CHILD A
SERIOUS CASE REVIEW

Report into the injury of
Child A

7 February 2020
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Serious Case Review Child A Report

1 Reasons for undertaking a Serious Case Review (SCR)

1.1. Child A was taken to hospital when just over six months old very seriously ill. He had an abscess at the back of his throat which required surgery and he was found to be seriously underweight and malnourished. A CT scan showed that he had a significant injury, a rib fracture, suspected to be non-accidental. The circumstances of Child A were considered by the WSCB SCR group. They concluded that the criteria had been met for a SCR as:
   a. Abuse or neglect of a child is known and
   b. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.

1.2 WSCB appointed a Chair for the Serious Case Review panel and commissioned an Independent Reviewer to undertake the SCR.

1.3 The review primarily focused on the period 1st January 2017 to 1st April 2018. Agencies were asked to provide any relevant background information that should be noted by the review about the family’s history or the history of individuals in the family prior to the review period that may be relevant.

2 Method for the review. The review has used the following sources of information:

2.2 Each agency was asked to provide a chronology of their involvement with child A and his family from 1st January 2017 to 1st April 2018 together with an analysis of their involvement

2.3 Review of records held by Wandsworth and Croydon Social Care.

2.4 Interviews with key staff who were working with Child A and his family from the NHS and the local authority

2.5 Meeting with Child A’s parents.

2.6 The information has been used to develop a full chronology of events and this report.

2.7 The chronology and report have been discussed by the SCR sub-group for this review to develop an agreed understanding of what happened, what the key points are, draw out the learning and develop and agree the recommendations.

3 Family

Ms B: Early 20s
Mr C: Late teens
Child A: dob Mid 2017
The Family lived with paternal grandfather and Ms B's younger brother when Child A was born.

4 Family history prior to the review period
4.1 The review period begins early in the pregnancy of Child A. At this point his parents were using universal NHS services. There was no involvement with specialist services either in the NHS or the Local Authority. Both parents had traumatic and abusive childhoods. Ms B had been the subject of care proceedings in adolescence because of abuse and neglect while living with her mother and her partner. The proceedings led to her and her sibling being placed with their father at the conclusion of the proceedings.

Mr C reported being abused by his father and while his family had less involvement with children’s social care the abuse led to him leaving home early at age 16 yrs and a period of homelessness.

4.2 In 2007 Mr C was assessed for a statement of Special Educational Need. He was described as having a high level of anxiety and as being hyperactive and restless. He had intervention in school from 2002 when he was 4 yrs old. There was consideration of whether he suffered from Attention Deficit Hyperactivity Disorder (ADHD) and an Autistic Spectrum Disorder (ASD). There was no diagnosis.

4.3 The parents met while on a training programme. They established their relationship and were pleased when the Ms B became pregnant. Neither parent has any criminal history nor has had any significant contact with the Police.

5 Review Period 1st January 2017 to 1st April 2018
5.1 Pregnancy. Ms B booked early in the pregnancy at between 8 and 9 weeks. This was a GP referral to the ante-natal booking office. She attended for scans and routine ante natal appointments with her GP and the midwifery services. Ms B appeared well, and this was a routine first pregnancy with no medical, surgical or social issues noted. Ms B kept all her ante-natal appointments. There were no concerns about the baby’s growth or development. Ms B wanted Mr C to attend the birth. The birth was straight forward, and Mr C was present and took part through clamping and cutting the umbilical cord.

5.2 The Maternity staff thought Ms B and Mr C were both a bit different but there was nothing inappropriate in their behaviour. The safeguarding specialist midwife was consulted and confirmed there was no current involvement with Wandsworth Children’s Services. This check did not reveal that there was involvement with Ms B’s younger brother who was a member of the household Child A would be part of on discharge from hospital following his birth. The specialist midwife asked those discharging Ms B to contact the community midwives to offer extra support to Ms B. Child A was discharged the day after his birth which is usual practice for a first child where mother and child are both well.
5.3 The follow up visits by midwifery were unremarkable with no concerns expressed about the home environment. Ms B came to clinic as requested for follow up and reported feeling well, coping well and being emotionally well. Child A was observed to be well. The Community Midwifery service discharged Child A to the Health Visiting (HV) Service.

5.4 The health records do not indicate that a referral was received from the GP at the point of booking or from community midwives. No information was made available to the HV service alerting the service to any known vulnerability or risks relating to either parent. Ms B proactively contacted the Health Visitor about her introductory visit. The Health Visitor on this visit found Ms B and Mr C welcoming, friendly and looking forward to the baby arriving. They were excited and prepared. Ms B had attended antenatal classes. Ms B said she had had involvement with children’s social care as she was abused by her mother. Ms B said she no longer had involvement with children’s social care services. Mr C had been open as a Child in Need to Children’s Social Care in a neighbouring Borough. The parents reported they had supportive families. Both parents reported a history of anxiety for which they no longer required support. Ms B did most of the talking but Mr C was following the conversation and appeared engaged. Both parents appeared emotionally well.

5.5 The Family’s accommodation was cramped but adequate. They were sharing a two-bedroom home with Ms B’s father and her brother. Ms B, Mr C and the baby shared one room. The home smelt of cigarette smoke as maternal grandfather smoked but the house was observed to be neither dirty nor untidy.

5.6 The Health Visitor, based on the information gathered, offered the parents a Level 3 Universal Plus HV service. Level 3 – Universal Plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering concerns about parenting. It includes additional support for families where health needs have been identified. The HV service completed home visits at 13 days, 5 weeks and 7 weeks, which was mid-October. This was the HV Service’s last contact with the family as the plan was for the family to access the local Children’s Centre and Child Health Clinics.

5.7 The three home visits by the HV service were unremarkable. Child A was maintaining his weight gain with a weight of 3.84 kgs, 25th percentile at 5 weeks and 4.65 kgs also 25th percentile at mid-October. The expert Paediatrician in the Care Proceedings assessed the mid-October weight as showing the Child as at the 15th Centile not 25th. Ms B reported that she was well and there were no reported concerns about her mood or interaction with the child. Mr C was reported as more stressed due to tiredness and was advised to see his GP. The mid-October visit was planned. The HV undertook a maternal mood assessment where there were no indications of Ms B feeling anxious, low in mood or hopeless. Ms
B reported she was happy and enjoying motherhood. The Health Visitor was aware of the Family’s visit to St George’s Hospital (SGH) in late September where they reported a one-day history of flea bites. On this visit appropriate handling was observed and advice was given on the treatment of the flea bites. A check was made with Wandsworth Children’s Social Care which said the parents were not known to services. There were no signs of the flea bites on the Mid-October visit of the Health Visitor and the Health Visitor was informed that the family dog had been treated for fleas. The Health Visitor was informed that Ms B planned to return to work in November and Mr C would then be the main carer. The Health Visitor did not explore the detail of the care arrangements or the implications of Mr C becoming the main carer given what was known about the history of both parents. Ms B was expressing some concern about Mr C’s mental health, namely anxiety. The parents presented as in a stable relationship.

5.8 The HV reassessed the family and decided to step down the level of service to Universal Service which meant future contacts would be undertaken at the child health clinic and a one-year health review would be offered to Child A unless the parents requested any further HV support. The parents were informed this would be the last visit unless there were any concerns or additional support was required. They were signposted to local community services such as Children’s Centre services and Child Health Clinics.

5.9 The GP saw Child A in early September 2017 when the parents were concerned about reflux and Gaviscon was prescribed. Further medication for reflux was requested by the parents in mid September and provided. On this visit the GP gave advice on dilution of Child A’s feeds. This advice was incorrect. Feeds should not be diluted as this affects the nutritional balance and calorific intake of the feed. Child A saw the GP again in late September when further reflux medication was requested and a small 8mm by 3mm mark on the bridge of the nose was seen. Parents thought this might be from Child A lying on his dummy. This unusual mark was not enquired into further by the GP or notified to any other professional. At the next GP contact at the 8-week check Child A’s undescended right testicle was noted for follow up. Routine 8-week vaccinations were given on this date. Child A was subsequently seen by the practice nurse for 12- and 16-week routine vaccinations in November and mid December. There is no indication that the practice nurse noted anything of concern about Child A on any of these visits.

5.10 Child A was seen in MidDecember at Croydon Emergency Department with acute bronchiolitis. Parents reported Child A as 12lbs (5.44kgs). Child A was reported as alert, not dehydrated and weighed 5.44Kgs. It is not routine to weigh babies in Accident and Emergency Departments. There is no information on why Croydon Emergency Department weighed Child A on this visit. He was reported as feeding well. The Expert Paediatrician in the care proceedings said that this weight was on the 2nd/3rd centile indicating clear weight decline. Parents were advised on
care and what to do if concerned about Child A’s health. There is no documentation from Croydon Hospital to suggest any professional informed the parents that Child A was overfed. The parents later said they were given this advice at Croydon Hospital. Croydon Hospital reported that the Health Visitor and GP were notified of the visit but there is no record of this notification to the Health Visitor. There is a record of notification to the GP which said normal observations and no respiratory distress. Unless this notification came with a message for follow up this would not lead to any follow up by a GP.

5.11 The Paediatric expert in the care proceedings noted a weight of 4.1kg for Child A in late January 2018 recorded in the Red Book. This was a drop of over 1kg from the weight recorded at Croydon Hospital on in December 2017. However, having examined the Red Book it appears the paediatrician may have misread a poorly written and barely legible entry for 16/10/17 as an entry for late January 2018. The SCR panel examined the record in the Red Book and agreed with this interpretation of the record.

5.12 There were no further recorded professional contacts with Child A until his acute admission to St. George’s Hospital (SGH) in early March 2018. Subsequent to that admission and as part of the enquiries made the Parents of Child A say that they contacted their GP and tried to make an appointment in mid-February and also spoke to the GP surgery for advice. They reported a telephone conversation with the GP who said it was normal for a child’s weight to drop after feeds were reduced. There is no record of these calls in the GP records and the review was unable to find out whether calls were made to the GP or not. The parents also say they consulted a pharmacist in the three days prior to the early March admission and again tried to get a GP appointment. There is no record of this call to the GP surgery. Calls to the GP surgery are recorded but the records are only retained for three months. As part of the enquiries by the Police following Child A’s hospital admission the record of calls to the GP surgery was sought but as this was more than three months after March 2018 the records of calls had been deleted. This means the Parents’ account of calling the GP surgery cannot be verified.

6 Child A’s admission to hospital
6.1 Child A was presented to the emergency department of SGH in early March. He was brought in by ambulance acutely unwell. He was noted to be pale, breathing with a grunt, eyes open but not reacting, had normal tone and a widespread non-blanching rash and swollen neck. A CT scan showed he had a neck abscess. His weight on admission was 5Kg which was below the 0.4 percentile. Child A was acutely and seriously ill and was admitted to the Paediatric Intensive Care Unit. He required numerous interventions while in hospital to stabilise his acute medical condition and to rebuild his weight and physical condition. A chest x ray undertaken four days after admission revealed a healing fracture of a rib judged to be about 4 weeks old. Subsequent expert assessment judged the fracture 8 to 10 weeks old in early March 2018. His parents had no explanation for
this injury. There is no medical explanation for this isolated rib fracture. A consultant orthopaedic surgeon reported that rib fractures require significant force and that even though Child A had faltering growth his bone chemistry was not significantly abnormal. His nutritional status at the time did not explain the rib fracture.

6.2 Child A was the subject of a child protection enquiry and an Initial Child Protection Conference which agreed a Child Protection plan for Neglect. A Police enquiry was also started. This has concluded as there was insufficient evidence for a realistic prospect of conviction of anyone for the injury to Child A. Care Proceedings were initiated, and Child A was made the subject of an Interim care Order in April 2018. He was placed in foster care when well enough to be discharged from hospital. A Care and Placement order was made in respect of Child A in December 2018.

7 Information disclosed within the care proceedings.

7.1 Both parents had traumatic and abusive childhoods. They were both uncared for children rejected by one parent from whom they suffered significant abuse and their other parent was unable to protect them. Ms B was the subject of a Child Protection Plan and moved from her mother to her father’s care under a supervision order in July 2011 following care proceedings. She experienced serious rejection from the age of 10 years. Mr C reports he suffered serious physical and sexual abuse from his father. He attended a school for children with special needs. He left home aged 16yrs and experienced a period of homelessness.

7.2 The psychologist who assessed Ms B found she was in the low average range of ability and should not have particular difficulty in understanding routine daily tasks. However, Ms B had little insight into the local authority’s concerns. This was not due to lack of cognitive function but a lack of ability to mentalise i.e. to reflect on her mental state and put herself in someone else’s shoes. The psychologist thought Ms B had an Autistic Spectrum Disorder (ASD) and was depressed.

7.3 The psychologist assessed Mr C as having non-verbal reasoning in the average range but verbal reasoning in the borderline learning disability range. Overall Mr C is in the low range of cognitive ability and should not experience difficulty in undertaking daily tasks. He was able to mentalise and link his childhood experience with his current feelings of mistrust. The psychologist thought Mr C’s current level of psychological distress left him little emotional availability for a child. The psychologist wondered if Mr C suffered from Post-Traumatic Stress Disorder. The psychologist thought he suffered from ASD, Attention Deficit Hyperactivity Disorder, Depression and anxiety. Mr C was referred to an ADHD service for assessment.

7.4 The Forensic Psychiatrist who assessed the parents found Mr C suffering from anxiety and depression. Mr C told the Forensic Psychiatrist he did not know A was so unwell. He believed the child had a cold as he had a low immune system. Mr C said professionals told him the child’s weight would drop when he went onto solids. The Forensic Psychiatrist found Ms B
showed no understanding of the Local Authority’s concerns and said it was “especially noteworthy that she was not able to describe why she did not seek medical attention for her son despite significant weight loss.”

7.5 The Family Assessment identified that the parents had not recognised Child A was severely underweight and concluded there was a combination of the parents’ mental health needs, traumatic childhoods and additional needs – ADHD, ASD and learning needs that made it hard for the parents to parent without a high level of support. The parents were fully compliant with the Family Assessment attending all ten sessions on time.

7.6 The Social Work analysis reflected on the traumatic and abusive childhoods of both parents and that they did not understand the seriousness of A’s weight loss and fracture leading the social workers to consider how well the parents understood and processed instructions. The social worker described the presentation of both parents suggested something “not quite right”. The feeling of “something not quite right” was linked to Mr C’s need to manage his anxiety, that both parents could be lacking in appropriate boundaries to their behaviour and how Ms B managed her emotions.

7.7 The parents had a lot of contact which they always attended. However, within contact they did not take their lead from Child A in how they responded to him. The care proceedings showed that neither the maternal grandfather with whom Child A and his parents lived nor paternal grandmother played any constructive role in supporting the parents or in Child A’s care. The care proceedings concluded it was likely that one or other parent was responsible for the fractured rib and that this injury was not necessarily deliberately inflicted.

7.8 The expert paediatric report for the care proceedings identified that Child A’s weight was declining from December 2017. Child A’s height percentile was also declining from 8 weeks of age. The Paediatrician comments on the role of gastroesophageal reflux in Child A’s recurrent chest infections, the impact of this on feeding including that Child A had a poor swallow and possible risks of aspiration.

8 Views of the Parents of Child A
8.1 The parents of child A responded promptly to the invitation to meet the Independent Reviewer.

8.2 The Parents are very distressed by the loss of their child. They said Child A was a loved and wanted child. Their view is that they have been discriminated against because of their disabilities. They both have an autistic spectrum disorder, and both suffer from depression and anxiety. They believe they have been judged bad parents because they were abused as children themselves. They are trying to get help with how their abusive childhoods have affected them.
8.3 The reviewer asked them about the injury their child suffered. They said they were not responsible for the injury and that either the Maternal Grandfather or Maternal Grandmother could have been responsible. The Maternal Grandparents both had care of the child during the time the injury occurred. The parents reported that the child always cried when with his paternal grandfather. If their child had been injured by one of the maternal grandparents, the parents could not have identified the injury. The expert evidence in the care proceedings was that the child would have shown discomfort and pain following the injury, but it would not have been identifiable from this that the child had a fractured rib.

8.4 The parents said they had not neglected their child’s feeding. They described the visit to Croydon Hospital in December when their child had bronchiolitis. They said the hospital weighed their child and said he was too heavy and that they should reduce his feeds to 5 or 6 ozs from 7/8ozs as he would eat all the larger quantity of feed. They said Child A was not suffering from reflux at this time. Subsequently they did notice a bit of a drop in their child’s weight but not enough to worry them. The major drop occurred when their child fell ill, and this weight loss was rapid in the few days prior to the hospital admission in March 2018. They said that in the days before they called the ambulance, they tried to get help. This included efforts to contact the GP and Tooting Clinic. Paternal Grandfather who did see their child said nothing to indicate he was concerned. The parents said they tried to get help but did not get this right.

8.5 Ms B said she did give information on her background to professionals. She recalls getting leaflets on feeding and clinics for weighing from the Health Visitor. Ms B did not recall getting advice about going to a Children’s Centre. The parents said they think they would have responded positively if there had been more enquiry about their background. They said they were open to help and would have responded positively if help and guidance had been offered.

8.6 The parents felt demeaned in meetings and made to feel bad parents. Terms were used they did not understand. There was no accommodation made for their difficulties as disabled people. They think advice to them may not have been worded properly. They feel positives such as them taking turns with their child were ignored. The parents feel they should have received help and that they have not had justice.

9 Analysis.
The analysis identifies key issues the review of the history raises and questions for the SCR panel to consider.

9.1 Child A was seriously malnourished, acutely ill and had suffered a significant injury when admitted to hospital in early March 2018. He was not seen by a professional after Mid December 2017. His parents had not responded to his seriously declining weight and acute health needs until he was very seriously ill. That he was seriously ill and malnourished and in desperate need of medical attention was obvious to the ambulance crew
who went to the home and to those who attended to him in emergency care. They described Child A as ‘skin and bones’ with knees, chest and ankles protruding. These obvious signs of being underweight had not been identified by his parents. This suggests they did not recognise the very serious level of neglect their child had suffered. Child A’s parents view is that they lacked advice and support that recognised the disabilities they have and the difficulties this meant for them as new and inexperienced parents.

9.2 A great deal is now known about Child A’s parents through the evidence gathered for the care proceedings that was not known to the professionals who met them during Ms B’s pregnancy and the post-natal contacts. A central issue for the review is whether the vulnerability of the parents and its possible implications for the care of their child should have been identified during pregnancy or in the weeks after A’s birth. Child A’s parents view is that their vulnerability and disabilities were not recognised and that they were greatly disadvantaged by this. They did not receive the help they needed. They say they would have responded to such help and given they kept all ante and post-natal appointments and were cooperative in all contacts with professionals the evidence is they would have responded to help, and guidance had it been offered.

9.3 Ms B did disclose they had history with children’s social care as children but had no current contact. Mr C also indicated he suffered from anxiety and had had treatment for this. This information did provide an opportunity for the midwife or health visitor to explore this history further. At least some of this information was known to the GP but was not included in the booking referral or any antenatal referral which might have set out risk factors in the history of either parent. However, given the absence of other contraindications e.g. no history of domestic violence, no substance misuse, no missed appointments, lack of preparation for the baby, poor emotional and physical health of Ms B, no developmental issues with the baby in utero, the review needed to consider what the expectations are for enquiries to be made of other agencies or for a health visitor or midwife to explore parental history in any depth.

9.4 Child A was born at full term a healthy baby. Mr C was present at his birth and Child A went home from hospital with his parents the day after his birth. The Midwives in hospital did note Ms B seemed a bit different but saw no inappropriate behaviour. It was hard to pinpoint what those meeting the parents were saying but they did seem different. In retrospect and given the parents difficulties which are now much clearer, identification of their needs at this stage would have led to the provision of greater support and advice. There was a lack of curiosity about what was different about the parents and a lack of recognition of their learning difficulties.

9.5 The post birth midwifery visits at home and to clinic were unremarkable. There were no indications of concern. Ms B reported feeling well, coping well and emotionally well.
9.6 The Health Visiting visits were also unremarkable. Child A was gaining weight, dressed appropriately, and parents were observed to handle him confidently. No issues were identified with the home environment. Child A having flea bites appears to have been a one off and the parents appeared to have taken action on this by ensuring the family dog was treated for fleas. There is no information on whether the members of the household or the house was also treated. Child A’s parents were accessing medical services for Child A appropriately at this point. There was no enquiry about the role of the maternal grandfather in whose home the family lived or the maternal uncle. The parents said that Ms B would be returning to work and Mr C would be the main carer. This was an opportunity to explore with the parents and make further enquiries about how the care arrangements would work when Ms B returned to work before a decision was made to step down from Universal Plus to Universal HV service. This was an early return to work given the age of Child A. This return to work was in part prompted by the urgent pressure on the parents to financially contribute to the household. The health visitor might have explored this more fully given Mr C had a history of anxiety and there was a background of vulnerability for both parents. A key issue for the review is what level of exploration of proposed care arrangements between parents is appropriate without contraindications beyond history.

9.7 The health visitor stepped the level of service down from Universal Plus to Universal. With the benefit of hindsight this was premature given what was known about the parents’ history and the planned change in main carer for Child A.

9.8 The review has not been able to get a full picture of the context of the HV Service in autumn 2017. This was a different provider to Central London Community Health Care who are providing these services now. The HV was working in the busiest team in the borough. In September 2017 the Team establishment was 10.55 Whole Time Equivalents (WTE) and there were 2.47 WTE vacancies i.e. nearly 25%. This staffing pressure may have influenced decisions about level of service to be provided. However, if the Parents’ learning difficulties had been recognised, they would not have had a universal service.

9.9 The national picture is of declining HV numbers and increasing need in terms of numbers of Child Protection cases and parents with significant mental health needs who have to be given priority in Health Visiting work.

9.10 Croydon Hospital records indicate that the GP and the health visitor were informed of the visit of Child A to the hospital in December 2017. There is no record that this notification was received by the health visiting service. Had this been received this notification might have led to a follow up visit by the Health Visitor.

9.11 Child A’s parents say they tried to make contact with GP services several times in February 2018. There is no evidence for these contacts in
the GP records. In the care proceedings the local authority took the view that regardless of whether the parents made these contacts or not when they were not able to get an appointment, they should have taken other action such as taking the child to an emergency or walk in service.

9.12 Child A’s parents were unable to recognise that their child was acutely and seriously ill. No one in their household recognised this. The ambulance crew who attended and those who saw him on emergency admission could see how acutely ill Child A was and that his level of illness and distress would have been evident to a non-medically trained person.

10 Conclusions
10.1 The Parents’ did not recognise that their child’s weight had fallen, he was seriously underweight and that he was very seriously unwell when brought to hospital in March 2018.

10.2 There were opportunities to make deeper enquiry into the backgrounds of both parents which were not taken by professionals in contact with them. There was sufficient information to identify that the parents were potentially vulnerable as adults and as first-time parents. Such enquiries and greater curiosity about the parents’ histories and needs might have led to a more realistic assessment of their vulnerability as adults, including of their learning difficulties, and as parents to Child A. This would have led to the Family remaining on Universal Plus level of Health Visiting Service and to proactive offers of services to support their parenting. Deeper enquiries might also have identified that though the parents reported good family support this support was limited. It is evident in retrospect that Child A’s grandparents were not providing supportive care, advice and guidance to the parents which might, for example, have identified Child A’s weight loss much earlier and ensured the parents sought help for this much sooner.

10.3 This leads to questions about:

- what are the expectations for the enquiry into and gathering of background information on parents where there is a history of vulnerability but where there are no or few contraindications in the care of a child or the behaviour of the parents?
- What is the scope of and legitimacy of greater professional curiosity?

10.4 The review raises questions about when and how judgements are made about providing a higher level of service on the basis of parental vulnerability where there are no contraindications in the care of the child. If there is an expectation of providing a higher level of service to such families who might provide such services and on what basis? The review emphasises the importance of routine information sharing of the kind that happens between A & E services and community health services.

10.5 The Parents did have significant additional needs which were not recognised. This lack of recognition disadvantaged them as they did not
receive the support they needed and would probably have responded to positively. At all times they were cooperative with services.

10.6 There were indications that the parents’ behaviour did raise concerns with some staff but the signals from the behaviour were not clear cut. The review raises questions about how staff should treat and act on feelings or observations which suggest something is different or may not be quite right but where it is hard to articulate such feelings or observations with any precision.

10.7 Finally, the review recognises that there should be a discussion with the parents about any future plans to have a child

11 Recommendations

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<th>Recommendation</th>
<th>Reason for Recommendation</th>
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<td>1. Learning event focused on:</td>
<td>Central to this SCR is that the vulnerability of the parents’ and what this might mean for their care of a child was not explored or sufficiently explored. This is a complex issue which needs to be reflected on in depth to consider what training and development would lead to practice improvement. It will be important to understand what facilitators need to be in place if there is an expectation of behavioural and practice change leading to fuller exploration of parents past and potential vulnerability.</td>
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<td>a. When and how to confidently explore parental background, indicators of vulnerability, and adverse childhood experiences.</td>
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<td>b. What training in neurodiversity would assist practitioners?</td>
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<td>c. How to create cultures of professional.</td>
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<td>d. How to use feelings of unease or discomfort to inform assessment and decision making.</td>
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<td>e. The role of early help services in working with and supporting vulnerable families.</td>
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<td>2. Development from the learning event of advice for WSCB on how to improve practice with vulnerable parents and their children.</td>
<td>To capture from the learning event advice that can help improve practice.</td>
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<td>3. Strengthen education, training and screening on ASD, ADHD, Anxiety disorders and what such difficulties mean for parents’ understanding and interpretation of information for all health agencies in contact with parents and children.</td>
<td>ASD, ADHD, Anxiety disorders can be difficult to identify. In this case there were indications from the parents of their difficulties. Staff need to feel confident when and how to explore such issues and when to seek specialist advice.</td>
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4. **Review of Health Visiting Workloads by the Wandsworth Safeguarding Children Partnership (WSCP)**

There are indications from this review of the pressures on the Health Visiting service. The WSCP needs a realistic picture of what the Health Visiting service is providing as a universal service for 0 to 4 yr olds as part of its quality assurance function.

5. **Wandsworth Children’s Social Care (WCSC) to review how checks of whether a child and their family are known to the service to ensure the responses to such checks include the whole family and household.**

In this case checks were made to WCSC with a narrow focus on whether Child A and his parents were currently known. There was no wider check of whether other members of the household were known or whether the Parents had been known in the past in that context.

6. **WSCP to undertake a review of how effectively the mechanism for alerts to community health services including GPs and the Health Visiting service of children attending Accident and Emergency or other urgent care NHS services are working.**

Child A attended A & E and a notification was sent to the GP and to the Health Visitor. The notification was never received by the Health Visitor.

7. **A reminder to GPs that infant formula should be made up only as set out by the manufacturers and that parents should not be advised to dilute formula under any circumstances.**

Evidence from this review that not all GPs are aware of this advice.

8. **Discussion with the parents about any plans to have a child in the future.**

The parents are together in a committed relationship and may want to have a further child. How this will be responded to and what help and support they will receive needs to be discussed with them.

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Colin Green
Independent Reviewer
21st August 2019