulate their emotions and it is thought that they have a narrow 'window of tolerance'.[7] It is important for those working with parents with a traumatic background to consider this when working with them, and for effective support to be in place to enable insight and the capacity to respond positively when feeling stress or anxiety.

3.13 An assessment completed in September 2021[8] resulted in a child in need plan for Ted, closely followed by a decision for an Initial Child Protection Conference (ICPC) to be held and then a Child Protection (CP) plan agreed. From October the father's mental health notedly declined. This was most likely due to a volatile relationship with his then partner and a recent ex-partner, deteriorating relationships with family members who lived locally and who were a known support with Ted, and him feeling overwhelmed with the news of Ted's special needs and the number of appointments related to this. He voiced his sadness and frustration that Ted was likely to have a disability, which was understandable and not uncommon for parents of children newly diagnosed with a serious health or developmental issue. The emotional impact of having a disabled child needed to be discussed with father, along with an understanding of father's mental health history and the likely impact on him of the emerging concerns for Ted. The therapists working with the family following the needs emerging provided good practical and emotional support to Father. An invitation to a group

[7] The Developing Mind (1999) Dan Siegel.
[8] Assessments must be completed in 45 days.

was made to Father and Ted, but Father was anxious about this type of setting and stated he would struggle to attend on public transport. The team recognised the issues and undertook home visits.

3.14 The issue of ongoing pain from his back condition was also evident in agency records from the time. He saw his GP several times and received prescription medication. He also contacted 111 due to the need for assistance in managing his pain. When Father rang for an ambulance prior to the injury being discovered, he told the call handler that he had not slept for five days due to the pain of his back. He had previously reported the practical impact of having a bad back, for example when he had to get Ted's pushchair up and down the stairs, and when undertaking some of the exercises required in Ted's physiotherapy. Pain medication has side effects and there is also a risk of dependence and withdrawal. Consideration needed to be given to addiction to prescription medicines as it has been identified as an emerging and potentially significant issue for individuals, and a child safeguarding issue. Prescription drugs are thought to be misused and abused more often than any other drug except cannabis and alcohol. In 2017, Public Health England were commissioned to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it. The report was published in September 2019[9] and shows a significant problem that is not always considered or recognised by professionals as a substance misuse problem.

3.15 When it is identified that a parent has a health issue that requires prescribed medication it is important that professionals ask detailed questions about the use of prescribed or over the counter medication, request and share information with other professionals, and consider the impact of any side effects, dependence, and withdrawal on their parenting, particularly if they are a single carer and if they have a young child or a child with special needs. In this case the early help worker was concerned enough on one occasion that she requested help from EDT to clarify if there was an issue with Ted staying alone with his father while he was on his pain medication, as he had reported he felt drowsy and was worried he would not wake for Ted. The early help worker was reassured by EDT (who had spoken to an 'on-call doctor' who did not know any of the family members) that there were no concerns about the sort of medication he was taking, with a statement made that it was available over the counter so was not a concern. This was not the case, as while lower levels of the medication prescribed may be available in the pharmacy, the dosage prescribed to Father was prescription only. They could have made him drowsy which may be more of a concern if Father was also using non-prescribed drugs, such as cannabis or alcohol.

3.16 Information from the GP records shared with the review show that Father's compliance was poor and mainly crisis led. There is no evidence the medications were then reviewed or that this information was shared with the health visitor with responsibility for Ted. Father's pain medication and management needed to be part of the plan for Ted. There were two liaison meetings between the GP and the health visitor where this family were discussed, in July and September 2021. The GP also emailed the health visitor in November 2021 alerting them to the change of address and

[9] https://www.gov.uk/government/publications/prescribed-medicines-review-report

concerns about Ted not being brought to appointments. This was good practice in respect of contact with Ted. GPs also need to engage in and invite communication with health visitors when there is an adult health issue that could impact on parenting, and for consideration to be given to a GP vulnerable person meeting to include the health visitors if a child is living in the household.

3.17 There were few opportunities for professionals in Southampton to explore or consider if Ted's mother had any vulnerabilities that could impact on her parenting of her child, as there was very little contact with her by any agency and an understandable acceptance that Father was the single carer when the family initially moved to Southampton. CSC in Hampshire shared that a child in need plan had been in place since the child was born because of both parents' mental health issues, housing and financial issues. Father initially stated that Ted's mother's poor mental health had been the main reason why he was now caring for Ted alone and this was partly confirmed by Hampshire CSC. In Southampton, Ted and his father were treated as a family and Father's explanation for why he was a single carer was largely accepted. Father later told the homelessness team that Mother had been abusive to him and that he was a victim of emotional domestic abuse. It is a legal duty for housing to accept domestic abuse, without question, as a criterion for rehousing. Hampshire Police have no record of any domestic abuse and on one occasion on an unrelated matter in November 2021, Father was asked if there had been domestic abuse in the relationship with Ted's mother, and he said there was not. There was no consideration given to making an adult safeguarding referral when Father told the homelessness worker that he was the victim of domestic abuse.

3.18 Consideration of a parent who does not live with a child is important, regardless of their gender and whether they are said to be a perpetrator of domestic abuse. There was initially little understanding of why Ted's mother was not in contact with him and what her views were. This replicated what is often the case when a single mother is caring for her children and there is little professional consideration to involving an absent father. The review was told that the health visiting service in Southampton inadvertently rang Ted's mother soon after the move to Southampton and she advised that Father had taken Ted but that she accepted the situation due to her own difficulties at the time. When Ted's mother was spoken to by the social worker as part of an assessment in September 2021, she said that Ted had been 'abducted' by his father and that she had felt helpless to do anything about it. When the social work assessment was completed, there was a commitment to involving Ted's mother which resulted in a very angry response from Ted's father. She was visited and informed of the child in need then child protection plan and was invited to meetings held virtually.

3.19 In Southampton there is a project that was devised to address the lack of professional focus on fathers and male carers, which Father was referred to by the early help worker. Families First seeks to deliver services to all fathers and men who provide care for children, and they work in collaboration with other agencies across the early help, child in need and child protection levels of intervention. This includes drop-ins, groups, outreach, and one-to-one work. They were involved with Ted's father at the time of the ICPC and attended the core group held in November 2021. This

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case shows the benefit of including these types of voluntary sector agencies as an important part of any team around a child where the parent requires support and a degree of advocacy.

When a family is homeless and living temporarily with friends and/or family members, or when they are in temporary accommodation, this can have an impact on the effectiveness of assessments, support and oversight and may require flexibility in the system

3.20 Practice in Ted's case was impacted due to the family moving from Hampshire to the Southampton area in the spring of 2021, followed by a period of insecure or temporary housing. On arrival Ted and his father were effectively 'sofa-surfing' with different family members, two in Southampton and one just over the border in Hampshire. There was a delay in him being accepted as homeless in Southampton as there was a tenancy in his name in his previous town in Hampshire. It was not until he made allegations of domestic abuse from his previous partner (Ted's mother) that his application was accepted. There was also then a delay in him completing the required forms, although he required and received support from the early help worker and No Limits[10] with this task.

3.21 While they were 'homeless' and Father was using the addresses of extended family members, this led to difficulties, particularly in registering with a GP and allocation to a consistent health visitor. From the time that Ted and his father moved to Southampton, there were five different GPs involved and four different health visitors. There were also other complications linked to the family's housing status. After Ted's significant needs emerged, the Southampton Equipment Store/Service did not provide the required equipment[11] for Ted as the family were living in emergency guest house accommodation at the time and not in a permanent residence. This was challenged but it was not until they were housed in more stable temporary accommodation that the delivery was made. The review was assured that this matter is being discussed with the relevant department.

3.22 The review has found systemic difficulties which led to a lack of a consistent health visitor, as would have been good practice for a child who had been on a child in need plan since birth, who was not living with his mother, who had no home, and who had emerging health and developmental needs. Health visitors in the area work geographically and allocation is determined by the address where the family are living. As one of the extended family members lives just over the border in Hampshire, this led to the Southampton health visitors transferring the case back to Hampshire for a short period after Father gave the Hampshire address when Ted was discharged from hospital. This was despite the address only being temporary while the family member was away on holiday and just 5.6 miles from the previous address in Southampton. The review was told that the health visitor was informed by Ted's father that the move was permanent, which justified the transfer. Other agencies knew this was not the case, however. There is a health visiting record that shows the health visitor spoke to a duty family support worker when the plan to stay at the family member's

[10] No Limits is a charity offering free and confidential information, advice, counselling, advocacy and support to children and young people under the age of 26 in Southampton and Hampshire.
[11] For example, a bath seat, positioning mat and specialist baby chair.

address 'broke down' after 12 days, to express her concern, although the family support worker was clear during the review that it was only a temporary place for the family to stay.

3.23 The health visiting service has been impacted by vacancies in the 0-19 service and COVID-19. The review was told that at the time there was little to no flexibility in the system to allow a health visitor to remain involved with a child when they move out of the area, even if it is to a temporary address very close by, but that such cases could be discussed in safeguarding supervision to reflect on the child's specific needs. There was a health visitor specifically for homeless families in Southampton at the time, but the role did not extend to covering a 'sofa-surfing' situation out of the city boundaries. There is evidence of good information sharing and some joint working between health visitors from Southampton and Hampshire through joint attendance at Ted's hospital discharge planning in June 2021. Once the concerns regarding Ted's developmental delay started emerging in May 2021 there was also good information sharing between the different health visitors allocated to Ted and a shared awareness of the concerns.

3.24 The Southampton early help service recognised the need for the family to have consistency of support and kept up their involvement with Ted and his father even while they were temporarily staying in the other local authority area. This was flexible, child centred practice.

3.25 The review has identified learning about the need for professionals to understand the practical realities of what can be offered to a homeless family like this one. The fact that Father had a tenancy in another local authority area legally limited what the homeless team in Southampton could do. There were reported delays in receiving information from the borough council in Hampshire despite efforts to chase this up. There is a potential lack of 'ownership' when a family is not permanently housed in an area, which can increase a child's vulnerability. This lack of ownership or delay in taking responsibility can impact on multi-agency contributions to assessments and plans.

3.26 There was an issue with the number of social workers involved with Ted and his father. From the start of the Southampton child in need plan in October 2021, until the injuries were identified in December 2021, there were four different social workers involved and a period where Ted had to be temporarily allocated to a practice manager. This was after Ted had been allocated to a new social worker on 18 November who then left on 8 December. He was then allocated to a new social worker on 10 December, who left on 23 December. This experience was largely due to general issues with social work staff leaving and issues with recruitment. For his father, who was known to get frustrated when having to meet new professionals and explain his and Ted's history, this would have been exceptionally difficult.

3.27 Contacting social workers at this time was a challenge for professionals and examples were shared with the review that included attempts during November 2021 by the health visitor to contact the social worker for an update on the case since the ICPC. She escalated the lack of contact by contacting the MASH. It appears that professionals had not been contacted about a change of social worker. Single agency learning has been identified about the need for CSC to ensure that 'out of office' messages are in place with a number to contact in an emergency and that there is a

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system in place for messages to be heard and calls to be returned. Further to this, for those involved in core groups to be informed in a timely way about a worker leaving or a change of allocation. There is also learning for community health professionals about accessing safeguarding support both in and out of office hours.

Professionals need to explore and understand a child's likely and actual lived experience

3.28 The importance of professionals having a child centred approach is well recognised in safeguarding work and there is evidence of a commitment to this in Southampton. The referrals and contacts over the summer of 2021 that led to a single assessment and child in need plan focused on the impact on Ted of his father's disclosed difficulties. The GP surgery showed good information sharing and child centred practice when they contacted the MASH in May 2021 stating that the family's insecure housing and lack of funds was having an impact on Ted receiving the medical care he needed, as Father had to cancel an appointment with the GP due to not being able to travel to the surgery they had registered at when they were staying with a different family member.

3.29 It is important that all professionals also consider historic information within the parents' own records and use opportunities to share this with other agencies as appropriate. The review has found that the available information in Father's GP record was very limited however and would not have indicated that Father's mental and physical health difficulties may have an impact on his parenting of Ted. There were no recent or consistent flags for mental health or substance misuse from the previous GP[12]; no multi-agency documents demonstrating Father's own self-reported care history; or that there had been a CSC pre-birth assessment and plan for Ted. There were references made in the consultation notes about some of Father's issues and his limited engagement regarding these, but not enough to indicate the level of vulnerability that is now known.

3.30 In August 2021 emergency accommodation was offered when Father reported he could no longer live with family members due to difficult relationships. His housing application was being processed. There is a severe shortage of accommodation locally and the need to use B&Bs for emergency accommodation is reportedly unavoidable. The early help worker shared concerns with CSC about Father's relationship with his then partner and their view that Father required significant support to provide consistent care to Ted, and that he was relying on his partner who there were concerns about due to her own child not living with her. It was the involvement of this partner in Ted's care and the early help worker's concerns about the real threat of the family being evicted from the temporary accommodation that led to the completion of a single assessment in September 2021, followed by child in need planning.

3.31 Towards the end of November 2021 there were concerns for Father's mental health when he told professionals he had gone to a local notorious suicide spot, with Ted, and had considered ending his life. He stated that his wish to be around for his son had stopped him from going ahead with the plan, but this episode showed the level of his despair at the time. While a child is often a protective

[12] The Southampton Named GP is sharing learning about this with their counterpart in Hampshire, so that it can be shared with Father's previous GP surgery.

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factor for a parent with depression, professionals need to ensure that they reframe this to consider the negative impact this can have on the children and that it may be an indicator of emotional abuse. The physiotherapist working with Ted was extremely concerned when Father disclosed this to her and tried to speak to the social worker who was undertaking the single assessment. Attempts were made that day, and the following week, to share the information and be assured that support would be in place for Ted and his father.

3.32 Unknown to the physiotherapist, who was increasingly worried, CSC were aware of the matter as they had been informed in a timely way by No Limits, who Father had also spoken to. A CSC social worker visited Ted the same day to address the matter. Despite this, there is little evidence of liaison with Father's GP or mental health services. The known issues at the time indicated a need for a mental health assessment to identify what treatment was required. No strategy meeting was held and no S47 investigation was undertaken about this concerning event. Ted was already on a child protection plan at the time; however a strategy meeting may still have been required and a S47 should be completed when there is further concerning information about a child who is already subject to a CP plan. The meeting could also have considered Father's needs and whether a referral to mental health services was required. A recommendation has been made in regard to ensuring that non-mental health professionals know what they need to do should they be aware of a potentially significant suicide event.

3.33 The impact on Ted of his father's demeanour was of concern. While there was a perception that Father was doing his best in difficult circumstances, this was not always enough in terms of Ted's lived experience. The single assessment completed early in October 2021 shows child centred practice by stating that Ted would become 'wide eyed, watchful and stare' at his father when he became 'angry and abusive'. The assessment reflected that it is likely that Ted would experience anxiety and fear during these incidents which would have a negative impact on his longer-term emotional wellbeing. There were triggers for Father's anger, including when Ted's mother tried to instigate contact with her child, and when professionals challenged Father about the need for him to facilitate this. It was Father's anger and emotional dysregulation during the first child in need meeting, along with evidence of his declining mental health, his ongoing cannabis use and the evident impact of his pain medication, that led to the ICPC October, and a unanimous decision was made for Ted to be the subject of child protection planning.

3.34 Ted's grandmother's GP made a referral to CSC on 9th December 2021, flagging concerns after a consultation where she shared how concerned she was about Ted. The same day an anonymous referral was received by CSC stating that Father got frustrated with Ted and would 'shout in his face to shut up' and handle him roughly. A duty social worker unknown to the family visited the next day and Father told them Ted may need respite care as his relationship with his mother (and main support) remained strained and he was finding things very difficult. There is no evidence that this was pursued further or that the increasing risk to Ted at this time was acknowledged. On the 16th December 2021, the day before Ted was injured, early help visited. There were no concerns

identified during the visit although Father described his frustration that Ted couldn't do the things that other 1 year old children could do.

3.35 There were examples of good practice in considering the child rather than focusing on the father, despite his own needs and how much support he required. This included monitoring the living conditions and Ted's physical care. There was flexibility in parts of the system and those involved worked hard to make sure that if an appointment was missed, that it was rearranged with flexibility to ensure that Ted received what was required. For example, the physiotherapy and occupational therapy teams would contact Father and make an appointment for the next day if he did not attend with Ted. The early help worker had very regular contact with father by text message and phone and was responsive to the family needs even when she was not due to visit. The paediatrician shared their concerns about the impact on Ted of the insecure housing situation and the family's need for support.

3.36 It was established by early help professionals in Southampton that Father did not have Parental Responsibly (PR) for Ted, and that Ted was not having any contact with his mother, who had PR for him. There was uncertainty about whether Ted's birth had been registered, and whether there was a birth certificate. The early help worker tried to assist by contacting the registry office and it seemed that there may have been a registration for Ted, but no information was shared by the registry office who suggested that the potential certificate was applied and paid for. Father did not prioritise this[13]. Father would not have been listed on the birth certificate as he was not present when the birth was registered, which is required if a couple are not married. The health visiting service and those providing therapy for Ted were not aware that Father did not have PR for Ted when they started working with him. There is a prompt on the Solent NHS recording system but it appears that an assumption was made that Father had PR rather than the health professionals specifically asking the question.

3.37 A mother automatically has parental responsibility for her child from birth. A father usually has parental responsibility if he's either married to the child's mother or is listed on the birth certificate. Neither of this was the case for Ted's father. To obtain Parental Responsibility, Father would have to have his name registered on the birth certificate (or re- registered if it was not included at initial registration); or by entering into a Parental Responsibility Agreement with the mother; or by obtaining a Parental Responsibility Order from the court; or by being named as the resident parent under a Child Arrangements Order.

3.38 The lack of PR did not hinder the engagement of services or Ted's health needs being met, but there are potential difficulties when the only person with PR for a child does not care for them and has no contact. Legally, healthcare professionals require the consent of the person with PR to approve treatment, and with hindsight those who were involved at the time recognised that they did not ask for proof of PR and did not consider making an issue of this to ensure that Ted's needs were met. This legal issue remained the case throughout the period being considered. There was also

[13] A birth certificate costs approximately £18 including postage.

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reflection about practice in an acute hospital setting regarding how PR for a child is sought during emergency department attendances and admissions and is documented in the medical record. For the ED attendances in this case, it is recorded separately that both Father and Mother had PR, and this was not questioned or discussed with agencies.

3.39 It is recorded by CSC and Early Help that Father was going to apply for PR and for a 'live with' order. This was accepted and encouraged, but there was delay in this happening and it was not until November 2021 that it was recorded in a Core Group that Father was going to be attending court for this matter. This issue does not appear to have been followed up with Father and in December he told a duty social worker that he was in the process of applying for PR. Father likely did not prioritise this issue as he had other priorities and also due to the cost involved. There is no evidence that support, either practically or financially, was provided by professionals. This is an unusual circumstance however, and like Father, professionals had more pressing priorities regarding Ted. More focused and timely support with this matter would have been good practice and in Ted's best interests, however.

3.40 The review has also found that there was a degree of acceptance and lack of challenge when Father stated that Ted was not having contact with his mother, at least until the social work assessment in August 2021. This was partly due to a wish by professionals not to be seen as penalising the father for his gender and being a single male carer, and an acknowledgement that had he been the mother there would have been little challenge about where the father was and why there was no contact. Father stating that there had been domestic abuse also made people cautious about asking too much about Ted's lack of contact with his mother. It is not often that professionals work with single fathers of young children and this had an impact.

When a child is made subject to a child in need or child protection plan, the family should not lose the potential for the type of hands-on and practical support provided by the early help service if this remains a need

3.41 When the family moved to Southampton, the child in need plan that Hampshire had in place was not transferred. An early help assessment had been completed and a worker was allocated to Ted and his father. At the time in Southampton, it was the practice for an early help worker to discontinue their involvement with a family when a social worker became allocated following a child in need or child protection plan being made. In August 2021, following referrals from the GP, the early help worker and Ted's community paediatrician, a social work assessment was undertaken in Southampton and a child in need plan was made. This meant that a professional who had a good relationship with Father, knew Ted, and held a lot of information, was no longer going to be involved. It was positive that the early help worker was invited to the child protection conference held shortly afterwards however, and that they could share their views and knowledge of the family. There was however a decline in 'hands on' support at the time, partly due to the differing roles but also due to staffing issues in the social work team, as described above. While there is evidence of social worker contact with Father at the time, the lack of consistency from social care staff and from

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health visitors would have been difficult for Father. Numerous reviews have shown the importance of working with the same practitioners over time; demonstrating that this enables parents and children to gain trust and build better relationships. It equally helps professionals when they understand the family history, the context in which the family live, and the other agencies and professionals involved with the family. There is also the benefit of recognising any deterioration or improvement in the circumstances, the parent's mental health and the child's voice.

3.42 The core group held following the ICPC included the community health professionals who attended the ICPC, such as the physiotherapist and occupational therapist involved with Ted and Father to enable him to meet Ted's needs. There is evidence of good support and flexibility from these professionals, who identified concerns and recognised the pressure that multiple appointments would put on Ted's father. They devised a plan for home visits in multi-disciplinary pairs to cut down on the demands on Father to take Ted to numerous appointments. At the core group, Father had a new partner who attended. There is no evidence that there was any plan made to undertake checks or assess her. A health visitor met her when visiting Ted and Father and did not record her name or other details. There is often risk to children when a new partner joins a family, as shown most recently in the 2022 national CSPR which considered the learning from the murders of Arthur Labinjo-Hughes and Star Hobson.

3.43 It was towards the end of October 2021 that things began to noticeably deteriorate. Father did not bring Ted to two scheduled appointments with the hospital paediatrician and with neurology in late October[14]. Housing department staff were trying hard to get Father to complete the paperwork required to ensure he was on the housing waiting list and for his housing benefit to be paid. He did not respond to numerous attempts to rectify the issue. Two homeless workers were invited to the ICPC and a report was provided. The housing department reflected that they would usually undertake home visits to their most vulnerable tenants who were living in temporary accommodation, but at the time the ongoing response to COVID 19 limited them to telephone contact and / or doorstep visits.

3.44 The ICPC was held on 20 October 2021 and Ted was made the subject of a CP plan, with the category of emotional abuse. There was a need for a timely multiagency plan for Ted with the social worker as the lead professional, but also with the active involvement of family support workers, health and housing professionals. Working Together 2018 states that the core group should meet within 10 working days of the ICPC and that the outline child protection plan should be developed by the core group, to 'set out what needs to change, by how much, and by when, in order for the child to be safe and have their needs met.' In Ted's case the core group was delayed, being held 16 days after the conference, and the record of the core group section that lists the child protection plan is blank. As this was a time where the concerns about Father and his care of Ted were high, there needed to be a timely response and plan with a high degree of oversight.

[14] The Lead Paediatric Consultant was proactive and contacted the Trust's Safeguarding Children Team (as per the Was Not Brought policy) when Ted's appointments were missed, and appropriate actions were taken.

3.45 While there was good practice from several health professionals with Ted and his father, there were also gaps in information sharing and understanding from non-health professionals about who was involved and in communication between different parts of the health systems. A number of reviews nationally have found that there is a common misperception by non-health professionals that by speaking to one health professional, for example the health visitor, they will be aware of all the necessary health information. Non-health professionals are not always aware of the complexity of health provision and there is no guarantee that different health professionals are communicating with each other, or that they have access to all health databases for the children and for the parents. When there are emerging vulnerabilities, comprehensive checks must be undertaken across all relevant health agencies.

4 Conclusion and recommendations

4.1 This CSPR has considered the learning from Ted's case and has identified learning that will be helpful for the wider system. Like the national CSPR published in 2021, The Myth of Invisible Men, this review considered a father/male carer of an infant to identify learning following an injury that was likely to have been perpetrated by him. The national review points out how important it is for professionals to be aware of the factors that interplay in cases where a child has been harmed. These factors include fathers with a 'background of abusive, neglectful or inconsistent parenting', who have 'histories of impulsive behaviour and low frustration thresholds', who 'abuse substances', who 'mitigate their difficulties with others through an easy default to violence and controlling and angry behaviour', and who are experiencing external pressures from homelessness and 'poor relationships with the mothers of the children'. The review also highlighted how common it was for the father's they considered to have 'significant relationship problems, within a spiralling negative cycle of drug abuse, deterioration in mental state and poor decision making, and a lowering of what was for many an already low frustration threshold.' Similar has been found in this case. The national CSPR states how important it is to identify which father's require support interventions and for professionals to engage with them. In the case of Ted's father this happened, largely because he was a single carer, but we have regardless found many examples of positive work undertaken with him in Ted's best interests.

4.2 In 2021 the SSCP published a thematic serious case review (SCR) concerning the non-accidental injury of three infant children. Some of the reflection and learning is relevant to the case of Ted, particularly in regard to the need to ensure that young parents are assessed and supported to care for their children in a way that recognises their own age and development, the impact of mental health issues, self-harming behaviour and substance misuse[15] on parenting capability, the impact of homelessness, anger management and domestic abuse, evidencing the child's lived experience within the family, and over optimism on the part of professionals as to the parents' capacity to care for a vulnerable child.

[15] The SCR notes that cannabis misuse by parents has become a common feature of the day to day work of social care and health professionals, which can lead to a degree of professional complacency about the impact on children.

4.3 The thematic review makes some recommendations relevant to this review. Firstly, about the need to seek, document and share a parent's history, and secondly about the need for professionals to consider and understand the impact and risk when a parent misuses substances, including cannabis, on their ability to care for and safeguard their child.

4.4 Single agency learning has been identified during the review and recommendations have been agreed to address the need for improvement actions. There has been excellent cooperation with this review from partner agencies, which was essential in establishing the learning from this case.

4.5 Having considered the learning outlined in this report, the following recommendations are made:

Recommendation 1

The SSCP to propose that the HIPS protocol for protecting children who move across local authority borders[16] is reissued and widely promoted across the HIPS partnership areas to encourage improved cross border working with vulnerable families

Recommendation 2

That the learning from this review is shared with the Southampton Safeguarding Adult Partnership

Recommendation 3

That the SSCP seeks assurance from the relevant partner agencies about the quality of core groups[17], to include timeliness and the attendance of professionals and family members

Recommendation 4

The SSCP to request that agencies review their practice in respect of ensuring that the person caring for a child has PR and provide feedback on what recent progress has been made

Recommendation 5

The Southampton MASH to be asked to consider their expectations and processes regarding transfers from other Local Authorities in respect of children subject to a Child in Need plan

Recommendation 6

The SSCP to consider how it can promote

- the responsibilities of partner agencies to care leavers
- the responsibility to make adult safeguarding referrals and/or a referral for a Care Act assessment when a parent is an adult with care and support needs
- trauma informed practice with children and their parents
- responses to men who allege they are victims of domestic abuse
- what non-mental health professionals need to do when they are aware of a significant suicide situation[18]

[16] https://hipsprocedures.org.uk/qkyyol/children-in-specific-circumstances/protecting-children-who-move-across-local-authority-borders
[17] held following a child being made subject of a child protection plan
[18] This issue could be taken to the HIPS suicide prevention group

Recommendation 7

The SSCP to ask its partner agencies to consider how they can ensure that non-medical professionals understand the systems that provide health services, and that ‘health’ is more than one agency/service

Final