



**Wiltshire Safeguarding  
Children Board**

# **SERIOUS CASE REVIEW**

**BABY J**

Baby J received injuries whilst in the care of his parents, which were considered to be non-accidental. The family were known to services.

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## INTRODUCTION

1. This Serious Case Review (SCR) concerns a baby who in September 2014, aged 6½ weeks, received injuries whilst in the care of his parents. The baby was medically examined and found to have a fractured rib, torn frenulum and bruising, considered to be indicative of non accidental injury.
2. The baby was placed with foster carers and he appears to have made a good recovery from his injuries. No one was charged with any criminal offence.

### Conducting a Serious Case Review

3. When abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.
4. In this case the family had been known to the universal services, that is doctors, midwifery, health visiting and housing and an assessment by Children's Social Care was underway at the time the baby was injured. Wiltshire Safeguarding Children Board (WSCB), after some debate about whether this case met the threshold for a SCR, decided the criteria was met and notification of the decision was made to the Department for Education.

### Review Period

5. A Review Group was established and agreed the review period would be eleven months, from the time the mother's pregnancy started to the date the baby's injuries were diagnosed.

### Method

6. The Review must be conducted in line with government guidance, Working Together to Safeguard Children, 2015. In view of the move towards using systemic models and practitioner involvement to promote learning, the Board decided to use a review model known as a Partnership Learning Review. Involving practitioners, the baby's family and working with a Serious Case Review Group, the Review addresses the question of who did what and why. It also recognises that people work in complex organisations where a range of factors can impact on the nature of the work; the findings are reflected in the learning points and recommendations to the Safeguarding Board.
7. This case was unusual in that a high number of staff who had worked with the family during the period of the review, particularly from Children's Social Care, were no longer

in post, and were unable to be contacted. This meant that there were some gaps in the information available to the reviewer.

### **Involvement of Family Members**

8. The Independent Reviewer, with the help of the SCR Group, tried hard to encourage family members to participate in this review. The baby's father declined the invitation to share his views and, although initially other family members agreed to meet the reviewer, after some significant family events, circumstances changed and it was not possible to arrange this. The baby's maternal grandmother spoke to the reviewer on the telephone and was able to provide some background information based on her limited involvement with Baby J during the review period.

### **Findings and Recommendations**

9. Each agency involved with this family prepared a chronology of their involvement and critically reviewed their own practice. They all identified learning and have made some changes to the way they work in order to improve their service. This SCR accepts those recommendations and in addition has produced findings which require further work by the WSCB before deciding what action to take. The SCR acknowledges that learning and practice development is an integral part of the work of the WSCB and findings from this review must be considered in the context of the ongoing work.

A Glossary of Terms is appended to explain the terminology

## FAMILY BACKGROUND

10. In order to protect the privacy of the family the baby is known as Baby J and his parents as Ms J and Mr J.

Significant family members are:

Baby J	Subject of this Review
Ms J	Baby's mother, aged 18 when the baby was born
Mr J	Baby's father, aged 21 when the baby was born
Ms J's father	The family lived with him for part of the review period
Ms J's mother	The family lived with her for part of the review period

### Summary of Family History

11. Ms J became pregnant just before her 18<sup>th</sup> birthday, Mr J was 21 years old. Ms J reported they had been in a relationship for over a year and, although unexpected, the pregnancy was welcomed.
12. Ms J was known to Children's Social Care. Her parents had separated when she was a child and she had lived for a number of years with her father who, at the time, had a substance abuse problem. As a result of the concerns about parenting, some of Mr J's children had been taken into care (Ms J's half siblings) and it was believed Ms J suffered neglect; her name was on the Child Protection Register for about a year.
13. Ms J moved back with her mother when she was about 14 years old.
14. Ms J reported that her relationship with her mother was strained at times and Ms J and Mr J made an application for accommodation which led to them moving into a supported housing project soon after Baby J was born.
15. Little was known about Mr J prior to Baby J's injuries. He was not known to Children's Social Care and had no criminal convictions. Ms J had told midwives that Mr J had used cannabis in the past but, in general, she reported that he was a supportive partner and their relationship was good.
16. Mr J had been working with a local service for people with drug addiction and in the days leading up to Baby J's injuries he had approached his GP to discuss his substance misuse.
17. In the single assessment by Children's Social Care which followed Baby's J's injuries, Mr J disclosed further information about the extent of his drug use and some difficulties in his own childhood including witnessing domestic abuse between his parents. This was not known to professionals working with the family during the period of this review.

## KEY EVENTS

December 2013	Ms J becomes pregnant
February 2014	Ante-natal booking, Ms J is identified as vulnerable because of her age
April 2014	A CAF is initiated on Ms J in line with the local protocol and Ms J discloses some family history
May 2014	On the basis of the information in the CAF, midwifery make a referral to Children's Social Care for the unborn baby
June 2014	Following a discussion about the referral, Children's Social Care advise that it did not meet the threshold for intervention and a TAC meeting was the best way forward
June 2014	TAC meeting held, support plan drawn up which includes referral to the local children's centre
July 2014	Ms J misses several ante-natal appointments
August 2014	Ms J reports problems in the relationship with her own mother and needing to use the food bank, referral made for housing
September 2014	Some concerns from the midwife about Baby J's growth, and Ms J's health, baby's growth checked, small but within normal limits. Mr J was assessed for service by a local drug and alcohol team because of his addiction to opiates
End September	Baby J born, normal delivery, 2.9 kgs Concerns about Ms J being homeless, going back to stay with her father and using the food bank. 2 <sup>nd</sup> referral to Children's Social Care. Referral meets threshold for a single assessment
October 2014 Baby J aged 12 days	Social worker visits to begin assessment. Family moves to supported housing placement in the same county but in a new area. They registered with a GP and had a new health visitor
Aged 36 days	Baby J seen at clinic, health visitor reports faltering weight gain
Aged 40 days	Baby J taken to GP by his father with concern about bleeding gums two days previously, nothing seen on examination
Aged 46 days	Mr J asked his GP for a medical certificate saying he couldn't work because of his treatment for drug addiction Baby J seen by health visitor who is concerned about his weight gain and recommends GP appointment Baby J seen by GP who referred the baby to paediatrician to be seen within five days
That night, baby aged 47 days	Baby J's parents call an ambulance saying the baby wasn't breathing, on examination the baby was found to have injuries considered to be non accidental. The baby was placed with foster carers when discharged from hospital

## ANALYSIS – PRE-BIRTH PERIOD

### Using the Common Assessment Framework (CAF)

18. This family first became known when Ms J was eight weeks pregnant and was booked in with her local maternity services. Because she was under 18 when she became pregnant, Ms J was subject to the CAF Pathway for all Expectant Young Mothers. This meant that she would get an enhanced service with a greater level of support, access to the Young Parents Midwife and have her needs assessed using the Common Assessment Framework, known as a CAF.
19. Participation in the CAF process is entirely voluntary. It originated from the reform agenda which following a child death inquiry in 2003; by identifying a family's support needs and strengths, it was intended to provide a "needs led, evidence based tool to promote uniformity, ensure appropriate early intervention, reduce referral rates to local authority children's services and lead to the emergence of a common language amongst child welfare professionals."<sup>1</sup>
20. If, during the assessment, any safeguarding concerns are identified, the CAF will enable a referral to be made to Children's Social Care. If the assessment identifies a need for help with, for example, housing or if other professionals are already working with the family, a meeting will be convened and a plan will be drawn up to clarify who will do what and when. This is known as a Team Around the Child meeting, often referred to as a TAC.
21. In Wiltshire there is guidance for staff in all agencies who lead the CAF process and a specific document relating to teenage mothers called "Practice Standards for the Wiltshire CAF Pathway for Expectant Young Mothers." The guidance details the purpose and benefits of the CAF and makes reference to the Multi Agency Pre-birth Protocol to Safeguard Unborn Babies. The guidance indicates that once completed, it must be registered with the CAF co-ordinator. It is also the midwife's responsibility to send the CAF to the health visitor, the local children's centre and the mother's GP (with the young person's consent).
22. If there are no identified needs, the CAF can be "closed". Although best practice would indicate that professionals would reach agreement about when to close the CAF, there is no guidance on this in the policy and the midwifery service said they believed this couldn't happen until the baby was born. There is a pictorial representation of the CAF pathway in the form of a flow chart.
23. The expectation is that 28 weeks into the pregnancy the health visitor will meet with the expectant mother, review the plan and take on the role of lead professional.

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<sup>1</sup> Warren House Group, Dartington Social Research Unit (2004) Towards a Common Language for Children in Need

24. In this case the CAF was initiated in good time and Ms J met with the midwife in May 2014, when she was about 11 weeks pregnant. During the assessment meeting Ms J gave information to the midwife which indicated that, in addition to her age, there were other factors in her life which enhanced her vulnerability. These were her own father's history of substance misuse, that Children's Social Care had been involved with her family and her step siblings had been taken into care; she also alluded to her own experience of neglect. Because of this, the midwife sought Ms J's agreement to refer the unborn baby to Children's Social Care. (Referring "unborn" children allows an assessment of need to take place before the baby is born and a support plan to be put in place.) The midwife also started making plans for a TAC meeting.

### **The Team Around the Child Meeting (TAC)**

25. The TAC meeting was held in mid June 2014. Shift patterns meant it was attended by a different midwife from the one who had carried out the CAF assessment. Two health visitors attended, one who was to take on the case later in the pregnancy and one to take notes. One or both of the parents attended, the notes don't say who was there and the professionals can't remember. The intention was that the local Children's Centre would also be invited to attend but they have no record of an invitation and were sent the plan after the meeting. The professionals cannot remember the written CAF assessment being seen by those at the meeting, suggesting it was not available to them.

26. The notes of the meeting indicate the focus of discussion was the family's need for housing.

### **How Effective was the CAF/TAC?**

27. In this case the CAF was completed, signed by Ms J and registered with the CAF Co-ordination Team.

28. The midwife allowed plenty of time to undertake the task but the form indicates only that Mr J was present. (I think this is a recording error, Ms J signed the form.) There is some useful information, some subjective comments and some general comments, overall the quality of information on the form was poor.

29. Whilst referring to Children's Social Care once the CAF was complete might have been an appropriate action, deciding to set up a TAC at the same time suggests the level of concern was unclear to the midwife. Children's Social Care decided that the referral did not meet the threshold for their intervention, they were reassured that the TAC meeting had taken place, citing this as a useful mechanism for supporting this family, although they were unaware of the outcome of the meeting or what was discussed.

30. The TAC plan was incomplete, family names and details had not been included and there was no named lead professional. The plan itself focussed on the housing issue and a desired outcome noted as “improved knowledge about parenting”; this was to be addressed by the parents undertaking a parenting course although the plan does not say why, where or with which provider. The Children’s Centre was given tasks but was not invited to the meeting. The plan was not reviewed at any stage and appears to have quickly become redundant.

### **What was the Benefit of the CAF/TAC for the Family?**

31. It is difficult to see any benefit for this family of having engaged in the CAF/TAC process. The CAF did acknowledge their need for housing and the couple was encouraged to make an application through the council which led to them being given a place in supported housing just after the baby was born. The TAC also provided an opportunity for midwifery and health visiting to meet each other and with the parents, although it is difficult to see what this achieved. By the time the health visitor became involved with the family, at around 28 weeks into the pregnancy, the TAC appears to have been forgotten.

### **What Factors Impacted on the Effectiveness of the Work?**

32. In discussions practitioners identified a number of factors impacting on the quality of individual CAFs and the effectiveness of the system:
- a) Midwives are required to undertake a CAF on all expectant mothers aged 18 and under.<sup>2</sup> Given that a CAF can take up to 1½ hours this is a substantial workload for a midwife and the quality may be compromised by the high demand. Balancing the competing workload pressures for midwives is a national problem and discussion during this review suggests midwives see completing CAFs as an addition to their primary task.
  - b) Some midwives consider that it can be clear early on in a pregnancy whether or not a CAF would be helpful to a particular family and therefore question whether it is actually necessary to do one on all young mothers.
  - c) Carrying out a CAF on every young mother may also diminish the value of the CAF, staff reported that they can feel “woolly and inconsistent” and that “not many progress to a TAC”. For those that do, the TAC might be a meeting of just one or two professionals described by staff as a “TAC chat”. The risk is that the focus of the TAC becomes on what the parent might want, for example practical help with housing, not on what they might need, for example support with a drug abuse problem.

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<sup>2</sup> 61 CAFs were completed in 2015, 73% of the number of expectant teenage parents. Reasons for non completion include lack of consent and moving away.

- d) There was useful discussion among staff during this review about the focus of the CAF/TAC being on the *parent's* support needs, not the needs of the unborn *child*, and how effectively the CAF assists with early identification of any potential risks in parenting capacity which might lead to a pre-birth assessment.
- e) The CAF relies on the expectant parent's self-disclosure. This means the worker carrying out the assessment needs a degree of skill in assessment practice, to demonstrate professional curiosity, be aware of potential risk factors and be confident about asking probing questions. It was evident during this review that not all staff were confident about when and how to ask probing questions, for example about the baby's father.
- f) Staff reported that the computer system in place at this time which was used to record information was inflexible and did not include sufficient space. Completed CAFs were sent by midwives to the central health visiting team by post because there was no shared secure email system at that time. This caused delays and risked documents being lost. There was also some confusion among staff about who should be notified when the CAF is completed; in this case the GP was not informed. The policy on when a CAF can be officially closed was not well understood.
- g) The CAF tends to be seen as one-off exercise which once done and the assessment concluded, is not re-visited as more information comes to light.
- h) There is no agreed process for managerial oversight of compliance with the procedure or the quality of the assessment.

#### **Learning Points**

- For CAFs to be effective they must be based on a robust assessment and plan.
- The CAF provides useful information for others in the safeguarding system, including GPs. It is important that the CAF is shared with the relevant professionals helping build a holistic picture of family functioning.
- Retaining a focus on the unborn baby enables practitioners to consider the impact of the parents' circumstances on their capacity to care for a baby.

## What Needs to be Done?

33. Based on this case, the evidence indicates the CAF/TAC process is not working effectively.
34. In November 2014 the Wiltshire Safeguarding Children Board commissioned an audit of the CAF Pathway for Expectant Young Mothers.<sup>3</sup> The audit looked at the three maternity service providers in Wiltshire and was based on a sample of 27% of the total CAFs completed in an eight month period.
35. The findings from the audit indicate that the ineffectiveness of the CAF in this case is not unique. The audit comments on, for example, lack of engagement with children's centres who were not invited to TACs, variable practice in how information was received and recorded, inadequate exploration of issues raised by young mothers and lack of outcome focussed planning or in some cases no action plans.
36. The audit makes 12 recommendations for action including that the Pathway be updated to include reference to the Multi Agency Pre-Birth Protocol to Safeguard Unborn Babies and the Peri-natal and Infant Mental Health Pathways. The WSCB is currently discussing Early Help with the Wiltshire's Children and Young People's Trust (Children's Trust) whose responsibility it is to develop the service; quality and safety of the practice remain the responsibility of the WSCB.

### For the WSCB

- Early identification of the most vulnerable young mothers is an essential element of the safeguarding system and the CAF process is an important part of early intervention. This case indicates the CAF/TAC process is not being used effectively with young mothers and the links with Pre-Birth Protocol to Safeguard Unborn Babies are not well understood.
- This review indicates that there are a number of challenges for staff in implementing the CAF process for young expectant mothers. Further work needs to be done by both the WSCB and the Children's Trust to consider the findings from the 2014 audit and those from this case to determine how the process can be embedded, improved and sustained. This case demonstrates that improvement cannot be easily addressed by further guidance or more onerous expectations.

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<sup>3</sup> Audit of the Wiltshire CAF Pathway for Expectant Young Mothers, WSCB, Currie and Gill, November 2014

### **The Period Leading up to Baby J's birth**

37. In July Ms J missed four ante-natal appointments at the birthing centre where she planned to have her baby, these were followed up and new appointments made. Ms J's mother told the midwives that Ms J was also being seen at the local general hospital and didn't know she had to attend both centres.
38. At 29 weeks pregnant Ms J was introduced to a health visitor. Practice standards for health visitors indicate that all expectant mothers should be seen at this stage however capacity issues lead to prioritisation of resources; therefore it was good practice that Ms J's vulnerability was recognised and the finite resources appropriately targeted.
39. In August, when she was 31 weeks pregnant Ms J told the midwife that she was having a difficult relationship with her own mother with whom she was staying and was about to be made homeless. The TAC plan had included providing support to find accommodation but this had yet to be brought to fruition.
40. Six weeks later, 10 days before Baby J was born, Ms J again reported to the midwife that she was sofa surfing and needed a food bank referral as she was struggling to feed herself.
41. In their management review as part of this SCR, midwifery posed the question of whether either or both of these pieces of information raised the level of concern about the family to a point at which another referral should have been made to Children's Social Care. Both were an indication that Ms J's ability to care for a new born baby was precarious however there is no indication that the midwives considered the impact of Ms J's current situation, along with what was known of her history.
42. The CAF remained open although there had been no review of the assessment or the plan.
43. The midwifery review highlighted as a contributory factor the lack of regular case management support and advice for the young parent midwives at that time, combined with staff sickness reducing the availability of specialist safeguarding advice. This inhibited discussion about making a referral with a safeguarding advisor. Although staff at the Multi Agency Safeguarding Hub are available to give safeguarding advice, the practitioners who participated in this review reported that it can be difficult to make contact with the appropriate person.

### Learning Points

- Assessment is a dynamic process: if new information comes to light or the family circumstances change, this may affect the nature and degree of the risk.
- All information must be considered, not just as isolated incidents, but as part of a whole picture. Retaining a child focus is important and it may be necessary to re-consider whether or not to refer to Children's Social Care.
- Access to case supervision and specialist safeguarding advice enables staff to reflect and think systemically about cases.

### Referral to Children's Social Care

44. The Multi Agency Pre-Birth Protocol to Safeguard Unborn Babies was approved by the Wiltshire Safeguarding Children Board (WSCB) in January 2014 and updated December 2015. Its stated aim is to

*'enable practitioners to work together with families to safeguard unborn babies where vulnerability and risk factors are identified. It provides an agreed process between Health and Children's Social Care and other relevant agencies on the planning, assessment and actions required to safeguard the unborn baby.'*

45. The Protocol lists a number of risk factors which "should alert professionals to consider a co-ordinated response", these include involvement in risky activities such as substance misuse, parents with mental health support needs or who are known because of historical concerns, including the parent's own childhood history, and those who are young parents or homeless. The Protocol also highlights the "important role of fathers".
46. It is this document which assists professional staff in deciding whether the case meets the threshold for a pre-birth assessment from Children's Social Care.
47. In this case, the first referral was made to Children's Social Care when Ms J was six months pregnant; Children's Social Care decided that it did not meet the threshold for a pre-birth assessment and that the TAC provided the best way forward for the family. In addition to the written referral, a conversation took place between the referring midwife and a social worker from the team which manages incoming referrals. The records and recollection of the staff suggest that during this conversation the focus was on the way the family presented themselves, which was caring, looking forward to the baby, excited about moving, wanting to move away from Ms J's father (although he was known to be a support to Ms J). These were all perceived as "protective factors". There was no consideration given to the unseen or underlying factors, for example, the potential impact of the parent's childhood experiences on their parenting capacity. The social work manager's thinking was also influenced by the undesirability of labelling all expectant mothers with a complex history as unable to parent safely.
48. There is little evidence that the protocol was used effectively either in making the referral or deciding on a response. The referral was not specific about the concern or the

cause for concern and the outcome, “to give information and advice” (to the referrer) gave no indication that the risk factors in the Protocol had been considered. It is also concerning that the baby’s father was not mentioned in either the referral or the decision making.

49. In discussion with practitioners during this review (in February 2016) half of the group (of nine practitioners) acknowledged they did not know about the Protocol. Further exploration indicated that this was because of a perceived overload of information coming from both the participants’ own agencies and the WCSB and lack of time to prioritise and read important documents.

50. In this case the use of the Protocol, and in particular paying attention to the language of the Protocol when making a referral, would have helped the referrer be more specific about why they were referring an unborn baby, mitigate the risk of subjectivity and lack of a shared language. A good example which was offered as part of learning from this review was using the phrase in case recording “*no concerns about parenting*” when this actually meant there was no evidence enabling the practitioner to assess parenting capacity.

#### **Learning Points**

- The Multi Agency Pre-Birth Protocol to Safeguard Unborn Babies is a valuable and practical tool for all practitioners assessing risk and protective factors. It is especially useful for those making and deciding the outcome of referrals.
- All practitioners need to be mindful about the importance of language when sharing information about families. Good intentions and parents’ awareness of potential risks to a baby are not protective factors.

#### **For the WCSB**

- This SCR highlights that a substantial percentage of staff in this case were not aware of the Multi Agency Pre-Birth Protocol to Safeguard Unborn Babies and that it could be used more effectively. Multi agency partners must consider how knowledge of the Protocol can be disseminated effectively within their agencies, consider a range of methods to disseminate the information and monitor its effectiveness.

## **ANALYSIS – POST-BIRTH PERIOD**

51. Baby J was born at the end of September, he was a relatively small baby at 2.9 kgs. For the first 10 days of his life Baby J lived with his mother at his maternal grandfather's home. The records do not indicate where Mr J was living.

### **Referral to Children's Social Care**

52. Following his birth, the midwife at the general hospital where Baby J was born telephoned Children's Social Care to discuss the case and made a written referral. The concerns were primarily Ms J's homelessness and her need to use the food bank. The referral noted these concerns which were exacerbated by the fact that Ms J was being discharged to her father's address and he had a history of substance misuse. Children's Social Care decided the referral met the threshold for intervention and said they would carry out an assessment, known as a Single Assessment.

### **The Single Assessment**

53. There are clear guidelines for social workers about how to undertake these assessments, which explain that they must include information from other agencies, state how quickly the child should be seen and within what timescale the assessment should be completed. There is a sliding scale to determine how quickly the work should be completed which depends on the urgency of the case, but in all cases the assessment must be completed within 45 working days. In this case the expectation was that the assessment would be done within 25 working days and the baby seen within five working days of the referral.

### **Quality and Timeliness of the Assessment**

54. In the event, neither of these timescales was met and the assessment was not completed before the baby was injured 6½ weeks later. Only one visit was made to the family when the baby was 10 days old. It appears from the limited records available (both the social worker and manager have since left the area and were not available to be spoken to) that the focus of the assessment was the risk posed by the maternal grandfather, with whom the family were temporarily living, housing and the family's support needs once they had moved. The recording was incomplete and the assessment was added to by a new social worker after Baby J had been injured.
55. The standards clearly state that all agencies and/or professionals who have had recent contact with the child should be consulted to inform and strengthen the assessment. There is no evidence this happened in this case.
56. There is very little information about Mr J and his background in the assessment before the baby's injury which suggests this was not considered important. After the injury,

child protection enquiries found that Mr J had a significant history of drug use, the records refer to cannabis, amphetamine and heroin, and he had witnessed domestic abuse in his own childhood. Whilst all agencies rely to some extent on self-reporting in assessing parenting capacity, the lessons are that information sharing is vital along with consideration of the history of both parents.

57. The assessment prior to the baby's injuries contains some information about Ms J's childhood experience but no analysis of the potential impact of this on her own parenting capacity.

58. In summary, the assessment would have been improved by:

- Seeing the baby within the agreed timescale
- Reaching a conclusion within the timescales that had been agreed with the manager
- Consulting with others who had knowledge and information about the family
- Paying attention to the background and role of the baby's father
- Considering the parents' history and the potential impact of their experiences on their parenting capacity
- Complete recording

### **What Factors Contributed to the Quality of the Assessment?**

59. Both the social worker and the manager were temporary, have since left the authority and were not available to participate in this review. Based on limited case records and common practice at the time, some assumptions have been made about the factors which influenced this case.

60. Children's Social Care's review of practice in this case indicates that, based on the one visit to the family and a conversation with the health visitor, the social worker formed the view that there was no role for them and early help would be the most appropriate way forward. Once this "mind set" was formed it appears that there was no urgency to complete the assessment or undertake any further enquiries. This poor practice was not challenged by the manager.

61. During the period of this review the authority was implementing an improvement plan following an Ofsted inspection, the social work team had been split up and new management arrangements put in place and there were recruitment difficulties; these factors created a sense of instability. A change in the way referrals were managed had led to bigger than usual caseloads and teams were staffed by a high number of temporary agency workers. The temporary staff were expected to pick up cases with little time for any induction training and although they were being given more frequent supervision than usual, their skills were relatively unknown.

### **Learning Points**

- At times when systems are stressed or likely to be overloaded, it is important that managers are vigilant and provide additional support.
- Children under one year old are especially vulnerable, managers should be especially alert to these cases and, where appropriate, challenge what might be fixed thinking.

### **The Role of Midwifery Services**

62. Following the birth of a first baby it is usual practice for a midwife to see the baby on days one, two, three and five and then to close the case and handover to a health visitor on day 10.
63. Between day 10 and day 14 the health visitor will make contact with the family and decide what level of support is appropriate. In the first few weeks after the baby's birth the health visitor should see the baby at home.
64. In this case midwife 1 visited the baby at home on day two, this midwife had not met the family before and the record indicates there were no concerns about the baby or his care. On day three a different midwife saw the baby at home and then on day five the baby was seen by a midwife at the birthing centre, the notes indicate his weight gain was low.
65. On day seven the baby was again seen by a midwife at the birthing centre, Ms J reported some feeding problems and the baby had lost weight. Ms J was given advice and a feeding plan for the baby, she was also advised to see her GP, which she did. On day nine and 11 the young parent midwife saw the baby and noted his weight gain had improved, he was discharged from midwifery services who noted the family had been offered accommodation and was planning to move to a new area.
66. From the record it would appear that five different midwives saw the baby in the post birth period. The implications of the lack of continuity, recognised by the service in their management review, were
- Difficulties in sharing information which was recorded in the mother's hand held maternity record which the mother did not have with her
  - The midwives visiting were not fully aware of the family's history and vulnerability, not all of which would have been written down
  - The difficulty of observing the parenting when the baby was not being seen at home

### **The Role of Health Visiting**

67. Prior to the baby's birth, two health visitors had met the family, one had attended the TAC meeting and a student health visitor had made one visit to the family and liaised with the Children's Centre. On day 11 of the baby's life, the case was handed over to the new health visitor for post birth care, just as the family was about to move

68. Ideally, after the baby's birth, the health visitor would have made a home visit and carried out a new birth assessment. However, in this case the family was about to move and a home visit was not possible. In the circumstances, the health visitor was pro-active, taking the opportunity to see the baby in the clinic before the family relocated.
69. The health visitor carried out a primary assessment and noted some vulnerability factors. In view of the mother's relative youth, the family's low income and imminent move to another area where they might be socially isolated, she concluded the level of intervention should be "Universal Plus" which means more frequent visits. The records were transferred to the new health visitor.
70. The new health visitor visited the family in their new home and took a social history, Baby J was now 24 days old. The Personal Child Health Record (PCHR) known as the "red book" was not available, the parents said it had not yet been unpacked, so the health visitor had no record of the baby's weight. Ms J gave the health visitor some misleading information, although she might well have understood the situation to be as she described it. She is alleged to have told the health visitor the family had been referred to Children's Social Care but said the case was closed, when in fact the assessment was not finished. (This view would be understandable as Ms J had only seen the social worker once.) She also said neither she nor Mr J were using drugs.
71. The same health visitor saw the baby at home nine days later and he was reported as looking bright, alert and responsive. The red book still was not available so the baby's weight gain could not be plotted on his centile chart, he had gained 0.24 kg since his birth; the health visitor had no concerns.
72. Aged 46 days the baby was seen at the clinic by a different health visitor who noted his poor weight gain and described him as looking "scrawny". In line with the Faltering Growth Pathway, the health visitor arranged for the baby to be seen by the GP the same day.

### **Continuity of Care**

73. It would appear that midwifery and the health visitors acted appropriately on the basis of what they knew and, until the baby's faltering weight became obvious, they were not especially concerned about this family. A Universal Plus service from health visiting is not uncommon, to the professionals, this family did not stand out as having any exceptional problems or needs.
74. However, in this case, between Baby J's birth and the date his injuries were diagnosed at 6½ weeks, he was seen by 11 different professionals, five different midwives, three health visitors, two GPs and once by a social worker. The reason for the high number was a combination of shift patterns, staffing issues and the fact the family moved to a new area.

75. Whilst in this case this we cannot know if better continuity might have influenced the outcome for the baby, the lack of continuity raises two potential issues; firstly the difficulty in assessing the baby's progress or picking up any changes in the parental behaviours and secondly the difficulty for the parents in making a relationship with any of the professionals in the network.

76. The importance of relationship based safeguarding practice is highlighted in Professors Munro's work.<sup>4</sup>

77. The report begins by saying:

*'It's all about relationships. We are talking about dealing with people with problems, with painful stuff. You have to know someone, trust them. They must be reliable and be there for you if you are going to be able to talk about the things you don't want to. The things that scare you.'*

Quote from a parent<sup>5</sup>

78. Despite the fact that this family was identified right at the start of the pregnancy as vulnerable, this appears to have made little difference to the arrangements for care after Baby J was born.

79. With regard to learning, the WSCB reports that there have been some significant changes in arrangements for vulnerable families since this case. Most notable is the launch of the Family Nurse Partnership (FNP) a national home visiting programme for first time young mothers, aged 19 years or under who meet specific criteria. A specially trained family nurse visits the young mother regularly, from the early stages of pregnancy until their child is two with a view to enabling them to:

- Have a healthy pregnancy
- Improve their child's health and development
- Plan their own future and achieve their aspirations

80. This service was not yet available during the period of the review. Having been piloted in the UK, it was launched in Wiltshire in November 2014. It is still relatively new and its impact within the authority is, as yet, untested. It also relies on the voluntary engagement of the young mums and there will therefore be some families for whom it will not be relevant.

81. The other initiative is the Baby Steps Programme, devised by the NSPCC. The Programme starts with a home visit in the 7th month of pregnancy and then includes six group sessions each week before the baby is born. After babies are born the family is visited again at home, and then there are three more group sessions. Groups are led by someone who works with children, such as a family support worker, health visitor or midwife. This Programme was launched in Wiltshire in January 2015, it too relies on voluntary engagement.

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<sup>4</sup> The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro

<sup>5</sup> Family Perspectives on safeguarding and relationships with children's service The Children's Commissioner for England, June 2010

### **Learning Point**

- Building relationships is essential in safeguarding children and those relationships can only be built if there is continuity of input from at least one service provider.

### **For the WSCB**

- The WSCB should recognise that the new initiatives such as the Family Nurse Partnership and Baby Steps may not reach families who are resistant to professional intervention.
- This family was identified as vulnerable early in the pregnancy however, after the baby's birth this did not influence the nature or quality of service provision. The WSCB should consider how the continuity of services for these families, already identified as vulnerable, can be improved.

## **The Role of Supported Housing**

82. When the baby was 11 days old the family moved into a housing project which provides accommodation and support for young parents aged between 16 and 29. The scheme is for those who need low level housing related support; support workers are available Monday to Friday, 9am- 5pm, their role is to help young parents sort out their finances, make any relevant benefit claims and learn how to manage a tenancy. The service is generally provided through one-to-one key working sessions. The Children's Centre provided an outreach service at the housing project organising activities to support young parents and help them develop their parenting skills, for example, through "play and stay" sessions for parents and young children.
83. This family appeared not to want the support provided by either the housing worker or the Children's Centre. Repeated attempts to encourage the couple to participate were not successful. Attempts at engagement were hindered by staffing problems at the housing project which meant that there was no continuity of worker but, given the couple's history, it seems unlikely that even if this had been different, Ms J and Mr J would not have wanted the support on offer.
84. The key issue for this review was the lack of knowledge among the professional group about what exactly the housing project was providing. Some staff were under the misapprehension that it was a mother and baby unit with 24 hour staffing. This led to false reassurance about the protection the facility might have provided to Baby J.

### **Learning Point**

- It is essential that practitioners are well informed about what local resources actually provide.

### **The Children's Centre**

85. In February 2014, when the CAF was being undertaken, the midwifery service made a referral to the Children's Centre suggesting work on parenting skills and help with benefit claims. The Children's Centre contacted the referrer and said they would contact Ms J nearer her delivery date, this is in with line with their policy.
86. In September 2014, just after Baby J was born, the case was allocated to a family outreach worker who visited Ms J at home, Mr J was there and the worker saw Baby J who was asleep. The worker gave Ms J some advice about ensuring the baby did not get too hot.
87. Ms J was about to relocate to the supported housing project and the outreach worker referred the family on to the Children's Centre in the new area. This centre is provided by a different organisation therefore there was no opportunity for continuity of service. Although the Children's Centre in the new area did attempt to engage with the family, it had no success.
88. Commissioning arrangements for children's centres are currently being reviewed to establish the viability of a single provider. This would assist with continuity and consistency of service provision across the county.

### **The Role of the GP**

89. The baby was seen twice by a GP prior to diagnosis of his injuries, the first time when he was brought by his father two days after he had been concerned about the baby's bleeding gum. Mr J alleged the baby was thrashing around on Mr J's shoulder when his gum had bled. The GP looked at the baby's gum, could see nothing of significance and decided that no further action was necessary.
90. A week later Mr J had an appointment to see a different GP in the same practice and asked for a medical certificate as he was unable to work because of his drug addiction. The GP gave him a medical certificate, this was the first time the GP became aware that Mr J was working with a local drug and alcohol service.
91. The following day another GP in the same practice saw Baby J at the suggestion of the health visitor because of concerns about his faltering weight. This GP examined the baby

and found nothing unusual in his presentation. The GP discussed feeding with Ms J and noted that she was feeling low and was estranged from her own mother.

92. The outcome of the appointment was a referral to a paediatrician for further investigation of the weight gain. The baby was to be seen by a paediatrician within five working days but was admitted to hospital that same night with the injuries which precipitated this review.
93. The issues in this case reflect the day to day challenge of information sharing for GPs. The GP who saw the baby the day before his injuries acted appropriately on the basis of what she saw, the GP was unaware that Mr J had been into the surgery few days earlier to talk about his drug addiction as there is no cross reference in patient notes.
94. What this meant was that the GP managed the consultation on the basis of what was seen and discussed about Baby J on that day with no reference to the other information. There is no evidence that the GP considered the possible implications of the two day delay in Mr J bringing the baby to the surgery with bleeding gums (delay in presentation can be an indicator of child abuse) or the potential relevance of Ms J's low mood and feelings of social isolation.
95. The GPs were also unaware of the earlier CAF or that Children's Social Care was in the process of carrying out an assessment because Children's Social Care had not contacted the surgery, asked for any information or told the GPs they were carrying out an assessment.
96. The GPs have reflected on the learning from this case and what might be possible to improve their internal communication. Putting information about one patient (for example a father) on another patient's file (for example a child) is not straightforward and the benefits need to be balanced with disadvantages. Further discussion is needed to clarify best practice in these situations.

#### **Learning Points**

- Faltering weight gain, delayed presentation of a baby with an injury and a parent's low mood can be indicators of concern about parenting capacity and should be considered alongside medical presentations when examining and assessing babies.
- It is important for all agencies which hold a number of separate records on family members to ensure information is collated and the whole picture can be clearly seen.
- GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.

## Substance Misuse Service

97. As this review progressed it came to light that Mr J had been receiving a service from a local drug and alcohol team. He referred himself in September 2014, just before Baby J was born asking for help with an opiate addiction.
98. Mr J was seen by the service on five occasions before Baby J's injuries; he was prescribed an opiate substitute and had regular tests to see if he was using illegal substances, none of the tests showed the presence of illegal street drugs.
99. The service was aware that Mr J had recently become a father. Their policy is to carry out a formal safeguarding assessment at the time of their initial interview, although this did not happen in this case, the support worker did ask Mr J questions about his parenting and, based on his self-reporting, at no time did they have any concerns about his behaviour which indicated he might pose a risk to the baby. A more formal assessment was unlikely to have shown anything of concern.
100. In common with some other agencies, the substance abuse worker knew Mr J had recently moved and assumed he was living in a "parenting unit" which was providing support to the family, they were re-assured by this.
101. Since this case the service has reviewed their safeguarding procedures and, in collaboration with the Multi-Agency Safeguarding Hub (MASH), has made some improvements. Their assessment of risk includes everyone who has contact with children, in whatever capacity, asks questions for example, about storage of drugs, others in the household and child care whilst using substances. The agency has introduced a regular audit of safeguarding practice, closer links with the MASH and training for all staff. They have a limited knowledge of the Multi Agency Pre-Birth Protocol but have introduced complex case reviews which include expectant parents.
102. No one in the professional network was aware at the time, or before this review, that Mr J was receiving a service for a drug addiction. As this service is confidential it is usual practice that only the service user's GP is informed.
103. In this case, although the drug and alcohol team noted that they had sent information to Mr J's original GP and then again to the new practice after he moved, the GP was not aware of their involvement until Mr J came requesting a medical certificate because he was unable to work. This was the first time the GP became aware of Mr J's opiate addiction, the day before the baby's injuries.

### Learning Point

- Communication is only effective if information is shared, received and understood by the recipient.

## Communication Difficulties

104. In common with most SCRs, in this case “communication” was a much debated topic for the practitioners and managers involved. Every agency who participated in the review identified some learning and action which might help improve information sharing.

There was debate about:

- IT systems which cannot share information
- The sometimes conflicting demands of data protection and “need to know” information
- Practical suggestions about the effective dissemination of new policies and guidance was acquired
- The need for clear and unambiguous language
- The need to clarify the role of anyone sharing information or giving advice
- The challenge of effective communication in the face of managing finite resources and shift patterns which make continuity of care difficult

105. Whilst there are some practical actions which will improve communication, for example, better record keeping, noting decisions and the reasons for them, IT systems which can share information and using the protocols already in place, effective multi agency communication is a complex and multi layered concept.

106. Common misconceptions can hinder communication, for example, that information sharing is sufficient to ensure effective communication when it is important to understand the meaning of information, and whilst communication at the point of assessment is vital, so is communication during analysis, planning and intervention.

## LINKS WITH OTHER REVIEWS

### Child A and Child V

107. In February 2015 the WCSB commissioned a review of practice in the case of two babies who received injuries believed to be caused by a parent or carer, Child A and Child V.

The review was also asked to consider how effectively learning from an earlier SCR, Child H (September 2012) had been.

108. The Child A and Child V review is important because it highlights a number of themes similar to those explored in this SCR.

Common themes are:

- Pressures on staff and a number of agency workers, evidence of lack of rigour in supervision
- Assessments not being carried out in the time scale specified
- Insufficient attention given to the parents' own experience of being parented
- Not gathering information from other agencies
- Minimal information about fathers
- Focus on the parents' current circumstances leading to a positive "fixed mindset"

109. Most of the themes had also been present in the 2012 SCR about Child H and the 2015 report casts doubt on whether there had been much learning or change in practice. As a result of the review, the WCSB put in place a multi agency plan which included a review of the actions from Child H and some new actions arising from the Baby A and V report.

102. This SCR concerns practice between December 2013 and November 2014 and the author acknowledges that since then work has been done to improve practice and achieve better outcomes for children; policies and protocols have been updated, national initiatives have been implemented, individual agencies have taken specific topics and integrated learning into practice development and Children's Social Care has a more stable workforce.

103. It is disappointing and frustrating that the findings from this SCR are so similar in nature to those from Child H, Baby A and Baby V.

#### Learning Point:

- Producing more guidance and updating policies is unlikely to improve effectiveness when staff are reporting they do not have time to read documents or lack the resources or basic skills required to carry out an effective assessment.

**For the WSCB**

- The similar findings from this review indicate that the action plan from Child A and Child V needs to be reviewed. Further thought must be given to the reasons why some of the practice in this case fell below an acceptable standard and any action plan must address the underlying factors.

## SUMMARY

- a) This Serious Case Review concerns a baby who, aged 6½ weeks, was injured whilst in the care of his parents. The review period covers 11 months, starting when the baby's mother became pregnant, until the date the baby's injuries were diagnosed.
- b) The review looks at the services provided to the family, what happened and why. The purpose is to identify any organisational learning and improvements necessary to make the safeguarding system more robust.
- c) The findings from the review are set out in two parts, the pre-birth period including the CAF, referral to Children's Social Care and assessment practice and the post-birth period, what happened after the baby was born including continuity of care and effective communication.
- d) In this case the CAF process and subsequent access to early help for this family, did not work well. The quality of the assessment and planning were poor and there were gaps in the information sharing.
- e) How to make the CAF process effective is not a new challenge or unique to this authority. Soon after its implementation, *Sue White et al* described some of the emerging themes, for example the implications of trying to establish a common language and the risk that this may evolve into a "sentence bank", how knowledge is increasingly transformed into "information" (to enable electronic manipulation, transfer and storage) and how in "form completing" the narrative and context can be lost in the aim of "managing accountabilities and accomplish disposals in locally artful ways".<sup>6</sup>
- f) The WSCB is aware of the need to know how well the CAF process is working and had commissioned an audit of practice prior to this SCR. This case demonstrates that improving practice is not easy and cannot be addressed simply by issuing further guidance or instruction. Ensuring all agencies understand the purpose (and limitations) of the CAF, how agencies work together and the barriers to effective communication will help improve practice.
- g) In this case the young parents were identified early in the pregnancy as vulnerable. Keeping a focus on the child and understanding that if the parent is vulnerable, the baby is vulnerable, will help all practitioners focus on the links between vulnerability and risk.
- h) The single assessment in this case did not comply with practice guidance in either its timeliness or quality. The issues of quality were similar to those found in the earlier

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<sup>6</sup> The Descriptive Tyranny of the Common Assessment Framework: Technologies of Categorization and Professional Practice in Child Welfare Sue White, Chris Hall and Sue Peckover, *British Journal of Social Work* (2009) 39, 1197–1217

reviews of Child A and Child V. Initially the case was seen as not meeting the threshold for a Children's Social Care assessment although there was no evidence that the relevant guidance, the Pre -Birth Protocol, was used. Attention was focussed on the most visible "problem", in this case the housing issue, with little thought given to the less obvious factors from the parents' history.

- i) Ensuring the quality of all assessments, including the CAF, is an ongoing task for all agencies and this case emphasises the importance of good quality supervision and case management which encourages reflection, challenges fixed thinking and enables practitioners to work effectively with families who are unco-operative. This case also indicates the particular vulnerability of services during times of change and when there are large numbers of temporary staff in post. The WSCB should be alert to these situations.
- j) Baby J was injured six weeks after he was born. The key learning from the period between his birth and the injuries is about the benefits of continuity of care, building relationships and effective communication. In this case during the first six weeks of Baby J's life an unusually high number of staff saw the family at different times. Although, to some extent, governed by resources, rotas and the circumstances of this particular family, the lack of continuity raises the question about how services for a family already identified as vulnerable should be delivered and how continuity can be improved.
- k) Effective communication is always essential and becomes even more so when a number of different workers are involved with the family. Communication is a common theme in SCRs. In Learning Lessons from SCRs 2009- 2010, an analysis of 85 SCRs, a common finding was that none of the main agencies had a complete picture of the child's family and "there were examples of poor communication and information sharing between agencies".<sup>7</sup>
- l) In this case similar themes emerge, some practitioners were not aware of the whole picture and had information which, if shared, would have helped provide a more complete picture of family life. Whilst some practical actions might help with the exchange of information, it is important to remember that professional communication is more than just information exchange. Each agency will ascribe meaning to information which will be dependent on, for example, professional understanding, relationships, contexts and hierarchies.
- m) Findings from the review have been reflected in the learning and in the recommendations and a number of the agencies involved in this case have already implemented some actions to strengthen their safeguarding processes. Brandon et al suggest that "*The best learning from serious case reviews may come from the process of carrying out the review*"<sup>7</sup> and evaluation of this process indicates that those who participated found the process useful. The WSCB will ensure learning is disseminated effectively as part of its ongoing learning and development programme.

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<sup>7</sup> Learning lessons from Serious Case Reviews: interim report 2009–10 Ofsted's evaluation of Serious Case Reviews 1 April to 30 September 2009

## SUMMARY OF LEARNING

- For CAFs to be effective they must be based on a robust assessment and plan.
- The CAF provides useful information for others in the safeguarding system, including GPs. It is important that the CAF is shared with the relevant professionals helping build a holistic picture of family functioning.
- Retaining a focus on the unborn baby enables practitioners to consider the impact of the parent's circumstances on their capacity to care for a baby.
- Assessment is a dynamic process: if new information comes to light or the family circumstances change, this may affect the nature and degree of the risk.
- All information must be considered, not just as isolated incidents, but as part of a whole picture. Retaining a child focus is important and it may be necessary to re-consider whether or not to refer to Children's Social Care.
- Access to case supervision and specialist safeguarding advice enables staff to reflect and think systemically about cases.
- The Multi Agency Pre-birth Protocol to Safeguard Unborn Babies is a valuable and practical tool for all practitioners assessing risk and protective factors. It is especially useful for those making and deciding the outcome of referrals.
- All practitioners need to be mindful about the importance of language when sharing information about families. Good intentions and parents' awareness of potential risks to a baby are not protective factors.
- At times when systems are stressed or likely to be overloaded, it is important that managers are vigilant and provide additional support.
- Children under one year old are especially vulnerable, managers should be especially alert to these cases and, where appropriate, challenge what might be fixed thinking.
- Building relationships is essential in safeguarding children and those relationships can only be built if there is continuity of input from at least one service provider
- It is essential that practitioners are well informed about what local resources actually provide.
- Faltering weight gain, delayed presentation of a baby with an injury and a parent's low mood can be indicators of concern about parenting capacity and should be considered alongside medical presentations when examining and assessing babies.

- It is important for all agencies which hold a number of separate records on family members to ensure information is collated and the whole picture can be clearly seen.
- GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.
- Communication is only effective if information is shared, received and understood by the recipient.
- Producing more guidance and updating policies is unlikely to improve effectiveness when staff are reporting they do not have time to read documents or lack the resources or basic skills required to carry out an effective assessment.

## SUMMARY FOR THE WSCB

- Early identification of the most vulnerable young mothers is an essential element of the safeguarding system and the CAF process is an important part of early intervention. This case indicates the CAF/TAC process is not being used effectively with young mothers and the links with Pre-Birth Protocol to Safeguard Unborn Babies are not well understood.
- This review indicates that there are a number of challenges for staff in implementing the CAF process for young expectant mothers. Further work needs to be done to consider the findings from the 2014 audit and those from this case to determine how the process can be embedded, improved and sustained. This case demonstrates that improvement cannot be easily addressed by further guidance or more onerous expectations.
- This SCR highlights that a substantial percentage of staff in this case were not aware of the Multi Agency Pre-Birth Protocol to Safeguard Unborn Babies and that it could be used more effectively. Multi agency partners must consider how knowledge of the protocol can be disseminated effectively within their agencies, consider a range of methods to disseminate the information and monitor its effectiveness.
- The WSCB should recognise that the new initiatives such as the Family Nurse Partnership and Baby Steps may not reach families who are resistant to professional intervention.
- This family was identified as vulnerable early in the pregnancy however, after the baby's birth this did not influence the nature or quality of service provision. The WSCB should consider how the continuity of services for these families, already identified as vulnerable, can be improved.
- The similar findings from this review indicate that the action plan from Child A and Child V needs to be reviewed. Further thought must be given to the reasons why some of the practice in this case fell below an acceptable standard and any action plan must address the underlying factors.

## APPENDIX

### List of Agencies Involved in the SCR

SCR Group	Agencies Involved with the Family
Designated Doctor for Wiltshire (Chair)	Children's Centre
Designated Nurse CCG	Children's Social Care, Wiltshire Council
Head of Safeguarding and Assessment, Wiltshire Council	Great Western Hospital NHS Trust, Health Visiting
WSCB Manager	GP
	Bromford Housing
	Wiltshire Police
	South Western Ambulance NHS Foundation Trust
	Royal United Hospitals NHS Foundation Trust, Midwifery
	Turning Point Drug and Alcohol Service

## GLOSSARY OF TERMS

**Local Safeguarding Children Board (LSCB):** These were established by the Children Act 2004 to enable organisations to come together to agree on how they will co-operate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.

**Review Group:** This is the small group of senior managers delegated by the LSCB to set the terms of reference for the SCR and oversee the work of the independent reviewer including providing information local practices and context.

**Torn Frenulum:** The piece of tissue that connects the upper lip to the gum is the frenulum. A torn frenulum may be evidence of physical abuse following a direct blow or forcing objects into the mouth, for example when feeding a baby with excess force.

**Child Protection Register:** This was a register of children considered to be at risk of harm following an assessment and a child protection conference. The register no longer exists, it has been replaced by a child protection plan for children at risk of harm which details what needs to be done to reduce the risk.

**Children's Trust:** Wiltshire's Children and Young People's Trust provides an opportunity for approximately 50 multi-agency representatives to come together in a workshop format to consider key themes or support the development of a strategy to ensure children and young people achieve the best possible outcomes. Their work includes the development of the Early Help Framework. They work closely with the WSCB and other groups such as the Health and Wellbeing Board.

**Common Assessment Framework (CAF):** Sometimes called the **CAF Pathway**, this is a process for gathering and recording information about a child for whom a practitioner has concerns identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. Sometimes referred to as **Early Help**, it helps to identify in the early stages the child's additional needs and promote co-ordinated service provision to meet them.

**CAF Team:** The team provides central registration of CAFs and advice and guidance to professionals.

**Team Around the Child Meeting, known as a TAC:** This is a multi agency meeting of professionals who are working with a family or may be able to provide a service. The meeting follows the CAF assessment and its purpose is to devise a plan detailing who will do what and when. It is aimed at those families who would benefit from early help but who do not meet the threshold for intervention from Children's Social Care.

**Single Assessment:** This replaced initial and core assessments with the intention of streamlining the assessment process, having fewer "tick boxes" and encouraging professional judgement. The assessment must be completed within 45 working days and

may be done more quickly. The manager will discuss the appropriate timescale with the social worker at the start of the assessment.

**Faltering Weight:** This is a term used in paediatric and adult medicine to indicate insufficient weight gain or inappropriate weight loss. It used to be known as failure to thrive (FTT.) If faltering weight is a concern the baby will be subject to the **Faltering Growth Pathway** which ensures that monitoring takes place and appropriate action is taken.

**Centile Chart:** The curved lines on a baby's growth charts are called centile lines, and they represent the range of growth that is considered normal. They also show what percentage of babies, on average, will grow at a particular rate. The baby's weight is written on the centile chart and this enables parents and professionals to see if the baby's growth is within normal limits.

**Multi Agency Safeguarding Hub (MASH):** The MASH is the central resource for the county receiving all safeguarding and child protection enquiries. It is staffed with professionals from a range of agencies including police, probation, health, education and social care. These professionals share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm.