Shropshire Safeguarding Community Partnership

Local Child Safeguarding Practice Review

'Ivy'

Reviewer Corinne Chidley

Introduction

1. This Local Child Safeguarding Practice Review was commissioned by Shropshire Safeguarding Community Partnership in response to sustained and significant non-accidental injuries inflicted on a 4-month-old baby. To ensure anonymity is maintained family members will be referred to as Ivy (4-month-old baby), Leo (brother who is 15 months older), Mum, and Dad. Dad is Hungarian, and Mum is Czech and the country of her birth will be referred to throughout this report as Czechia rather than Czech Republic. Mum has two older children, Sibling One lives in Czechia with his Dad, Sibling Two lives in Czechia with his maternal grandma. At the time the non-accidental injuries were suspected, Ivy lived with her Mum, Dad, and brother Leo in a small market town in Shropshire.

2. Ivy was an extremely growth restricted baby and was born prematurely by emergency caesarean weighing 1kg (2lbs 2oz), in December 2022 throughout her pregnancy Mum had serious pregnancy related health issues.

3. Dad telephoned the GP (General Practice) when Ivy was four months old asking if they could see her as they were worried about a lump on her back. Ivy weighed 3.44kg (7lb 5oz). Ivy was brought to the GP Practice by her Mum who smelt of alcohol. After examining Ivy, the GP phoned for an ambulance.

4. On two separate occasions Dad explained that Ivy had been injured when she had fallen off the sofa, and that Leo had thrown a toy which caused the injuries.

5. The Child Protection Medical was undertaken in the hospital and established the following:
    - Prior to and during the examination it was noted that although Ivy's pupils were responding to light, she did not appear to be able to see and did not react to sound stimulation.
    - There was significant bleeding behind both of Ivy's eyes
    - No bruises were observed on Ivy's body
    - The lump on Ivy's back which could be callus formation where bones are healing from a fracture
    - Oral thrush in Ivy's mouth
    - Torn Frenulum (a thin band of skin connecting tongue to floor of mouth)
    - Concerns regarding Foetal Alcohol Syndrome due to facial features
    - Fractured collarbone
    - Fractured rib
    - Ivy struggled to hold her head up
    - Ivy was not able to hold herself up when on her tummy

6. Ivy's Mum and Dad were both arrested for grievous bodily harm (GBH) with intent and are subject to ongoing criminal investigations. Leo was found to have no injuries however there was reasonable cause to believe that he had experienced neglect in his parents' care and that neglect had also extended to Ivy's care. Leo was placed in foster care following removal under police powers of protection.

7. Following a skeletal scan four days after being admitted into hospital Ivy was found to have further extensive and serious non-accidental injuries. Birmingham Children's Hospital (BCH) reviewed the skeletal scans and confirmed the following injuries:
    - Healing fracture of left clavicle
    - Healing fracture of left seventh rib
    - Healing fractures of both bones in the right forearm
    - Healing fractures of both bones in the left forearm

- Suspected healing fracture of left distal femur
- Suspected healing fracture of left tibia
- Subdural bleeds and thrombosed cortical vessels (in brain)

The medical outcome from BCH was that these injuries were suggestive of a traumatic injury, most likely caused by shaking. The healing fractures were estimated as being caused between the 1st and 12th of April 2023.

8. When Ivy was discharged from the hospital she went to live with her brother Leo in his foster placement.

9. The circumstances around Ivy's injuries were notified to Shropshire Safeguarding Community Partnership and a Rapid Review (RR) took place. Safeguarding partners confirmed that the criteria had been met to carry out a Local Child Safeguarding Practice Review (LCSPR).

10. National Panel were notified who agreed with the decision to conduct a Local Child Safeguarding Practice Review (LCSPR).

11. Eleven months after being subjected to the non-accidental injuries Ivy's Social Worker reports that Ivy has recovered well from most of her injuries. Lasting impact to Ivy is that she is likely to only ever have peripheral vision in one of her eyes. It has not yet been established if there will be any other long-term difficulties and/or disabilities because of her injuries and what the impact on her may be. Ivy and Leo are still with their foster carers and are thriving.

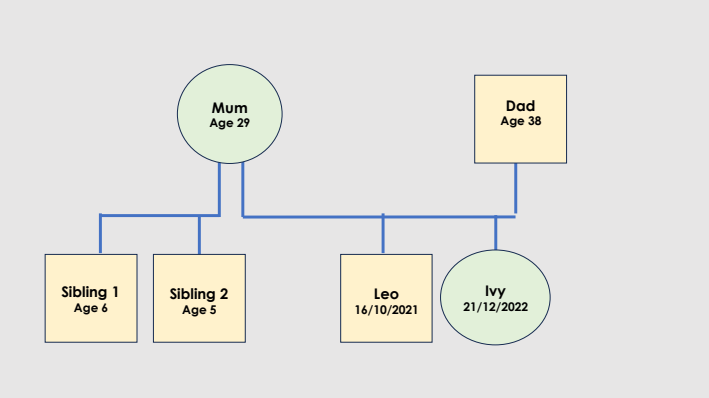
Family Background

12. The reviewer was unable to speak directly to parents due to ongoing criminal investigations. Through conversations, and records held within services it is documented that Dad came to live in England from Hungary in 2011; practitioners found that he understood and spoke English well. Dad is a quadruplet, two of his brothers live in England, one in the same street as Dad and one just under forty miles away. Dad worked 12-hour shifts in a local food processing factory, and if he did not work, he did not get paid.

13. Mum came to live in England from Czechia in April 2018. Mum has two children that live in Czechia; Sibling One born in 2017 that lives with his father, and Sibling Two born in 2018 that lives with his maternal grandma. Subsequently it was evident that these living arrangements were determined by the courts in Czechia and Mum pays child maintenance.

14. In an incident recorded by West Mercia Police, Mum was assaulted on 21st April 2018 by a previous partner who was subsequently convicted of this assault. It is recorded that Mum spoke little English and had been resident in the United Kingdom for a week. A Domestic Abuse Stalking and Harassment (DASH) risk assessment was completed by the attending officer. Many of the questions asked were unanswered by Mum, and there is no documentation to support or clarify whether they were unanswered, or whether Mum declined to answer, or that interpretive services were used.

15. There are significant differences in the information that is held by agencies on Mum's two eldest children. There are three different dates of birth recorded for each child that were given by Mum; this may have caused problems or delays in response from the authorities in Czechia.



Terms of Reference

17. In line with Working together to safeguard children 2023: Statutory Guidance[1], the aim of this review is to provide a way of looking at and analysing frontline practice, as well as organisational structures and learning, to allow those involved in the review to reach recommendations that will improve outcomes for children. This review aims to reflect both the child's perspective and the family context.

18. The reviewer Corinne Chidley is the Learning and Development Coordinator within Shropshire Safeguarding Community Partnership Business Unit and is not affiliated to any agencies within this review.

19. The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systemic issues, and if, and or how, policy and practice need to change.

20. This review is not being conducted to hold individuals, organisations, or agencies to account as there are separate processes for this. Agencies are responsible for following their own organisational policies.

21. The period under review is from April 2022 to the end of April 2023. This period covers Mum's pregnancy, birth, and Ivy's life until she went to live with the foster carers. This will enable understanding of past history, and any signs and indicators.

Methodology

22. A Serious Incident Notification (SIN) was made on 21st April 2023.

23. Initial Scoping identified which agencies were involved with Ivy and her family. The following agencies provided information:
    - GP Practice
    - Pre-school
    - Shrewsbury and Telford Hospital NHS Trust
    - Shropshire Community Health Trust
    - Shropshire Council - Children's Social Care
    - Shropshire Council - Early Help
    - West Mercia Police

[1] Working together to safeguard children 2023: statutory guidance

The family were not known to Shropshire Council's Housing Department, Shropshire Fire & Rescue Service, Midlands Partnership NHS Foundation Trust (MPFT), Shropshire Council's Adult Social Care, or Shropshire Council's Special Educational Needs (SEN) Team.

West Midlands Ambulance Service only became aware of the family through the emergency call response. To ensure anonymity of the family the local agencies involved have not been specified in this report.

24. At the Rapid Review meeting on 12th May 2023 the following agencies were represented:
    - GP Practice
    - Shrewsbury and Telford Hospital NHS Trust (SaTH) SaTH includes all departments that the family accessed – Women & Children's Division.
    - Shropshire Community Health NHS Trust (ShropCom)
    - Shropshire Council - Children's Social Care
    - Shropshire Council - Early Help
    - Shropshire Telford & Wrekin Integrated Care Board (ICB)
    - West Mercia Police

25. It was discussed at the Rapid Review (RR) that it had not been possible to identify why the Safeguarding System was not able to protect Ivy and that only a superficial picture of the family was given. Partners discussed and agreed that the requested methodology for this review would be an independent author having conversations with practitioners before facilitating reflective workshops for practitioners, and then for managers.

26. Conversations with practitioners were to include exploring if Ivy's additional vulnerabilities were recognised:
    - Prematurity and requiring support and care from neonatal specialists due to growth restriction, before being discharged home.
    - Length of stay on neo-natal reduced opportunities for parental and sibling bonding and attachment with Ivy.
    - Parents first language was not English which may have identified that support for the family was required.

27. The author acknowledges that there have been delays in the safeguarding practice review process at every stage, including completion of the Rapid Review report before being sent to National Panel. Confirmation was received from National Panel in November 2023 that they agreed with the decision to progress with a Local Child Safeguarding Practice Review. Lack of capacity in the Safeguarding Partnership Business Unit delayed progressing and completion of the report, and there was delay in reviewing the final draft by local case review group members.

28. As part of the analysis process, the reviewer had thirty-four conversations with practitioners to get their perspective of their involvement with the family.

29. Arranging the conversations was not always straightforward, as initially there was some resistance from managers who wanted to have a full understanding of the process so they could support their staff members appropriately. Leaflets designed by SSCP for managers and practitioners explaining the purpose and process helped to alleviate concerns.

30. From February to April 2024, twenty-six one-to-one conversations took place and three joint conversations. The first of the joint conversations were with the two members of West Mercia Police, another with a practitioner who came back especially during her maternity leave and was

accompanied by their manager; and the last involved the foster carers; although they were not involved at the time of the incident both Ivy and Leo were living with them before the end of April 2023. There were also two short conversations with practitioners who had no recollection of Ivy or her family, this was due to the considerable number of babies and families that the practitioners had met and cared for, and due to the minimal contact with Ivy and her family.

31. Every practitioner engaged with the review process and talked openly about their memories of Ivy and her family; their work context, what made doing their job harder, if anything would be done differently today, and if any changes have been made. Several practitioners were overwhelmed emotionally during conversations, they had critically reflected on their own practice and that of their agency both prior to and during the conversation, with a view to identifying key points in their practice that could be done differently.

32. The reviewer spoke to practitioners from a range of services that supported the family and Mum during her pregnancy, and after Ivy was born until the end of April 2023. Conversations included staff from the Midwifery Led Unit (MLU), GP Practice, Emergency Social Work Team, Foster Carers, Neo-natal Unit, West Mercia Police, West Midlands Ambulance Service, Social Workers, Pre-School, and the Health Visiting Service.

33. The reviewer asked each practitioner to paint a picture of when they met Ivy and her Mum, Dad or brother and if they had any worries or concerns. Practitioners were then asked about the context of what was happening in their organisation and if there was anything that made their role harder such as workload, documentation, or supervision arrangements. They were then asked if anything would be done differently today and if there had been any changes made to their practice.

34. After the conversations with practitioners a manager's reflective workshop was held online. Eight managers were present from a range of services including West Mercia Police's Vulnerable Persons Team and a Detective Inspector; Children's Social Care Assessment Team and Emergency Social Work Team; Lead Safeguarding Midwife from Shrewsbury and Telford Hospital NHS Trust; Lead Nurse for Safeguarding Children from the Shrewsbury and Telford Hospital NHS Trust; Shropshire Community Health Trust; and a Clinical Safeguarding Lead from West Midlands Ambulance Service.

35. The reviewer grouped the information from practitioners' conversation into themes and presented them as Key Practice Episodes:
    1 - Concerns for Mum and child during pregnancy.
    2 - Ivy's Birth.
    3 - Visiting newborn baby.
    4 - Good practice home visits.
    5 - Multiagency Referral Form (MARF) Assessment and Outcome.
    6 - Safe discharge.
    7 - Notifying Emergency Social Work Team (ESWT).

36. To ensure that the workshop remained a safe space it was not recorded. Managers were asked open questions to reflect on and discuss in breakout rooms. They were then asked to provide individual anonymous feedback using an online platform that operates in real time. Managers were then given the opportunity to verbally feedback to the whole group.

37. In the first breakout room, managers were asked to reflect on the circumstances shared about Ivy and reflect on good practice.

38. Four more themes were presented which were:

- Key line of enquiry - Barriers to effective interpretation services.
- Key line of enquiry - Unseen men.
- Key line of enquiry - Injury to Under 2 policy, Regional Child Protection Procedures for West Midlands.
- Key line of Enquiry – Use and understanding of Shropshire Thresholds.

39. In the second breakout room, managers were asked to reflect on and discuss the following areas:
    - Consider why children cannot stay in a neonatal flat or what other provisions can be made for families with low incomes and no transport to visit their baby on the neonatal unit?
    - How do we ensure that the injuries in babies and children under two years of age policy is understood and followed, including during out of hours periods?
    - For parents, whose first language is not English, what might the language and cultural barriers be? Why is it that some professionals can communicate well, and others cannot?
    - Are you confident that your staff safeguarding training is effective in supporting frontline practitioners when reporting concerns, completing multiagency safeguarding referrals, understanding pathways, and using the thresholds? If not, what can you do to ensure they do?
    - With regards to Unseen Men, Dad was seen but what could be the impression we gave him? *(To put this into context further explanation involved asking managers whether Dad's working arrangements and own tiredness were considered.)*
    - No practitioner mentioned supervision as an issue; does that mean we are getting it right?

40. Whilst writing the first draft in preparation for the first Review Panel Meeting on 20th June 2024 the reviewer sought clarifying or additional information from, West Mercia Police, Pre-school, Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health Trust, Compass (front door for Children's Social Care) and Children Social Care, and all agencies responded with the information that was requested.

41. The second and final Review Panel Meeting was held on 5th December 2024.

Chronology of Events

Mum attended medical appointments during her pregnancy with Ivy which are described throughout this report in terms of the distance in miles away from home.

23rd June 2022 - Mum attended the Midwifery Led Unit (9 miles away from home). Mum was assessed as speaking minimal English and a telephone interpretive service was used.
It was noted by the Community Midwife that the family had an extensive social services investigation, following the birth of Mums third child Leo, when Mum disclosed that her eldest two children were not with her and had been removed from her care in Czechia. Mum informed the Community Midwife that currently there was no Children's Social Care involvement. The Community Midwife sent a safeguarding referral to the Maternity Safeguarding Team, noting that a Compass (front door for Children's Social Care) enquiry was to be completed to clarify the presenting history.

24th June 2022 - The Maternity Safeguarding Team reviewed the referral from the Community Midwife and noted a plan to inform Compass following Mum's dating scan.

22nd July 2022 - Mum attended dating scan (23 miles away from home), where discussions included the risk of smoking in pregnancy.

18th August 2022- Mum attended appointment at a medical practice (19 miles away from home), where it was arranged that regular scans would be offered to monitor the baby's well-being as Mum was a smoker and had had two previous caesarean deliveries.

14th September 2022 - Mum attended scan appointment (23 miles away from home); an interpreter was present to assist with communication.

15th September 2022 - Mum attended a Consultant Obstetrician scan appointment (33 miles away from home), where it was noted that the baby was a 'globally small foetus', which is a sign of intrauterine growth restriction by all measurements. Mum was referred to the Obstetrician Led foetal medicine team, and an appointment was made for 15th November to perform an amniocentesis (a test to check if the baby had a genetic or chromosomal condition which could explain the intrauterine growth restriction).

22nd September 2022 - at the monthly Shropshire maternity multi-disciplinary team meeting, safeguarding concerns were discussed. A Senior Social Worker from Compass (front door for Children's Social Care) confirmed that there was no current Children's Social Care involvement and that an Early Help Assessment was not required. The Community Midwife was requested to arrange a home visit.

29th September 2022 - Mum attended an antenatal appointment at her GP Practice, which was within walking distance from home, and was asked routine screening questions about domestic abuse. Mum confirmed that there was no domestic abuse present in her relationship. A home visit was to be arranged within the next month.

2nd November 2022 - Mum attended her scan at 13:30 hours, (23 miles away from home). The baby was assessed to be extremely growth restricted.
At Mum's antenatal appointment it was found that she had raised blood pressure and other serious, pregnancy related, health concerns - pre-eclampsia. Mum's care was to be moved immediately to maternity triage (assessment area) at the hospital (33 miles away from home).

By 18:30 Mum had not attended maternity triage. Despite several attempted conversations with Mum and Dad about the importance of attending maternity triage, Dad explained to the midwife that they had no money or transport until the Friday 4th November. The situation was escalated to a senior midwife as Dad had declined to ring for an ambulance although he understood that there were serious risks to Mum's health. The situation was escalated again to the midwifery matron on call who advised that a taxi could be arranged and paid for by the maternity unit. Numerous phone calls were made to Mum, but when she answered the signal went and the message about the taxi could not be conveyed.

3rd November 2022 - Between 09.30 and 18.30 hours, numerous attempts were made by the Community Midwife to contact Mum by phone. Mum informed the Community Midwife that she would attend maternity triage, but she did not. When escalated to the matron it was advised that the next day a home visit may be needed.

4th November 2022 - Community Midwife conducted an antenatal check during a home visit. Dad explained that they were on their way to maternity triage the previous day, but the friend who was driving them had chest pain, so they turned back.
Mum's blood pressure was not a concern at this time. An antenatal appointment was made at the hospital (33 miles away from home) for four days later.

6th November 2022 - Community Midwife conducted an antenatal check during a home visit, there were no concerns, and a home appointment was made for two weeks later.

8th November 2022 - Community Midwife conducted an antenatal check during a home visit following discussion with Maternity Triage as Mum had signs of serious, pregnancy related, health concerns. An interpreter was present to ensure that Mum was reminded about the importance of attending her antenatal appointment on 10th November.

10th November 2022 - Mum attended her scan and antenatal appointment at the maternity out-patients unit (33 miles away from home). The possible causes of the baby's growth restriction were discussed via an interpreter, and Mum was asked to consider having amniocentesis (a test to check if the baby had a genetic or chromosomal condition). The consultant obstetrician advised that the Community Midwife would conduct weekly blood pressure checks.

15th November 2022 - Mum attended hospital (33 miles away from home) for a specialist scan. Consent was gained from Mum to proceed with amniocentesis. An interpreter was present to aid communication.

18th November 2022 - Parents were informed via phone call that the results of amniocentesis were normal, Dad interpreted this.

29th November 2022 - Mum did not attend her antenatal clinic appointment. Dad rang to inform the clinic that Mum had the flu so could not attend. Appointment was rearranged for 5th December.

5th December 2022 - Mum attended her antenatal appointment at the Midwifery Led Unit (9 miles away from home).

7th December 2022 - Mum attended maternity triage with Dad, Leo, and an interpreter was present. Mum was advised that she needed to be admitted to the antenatal ward due to raised blood pressure however, Mum declined this and so medication was prescribed. Community Midwife was contacted to offer home visits to continue monitoring as Mum could not attend the hospital (33 miles away from home) due to not having transport.

8th December 2022 - The Community Midwife attended Mum's home as arranged. No-one else was present. Mum refused to attend maternity triage at hospital (33 miles away from home); however, a taxi had been arranged to take Mum to the hospital and was waiting outside. Concerns for Mum and baby's health were escalated by the Community Midwife as monitoring needed to take place due to this being a high-risk pregnancy.

10th December 2022 - Mum attended maternity triage at the hospital (33 miles away from home). The Consultant Obstetrician advised that Mum needed admitting to the antenatal ward as her blood pressure was raised and there was significant foetal growth restriction. Mum was also advised that a caesarean section delivery may be probable in the next few days; Mum agreed to be admitted into hospital.

13th December 2022 - Mum was discharged after staying in hospital for three days.

15th December 2022 - Ages and Stages Questionnaire (ASQ) and appointment letter for Leo's 12-month development review were hand delivered to the home address. Since September, the Health Visiting Service had sent and texted appointments, and subsequent reminders to parents.

17th December 2022 - Mum attended the Maternity Day Assessment Unit (DAU) at hospital (33 miles away from home) for raised blood pressure.

20th December 2022 - Mum attended her scan appointment. The midwife organised a taxi to pick up and then drop Mum back at home to enable her to attend her antenatal assessment.

21st December 2022 - Mum took Leo with her when she attended her appointment at Maternity Day Assessment Unit at 13:00 hours at hospital (33 miles away from home). A telephone interpreter was arranged; the Consultant Obstetrician made the decision to deliver the baby by emergency caesarean section as Mum had a severe pregnancy related medical condition.
The Maternity Unit in the hospital telephoned the Emergency Social Work Team (ESWT) about Leo staying with Mum, as Dad was working. The Emergency Social Work Teams response was that they did not offer financial support. Dad said he could not come to the hospital to collect Leo as he could not afford it. A taxi was arranged for Dad to come to the hospital. Dad and Leo stayed on the delivery suite until Ivy was born.

21st December 2022 - Ivy was born by emergency caesarean section at 34 weeks gestation due to low birth weight weighing 1kg (2lbs 2oz), at approximately 22:00 hours.

22nd December 2022 - Ivy was reviewed by the Neonatologist and their team on the Neonatal Unit (NNU), parents were present during the ward round and were updated via interpreters.

- The Health Visiting Service received the birth notification.

23rd December 2022 - Ivy's daily review was conducted by Neonatal Unit Team (NNU) (A daily review was conducted from birth to discharge). Ivy was in an incubator and was doing well. An interpreter was booked for the following day so that parents could be informed of Ivy's progress.

24th December 2022 - Ivy's daily review was conducted by Neonatal Unit Team (NNU); Ivy continued to progress well. Google translate was used to interpret for Mum as the interpreter that had been arranged the previous day did not attend. Mum was later discharged from hospital and went home.

25th December 2022 - Community Midwife conducted a day four post-natal home visit. Dad and Dad's brother were present. Mum said she wanted to visit Ivy on the Neonatal Unit, but transport was an

issue. Dad had two weeks paternity leave to support Mum but as it was Christmas Day no transport was available.

26th December 2022 - Mum attended a planned post-natal appointment at the hospital. Arranging visits to Ivy by taxi were discussed, and for Mum to liaise with the Neonatal Unit (NNU).

27th December 2022 - Community Midwife conducted 6 days post-natal home visit. Mum was recovering well and said she would like to visit Ivy more, but her partner did not drive, and they had to rely on friends and public transport.

28th December 2022 - Interpreter attended the Neonatal Unit (NNU) for the parental update, however, Ivy's parents were not present. A phone call was made to the parents by the interpreter with the nurse to update them on Ivy's care and progress. Parents informed the nurse via the interpreter that they struggled to visit Ivy due to transport issues, and as Dad was working, he did not get paid if he did not work. Parents said that they would visit on 30th December.

- Dad visited and was assisted in giving Ivy her first bottle feed.
- The Health Visitor contacted Neonatal Unit, informed them of previous family history, and shared her direct contact details.

30th December 2022 - Mum, Dad and Leo visited Ivy where Mum cuddled her. A nurse noticed that Leo's bottle was very dirty. This was noted to ensure that the parents were advised regarding hand hygiene and making formula feeds including sterilising bottles.

1st January 2023 - Community Midwife conducted a 10-day post-natal home visit. Mum was advised to go to Triage.

- The Neonatal Unit nurses printed Lullaby Trust leaflet in Czech for parents and one for bottle feeding was given in English.

2nd January 2023 - Mum attended appointment at hospital (33 miles away from home) and was reviewed on maternity triage. Treatment was prescribed for an infection of a wound, from the birth of Ivy.

- Community Midwife liaised with Health Visitor,
- Neonatal nurses discussed an Early Help Assessment regarding lack of finances and transport to visit Ivy; this was declined by parents.

5th January 2023 - Community Midwife made home visit to check Mum's wound and blood pressure.

6th January 2023 - A Multiagency Referral Form (MARF) was sent to Compass (front door for children's social care) by a nurse on the Neonatal Unit, due to parents needing support to meet Ivy's nutritional and environmental needs. Additional factors that contributed to the decision to submit this referral included not knowing why Ivy's older siblings were removed from Mum's care; Leo previously presenting as unkempt and feeding from a dirty bottle (suggesting that his basic hygiene needs were not being met); and the parents' declined an Early Help assessment.

7th January 2023 - Community Midwife made home visit to check Mum's wound and blood pressure.

8th January 2023 - Mum, Dad and Leo visited for four hours. Contact details were checked as staff had been unable to get through on the phone, and Dad's contact details were not correct, so they were updated. Parents said that they would visit again on the 10th of January.

9th January 2023 - Neonatal staff rang Ivy's parents to ask if an interpreter was needed for the following day, they said no as Ivy's Dad speaks English.

Later, Ivy's Dad rang the Neonatal Unit and told them that they could not visit on the 10th as they had no transport.

10th January 2023 - Community Midwife made home visit to check Mum's wound and blood pressure.

- In response to the Multiagency Referral (MARF) a letter was sent to parents by Children Social Care, advising that no further action would be taken and recommending they contact Early Help if they need some support.

11th January 2023 - The Consultant Neonatologist wanted to be sure that Ivy was safe to be discharged therefore a meeting was arranged with the consultant, registrar, parents, nurse in charge and an interpreter; toys were provided to occupy Leo during the conversation. The Health Visitor could not attend. Ivy's progress was discussed; during the meeting, the professionals wanted to understand why Ivy's Mum and Dad had not been visiting very often. Parents explained that Ivy's Dad did not drive, but they could claim refund on train tickets each time they visit. Parents agreed that they would visit four times a week; Tuesday, Wednesday, and the weekend.
The current management plan was discussed with parents, once Ivy reached 1.6kgs (3lb 5oz) she would be ready to go home.
Ivy's Mum agreed to move into a parent's flat on the NNU from 13th January.
A referral for Early Help was discussed and agreed by the parents.

13th January 2023 - Mum moved into a parent's flat on the NNU to help with bonding with Ivy. An interpreter was arranged to attend the following day to discuss the plan to discharge Ivy and complete the Early Help assessment form, with both parents.

14th January 2023 - Ivy's Dad rang informing the Neonatal Unit that he could not attend the appointment. Staff emphasised the need for him to be present so the plans for Ivy's discharge including parentcraft could be discussed. Parentcraft is a supportive and educational process designed to help parents bond with their newborns and learn essential care techniques. Ivy's Mum was fully updated by the Consultant Neonatologist via an interpreter. There was no parenting concerns noted while Mum was in the parent's flat on the NNU. The interpreter was rescheduled for the next day when Dad could attend.

15th January 2023 - Community Midwife telephoned Mum to ask about her wound.

17th January 2023 - Ivy was discharged from Neonatal Unit at hospital into her parent's care. Planned Health Visitor weekly visits and twice weekly weight checks by the Neonatal Community Team were discussed.
An out-patient appointment was made for an eye-check, due to Ivy's prematurity.
Ivy's Dad informed the staff that he could not bring Ivy to this appointment as he could not miss any more work. Understanding was shown regarding his difficulties; however, it was explained to him that this is an essential appointment, and monitoring could avoid missing a condition that could impact on Ivy's sight. Dad then agreed to bring Ivy to this appointment and requested an appointment card as evidence for his workplace.

18th January 2023 - The Community Midwife made the final home visit to see Mum and Ivy (midwifery support ends when a baby is 28 days old).

- Health Visitor conducted the first of the weekly home visits, this was a joint new birth visit with the Healthy Child Practitioner, and an interpreter was on the telephone. Ivy's weight was 1.75kg (just under 4lbs).
- Formula feeding and safer sleep assessments were completed. Ivy had slept in a cot with pillow, bumpers, and teddy and the room temperature was very high. Advice included, to place Ivy's Moses

basket in the larger cot, and the importance of having a flat mattress without pillows, bumpers, or soft toys, and information was given around suitable temperatures.

- Ivy's Mum and Dad responded 'no' when they were asked if they drank alcohol, smoked, used drugs, or took medication.

The Lullaby Trust (Safer sleep for babies) guidance card in Czech was emailed to parents and reinforced by the interpreter.

- Maternal mental health was assessed using Whooley questions (evidence-based questions to assess for pregnancy related depression)
- Ivy was registered as a patient at the families GP Practice.
- Health Visitor contacted the Neonatal Unit (NNU).
- The Community Midwife contacted the Health Visitor and shared concerns that the family had lack of support and financial difficulties. Mum had declined Early Help when offered this by maternity services, the Health Visitor said she would ask Mum again at the next appointment.

20th January 2023 - Home Visit from Neonatal Community Outreach Nurse. There were no concerns identified at the home visit and Leo was observed drawing, whilst Dad was cuddling Ivy; Mum was very tired. Conversations were around sharing Ivy's feeds through the night. Dad had just gone back to work; it was appreciated that he was tired and was asked to just help out Mum when he can.

8th February 2023 - Leo was brought to his 12-month development review at 16 months old by his Dad. Dad had completed the Ages and Stages Questionnaire (ASQ) form which showed that Leo's development in all areas was on schedule. Leo completed the assessment activities with a bottle of milk between his teeth, although Dad indicated he drank from an open cup at home. The Healthy Child Practitioner contacted the Pre-school to enquire about a place for Leo to give him play experiences.

15th February 2023 - Ivy was brought to the GP Practice for her six-week check, she weighed 2.61kg (5lb 7oz) no concerns were identified.

15th February 2023 - Mum and Dad visited the Pre-school with both Leo and Ivy asleep in separate prams. Leo was offered a place to start after Easter. Dad did most of the talking as Mum did not speak much English.

16th February 2023 - Ivy was brought to the GP Practice to have her first set of childhood immunisations by Mum. Mum was specifically asked about the situation at home by the practice nurse, which was reported as good, and was asked routine questions about domestic abuse to which Mum said there were no problems. Mum had a good rapport with the practice nurse and interpretative services were not used.

20th February 2023 - Ivy was brought to her outpatient appointment for an eye check at the hospital (33 miles away from home); this was due to her prematurity. There were no concerns with eye development and Ivy was discharged.

16th March 2023 - Ivy was brought to the GP Practice by Mum to have her second set of childhood immunisations. Practice nurse asked routine questions which included circumstances at home and domestic abuse. Mum confirmed that there was no domestic abuse present in her relationship.

21st March 2023 - Ivy was brought to the GP Practice by Mum as she had had white deposits on her tongue; she was prescribed treatment for oral thrush.

29th March 2023 - Health Visitor made a home visit and noted that Ivy was smiling, fixing on, and following people. Health Visitor also noticed a mark on Mum's neck and spoke to Mum about it; Mum

laughed and said there was no problem. From now on the Health Visitor appointments were going to be monthly as no additional concerns were noted.

13th April 2023 - Ivy was brought to the GP Practice by Mum for her third and final set of immunisations.

18th April 2023 - Mum and Dad brought Leo to his first day at Pre-school and both stayed with him. Parents were fully funding his Pre-school place. Throughout the session Ivy was crying in-between dosing off. Mum declined help from nursery manager and staff which included offering to cuddle Ivy, warm her bottle, and the use of a cot. There was a language barrier with Mum and gestures were used rather than speech. Dad went outside to smoke approximately every 20 minutes. As this was the first time that the pre-school staff had met the family it did not raise a concern that Ivy was crying, as there could be many reasons for this. They did not want to be judgmental, and they could see that Mum was trying to meet Ivy's needs by feeding and comforting her; it was thought that Mum was being protective as Ivy was so tiny.

20th April 2023 - Mum along with Leo's uncle dropped him off at pre-school and left.

- Dad telephoned the GP Practice asking if Ivy could be seen as they were worried about a lump on her back. Ivy weighed 3.44kg (7lb 5oz).
- Mum said that Ivy had been crying for 3 days and had only been feeding small amounts. Mum had noticed a lump behind her left shoulder. Mum was not aware of any trauma to account for the lump which the GP suspected was a fracture.
- The practice nurse who knew Mum was called into the consultation room by the GP, it was noted that alcohol could be smelt on Mum. A safeguarding concern became evident, and an ambulance was called for Ivy to be taken into hospital.
- The Emergency Duty Team EDT safeguarding number went through to an answerphone. When the paramedics arrived the GP relayed concerns by phoning the paramedics safeguarding team.
- Ivy's Dad came to the GP Practice and helped to persuade Mum to go with Ivy to hospital in the ambulance.
- Ivy was brought to the Emergency Department at the hospital (33 miles away from home) by ambulance and admitted to the Children's Ward for further investigations. The initial x-rays taken in the Emergency Department showed a healing fracture to Ivy's left clavicle, and a healing fracture to her seventh left rib.
- Dad later explained that Ivy had fallen from a sofa whilst he was making her a bottle in the kitchen. Earlier, Dad had told medical staff that Leo had thrown a toy at Ivy which had caused her injuries.
- Mum explained that Ivy had fallen off a bed while Dad was looking after her. Mum said that she had noticed the lump on Ivy's back the previous afternoon, while she was changing her. Mum denied drinking alcohol and said that she had two drinks at the weekends.

21st April 2023 - A Strategy meeting was held.

- Mum and Dad were questioned separately and were arrested for Grievous Bodily Harm (GBH) with intent.
- Leo was placed into foster carer.

Important Context-Analysis and Learning

42. While these dates are outside of the time frame of the review there are related issues which give important context.

43. 20th April 2018 - police responded to an incident as Mum had been assaulted by her partner at the time. She had been living in the United Kingdom for one week and it was noted that Mum spoke little English. A DASH (Domestic Abuse, Stalking and Harassment) risk assessment was completed by the attending officer and Mum did not answer many of the questions. This resulted in Police pursuing an evidence led prosecution. Mums partner at the time was charged with common assault and ordered to pay a fine, court costs and a victim surcharge; he was released from court the same day.

44. 15th October 2021 - Mum disclosed while she was in hospital just prior to giving birth to Leo that her two older children lived in Czechia. It is recorded in midwifery notes that Mum stated that her own mother said she was not fit to care for her children. Sibling One lived with his father and Sibling Two with his maternal grandma. Midwives completed a Multiagency Referral Form (MARF) the day before Leo was born due to concerns that Siblings One and Two had been removed from Mum's care in Czechia.

45. A Compass (front door for Children's Social Care) Social Worker attempted to contact Mum numerous times via translation service and other agencies but there was no response from Mum. Compass confirmed that they would make enquiries with relevant agencies in Czechia to establish the nature of Children's Social Care involvement. (A reply was received from the authorities in Czechia in January 2024.)

46. A Compass Social Worker informed Health Visiting services that the threshold for a child protection response or further Social Work Assessment was not met so there would be no further action. The recommendation was for Early Help support to be implemented with the Health Visiting Service completing an Early Help Assessment to start the support. The Social Worker said that they would contact International Child Abduction Contact Unit (ICACU) requesting information about Sibling One and Two and their relationship with their Mum.

47. The Health Visitor contacted the Social Worker expressing regret that the involvement of Compass was closed as concerns remained about why Mum's other children were not living with her. The Health Visitor used interpretative services to discuss completing an Early Help Assessment with Mum. The Health Visitor was confident in gaining parental consent and knowledgeable when explaining the benefits of accessing Early Help for the family. Mum did not agree to receiving support and declined to complete the Early Help Assessment.

48. Prior to Leo's discharge from hospital with Mum, the Maternity Unit checked with Compass that discharge was allowed.

49. Hospital records state that in October 2021 after a Multiagency Referral Form (MARF) was completed, there was a Social Services investigation. However, Children's Social Care records first recorded information about Leo on the 21st of April 2023, which was the day that the non-accidental injuries were found on Ivy.

50. There was a lack of clarity with Sibling One and Two's dates of birth. Three separate dates of birth for each child were given by Mum to Health services; Health and Social Care practitioners also contradicted each other and did not correspond with the dates of the recorded incident that the police responded to on 20th April 2018.

Analysis

51. Although Children's Social Care attempted to contact Mum, there is no record on their system that this progressed to an investigation. The information about the referral was recorded on the Early Help System/Module (EHM); this part of the system is not automatically linked to the Children's Social Care part of the recording system. All Social Workers are trained to access EHM and it is considered good practice for them to access and update themselves on Early Help Interventions. There is a rolling Training program in place for this purpose.

52. It is crucial that if professionals are not satisfied with the outcome of an initial contact, that they resolve a disagreement or concern. The multiagency Escalation Policy should be used until a satisfactory outcome is understood and accepted.

53. The threshold document indicates that a level four concern is having children that have been previously removed from parental care. Apart from the information Mum shared about her children not being in her care, there was no evidence that children had been removed. There was a miscommunication between agencies about investigation versus enquiries; the way this was subsequently recorded seemed to give a false sense of reassurance to practitioners.

Learning

54. Recording systems for Children Social Care and Early Help should be linked. All information shared between agencies should be recorded clearly.

55. When a referral is sent to Children's Social Care all staff should check any Early Help information; this includes referrals.

56. If professionals are not satisfied with the outcome of an initial contact, any disagreements or concerns should be addressed and resolved in line with the multiagency Escalation Policy.

57. The Threshold document should be accessible to all staff in different formats.

Key Practice Episode 1 - Concerns for Mother and Child During Pregnancy
Key Line of Enquiry - Barriers to Effective Interpretation Services

58. There were medical concerns for Mum and baby during pregnancy, as baby had intrauterine growth restriction, and Mum was not attending all her antenatal clinic appointments.

59. Leo was seen during home visits, and his interaction with both Mum and Dad were considered normal; and there were no concerns about the home environment or Leo's physical and emotional care. During practitioner conversations with the reviewer, the feeling was that the family were doing as well as they could with limited finances and resources. For example, Mum and Dad fitted home-made baby protectors for corners on the furniture which was at Leo's head height.

60. Leo was also seen at the GP Practice and Mum was always prepared with snacks and nappies. Mum said that she regularly spoke to Sibling Two via video call but that she was not in contact with Sibling One.

61. Parents were in receipt of Universal Credits and were supported by the Community Midwifery Service to claim their train fares back, as they did not have transport.

62. The Community Midwifery Service felt that for the first time in a long time they were supporting a family who were 'experiencing severe deprivation,' and that this was due to their 'financial situation and sign of the times,' rather than a safeguarding concern.

63. The different Health Departments used the translation service Language Line, where interpreters could be booked to attend appointments by phone or in person. On occasions where interpreters or translation services were not available, Google Translate was used. Sometimes Dad would also interpret, and when Mum was given information that was written in English, Mum said she would get a friend to translate.

64. There are differing perspectives about the support that Mum had from family, friends, and within the community. The midwives who visited the family home most regularly described Mum as isolated and without support, a practitioner recognised with sadness and concern Mum had absolutely nobody to ask for help when she really needed it. Other practitioners that had seen both Mum and Dad within the community within friendship groups and therefore voiced that they were perhaps not as isolated. This highlights the difference of the views of practitioners who visited the family at home, and those who met and saw the family within community settings.

65. When looking at the sixteen ante-natal appointments Mum had attended during her pregnancy, it was recorded that Dad and Leo accompanied mum during one appointment, and that Dad also attended one other appointment.

66. Some professionals who met Mum during her pregnancy found Mum was not forthcoming with information and often did not make eye contact. They identified that there was a significant language barrier and that Mum had no support and was very isolated. Other practitioners identified that Mum often gave answers in English in context before an interpreter had finished interpreting.

67. The Health Visiting service sent letters and texts to Mum and Dad about Leo's 12-month development review. After Leo was not brought to his development review and no response had been received for two months, another appointment was hand-delivered. When the reviewer asked how usual it was to hand-deliver reminders, the practitioner said that it was not usual practice. All correspondence was written in English.

68. The Health Visitor also rang the GP Practice in an attempt to contact Mum and at the time of the phone call, Mum was attending the GP Practice. The Health Visitor requested that her phone number was written down and given to the Mum with a request to phone her.

69. The practitioners who made home visits during this time gave descriptions of Mum that can be summarised as being reticent and not inclined to talk or provide information.

Analysis

70. Between 23rd June up to 21st December when Mum gave birth, she attended sixteen antenatal appointments in four different locations which were either 9, 19, 23, or 33, miles away from the family home. Mum did not attend two antenatal appointments. To ensure they were supportive of Mum and baby's medical needs, there were regular home visits from Community Midwives who recognised that Mum had limited finances, did not have her own transport, and needed the antenatal care. These visits were over and above the home visits that would usually be made. Interpretive services were used consistently which enabled difficult conversations with Mum as she had serious pregnancy related health concerns and said that she smoked 6 or 7 cigarettes a day. It is not known who cared for Leo when Mum attended her antenatal appointments.

71. Health services consistently used interpretive services to communicate effectively because of Mum's assessed level of English. It is unclear how the parents communicated with each other; practitioners are under the impression that it was in Czech and English. It was thought that Mum did not speak Hungarian, and Dad had a good understanding of English but spoke minimal Czech.

72. When Mum visited midwifery led unit (MLU) the Community Midwives supported parents by giving information on how to claim reimbursement of public transport costs. Good practice was evident by the level of home visits and support from Community Midwifery Service and the Health Visiting Service. The support received showed that practitioners took the families circumstances into consideration.

73. There was effective communication between: the Community Midwifes and maternity services at the hospital (33 miles away from home); the Health Visiting Service, Healthy Child Practitioner and GP Practice. When needed, taxis were booked and paid for by the hospital (33 miles away from home) to ensure that Mum could get to antenatal appointments to meet her medical needs.

74. It is important that the good practice and effective communication between health services is recognised and commended. Staff members within health services recognised the level of health needs of Mum and the financial constraints of the family and they responded promptly; basing the service they offered on the identified needs of the family and taking the services they provided into the family home whilst recording and sharing information promptly.

75. When Mum was at the GP Practice it was requested that she make a phone call to the Health Visitor, however, if the parents had limited funds for example, no credit on their phones, making a call could have been difficult. It could have been beneficial to have a discussion with the GP Practice about booking a follow-up appointment and inviting the Health Visitor.

76. Although there is no doubt that it showed persistence to hand deliver the letter for Leo's 12-month review, NSPCC[2] learning states 'Write to families in their first language'. It would have been beneficial to use a translation service to ensure that the information received was written in Czech.

[2] People whose first language is not English: learning from case reviews | NSPCC Learning

77. For parents, whose first language is not English, there can be significant language and cultural barriers. The reviewer cannot ask Mum why she was able to communicate well without an interpreter with some professionals and not others. However, it needs to be considered as a Partnership what agencies and practitioners need to understand about how they communicate.

78. Parents from Eastern Europe living in the UK may face significant cultural differences. While the reviewer cannot ask Mum if she felt isolated despite her local friendships, it's important for partnerships to consider possible biases among agencies and practitioners toward parents.

79. Mum's partner was used on occasion as an interpreter. When Mum was given written information in English, Mum said she would get a friend to translate. Although understandable in some situations, using a partner or friend to interpret/translate cannot be considered good practice.

80. The reasons for Mum being reticent are not known; this could be because she was naturally quiet, did not feel comfortable sharing information, did not understand fully even when interpretive services were used, or was knowingly not sharing information about the reasons that Sibling's One and Two were not living with her. Using a trauma informed approach to questioning, to understand what happened to Mum rather than why it happened, may have generated a different response.

Learning

81. A trauma informed approach to questioning should always be used; that assumes trauma has occurred and seeks to understand what happened.

82. Family members and friends should not be used as an interpreter under any circumstances (NSPCC Learning).

83. All written correspondence should be in parents preferred language.

84. Caution should be used when relying on translation services such as Google Translate.

85. Professionals should consider more assertive ways to engage parents, rather than it being the parents' responsibility to contact the professionals.

Key Practice Episode 2 - Ivy's Birth

86. On 21st December Mum took Leo with her when she attended her appointment at the Maternity Day Assessment Unit at hospital (33 miles away from home). A telephone interpreter was arranged, and the Consultant Obstetrician made the decision to deliver the baby by emergency caesarean section as Mum had a severe pregnancy related medical condition.

87. The Maternity Unit in the hospital telephoned the Emergency Social Work Team (ESWT) about Leo staying with Mum, as Dad was at work. The Emergency Social Work Team (ESWT) response was that they did not offer financial support.

88. Dad said he could not come to the hospital to collect Leo as he could not afford it. A taxi was arranged and paid for, to collect Dad and bring him to the hospital. Dad and Leo stayed on the delivery suite until Ivy was born by emergency caesarean section at approximately 22:00 hours.

Analysis

89. The family were cared for while they were in the delivery suite; they made it clear that they faced barriers with childcare, finances, and transport, and their needs were accommodated.

Learning

90. A more inclusive and robust approach to supporting families where there are identified transport, financial and language barriers is needed.

Key Practice Episode 3 – Barriers to Visiting New-born Baby
Key Practice Episode 4 - Home Visits

91. On Christmas Eve 24th December 2022, Mum was discharged from hospital and went home to Dad and Leo.

92. On Christmas Day Community Midwives made a home visit to Mum. Leo, and Dad were also in the house, and Dad's brother who lived two doors away was visiting. Parents said that they would like to see Ivy but had no transport so were unable to get to the hospital. Dad's brother (Leo and Ivy's uncle) had a can of beer, said a friendly Merry Christmas, and left the house with his beer. That was the only time a professional had seen alcohol being drunk in the house.

93. On Boxing Day Mum attended her planned post-natal appointment at the hospital where Ivy was on the Neonatal Unit (33 miles away from home). Mum was asked to liaise with the Neonatal Unit to discuss arranging visits to see Ivy by taxi.

94. Ivy's family could not visit every day as Mum and Dad did not have their own transport, public transport was infrequent and expensive (non-existent on Christmas day and Boxing Day), and the Neonatal Unit did not provide any assistance with taxis, in addition there had been train strikes during the first week of January 2023. A family friend was relied on to give the family lifts to and from the hospital.

95. Whilst Ivy was on the Neonatal Unit, a flat for parents of babies on the Neonatal ward became available, however it could not accommodate siblings. As Leo was not allowed to stay, they could not take the flat as Dad said that if he did not work, he did not get paid, therefore Mum needed to look after Leo.

Analysis

96. By the time Ivy was 16 days old parents had made three visits to see her. Mum and Dad had been making telephone contact with the Neonatal Unit to get updates but had not rung for four days. Neonatal Unit staff escalated their concerns to their safeguarding team.

97. The lack of accessibility to support visits to the Neonatal Unit is a barrier. It is not known whether the family had been informed that travel costs would not be covered after Ivy was born, or whether the family's significant financial constraints were considered. This may have enabled the parents to consider how they would manage travelling to the hospital if Ivy was admitted to the Neonatal Unit.

98. Staff in the Neonatal Unit cared for Ivy and encouraged her parents to visit. When they were unable to visit, staff asked why; they explained that they had no transport. The journey from home to the hospital using public transport is not straightforward. On a Saturday, the journey to the hospital could take 1 hour 5 minutes using two different trains, a bus and walking in-between. Without using trains, the journey could take 3 hours 15 minutes, using four different busses and walking in-between. There are even less, and at times no options to use public transport over the Christmas period. It is crucial that all staff in the Neonatal Unit have information from other agencies that support 'Think Family' and feel empowered to consider approaches to support contact and visits from parents to their babies on the Neonatal Unit from Early Help or Charities [3] such as Neonatal Support Rainbow Trust.

99. Discussion and review are needed around the Neonatal flat being fit for purpose, as only Mothers, rather than families and their children, can be accommodated. A flexible and individual approach to accommodate and support parents and siblings is needed when a baby is on the Neonatal Unit; this will then support bonding and attachment for all family members.

[3] Neonatal support | Rainbow Trust Children's Charity

100. Although there were regular home visits to Mum from Community Midwives to ensure that Mum's medical needs were met, there is a need for those practitioners caring for Mum at home, and Ivy in hospital, to work together and 'Think Family.' On Christmas Day it may have been possible to arrange a video call or a visit to Ivy, if all staff had autonomy and were able to make those decisions.

101. The first time that evidence of alcohol was seen in the home was on Christmas Day when the Community Midwife visited. Leo and Ivy's uncle (Dad's brother) was present, said Merry Christmas and left with his can of beer. When the house was searched after police arrested both parents, there was evidence that a quantity of alcohol had been consumed. Empty cans were neatly stacked back inside their original cardboard packaging and stacked outside the back door. Public Health England (2019)[4] report that 'anecdotally it is thought that people often tell their GP (or, in this case, midwife) that they drink less than they do.' Consequently, it is possible that Mum said that she was drinking less than she was.

102. Mum was routinely asked questions about alcohol consumption, but only after the non-accidental injuries were found on Ivy did Mum admit that she had drunk alcohol throughout her pregnancy. This is significant as when Ivy had a child protection medical, it was identified that she may have signs of Foetal Alcohol Syndrome.

103. When conducting home visits practitioners should be professionally curious and ask questions in different ways about a child's daily lived experience, for example 'Can you tell me what happens when Dad comes home from work?', 'Can you tell me what Ivy and Leo's bedtime routine is?' These can open conversations up about alcohol and other issues without being direct.

104. The length of time Ivy spent on the Neonatal Unit increased her vulnerability as she was premature and growth restricted. As Ivy's family could not visit regularly, this increased the challenges for her parents and sibling with bonding and attachment. There was good communication between the Health Visitor with Neonatal Unit and Community Midwives, and Ivy's additional vulnerabilities were recognised by health staff who encouraged Mum to visit and spend time with Ivy to help with bonding.

105. Although it was recognised at Mum's postnatal appointment that support was needed to visit Ivy, it is not known whether Mum had a conversation with the Neonatal Unit about arranging taxis to visit Ivy, whether it was intended that Mum was to pay for them and get reimbursed, or whether the Neonatal Unit at the hospital would arrange them.

106. There was a marked difference between the way the hospital departments addressed the financial and transport issues of the family. It is not clear after Mum's post-natal appointment when Ivy was five days old if Mum spoke to the Neonatal Unit about taxis, or what the outcome was.

Learning

107. To meet individual family needs, alternative more accommodating solutions need to be considered to complement the flat that is available in the Neonatal Unit, this will ensure that there is flexible and equitable provision to meet families' circumstances.

108. Staff across our safeguarding system including in different hospital departments need the autonomy to work collaboratively with other departments and agencies, to 'Think family', and decide on practical solutions to meet a family's presenting and immediate needs. This includes parents who have financial

[4] Public Health England (2019) Health of women before and during pregnancy: health behaviours, risk factors and inequalities

issues who do not have their own transport or, the funds to pay for public transport even when they can be reimbursed.

109. There needs to be consistency across the safeguarding system to ensure families receive the same message. When families decline Early Help services, signposting and other options need to be clearly understood and revisited at every opportunity by all agencies.

110. Understanding of bias is needed to ensure that parents whose first language is not English receive as equitable a service as those parents whose first language is English, with 'Think Family' at the centre.

Key Practice Episode 5 - Multiagency Referral Form (MARF) Assessment and Outcome
Key lines of Enquiry – Use and understanding of Shropshire Thresholds

111. As safeguarding concerns were increasing, a Multiagency Referral Form (MARF) was completed. Concerns outlined were:

- During one of the short visits to see Ivy, Leo was present and was drinking out of a very dirty bottle. The Health Visiting Team had flagged up previous concerns when Leo was born around poor safer sleeping practises and not sterilising bottles.
- Not knowing why Mum's two children in Czechia were not in her care and having a history of involvement from Social Services.
- The neonatal unit staff were unable to complete a parenting assessment with an interpreter present as the parents did not attend the appointment.

112. After receiving the Multiagency Referral Form (MARF), a Social Worker from Compass contacted Mum via an interpreter and was satisfied with Mum's explanation of their financial difficulties that resulted in infrequent visits to Ivy. Advice was also provided around keeping Leo's bottles sterilised. It was recognised that midwifery had been significantly involved with the family and had raised no concerns, and that a Health Visitor would soon be allocated. The outcome of the Multiagency Referral (MARF) was that it was closed with no further action.

Analysis

113. A multiagency referral form was completed which articulated safeguarding concerns. Completing the multiagency referral form (MARF) became the responsibility of a member of staff who did not know the family; it is important that the MARF is completed by staff who have most contact with families. It is not known what conversations were had with the parents about the safeguarding concerns prior to the MARF being completed.

114. It is important that conversations are held initially with parents when concerns do not meet the threshold of significant harm. Agencies need to ensure that the latest version of the Thresholds Document and any accompanying resources, for example video are widely accessed and by every practitioner in every agency.

Learning

115. Understanding bias is important to ensure that parents whose first language is not English receive as equitable a service as those parents whose first language is English, with 'Think Family' at the centre.

116. Staff audits should be conducted regularly to ensure that all staff are aware of policies, procedures and how to make safeguarding referrals. Copies of the threshold document would be beneficial to have on the neonatal unit, with regular links to the thresholds video being communicated.

117. Ensure that within Shrewsbury and Telford Hospital NHS Trust that the member of staff that has worked most closely with the family gets the support they need in completing a MARF regardless of their banding.

Key Practice Episode 6 - Safe Discharge
Key Practice Episode 4 - Home Visits
Key lines of enquiry:

- **Barriers to Effective Interpretation Services**
- **Unseen Men**

118. The Consultant Neonatologist wanted to be sure that Ivy was safe to be discharged and so a meeting was arranged with the Registrar, parents, Nurse in Charge, Health Visitor, and Interpreter. The Health Visitor could not attend. Toys were provided for Leo to play with.

119. At the meeting, the professionals wanted to understand why Mum and Dad had not been visiting Ivy. It was found that the wrong mobile telephone number was on file for Dad. Mum and Dad explained that they had wanted to visit but could not afford to. They relied on a friend to give them a lift; during the meeting the friend was in the waiting area near to the room saying that they needed to leave as they did not like driving in the dark. During the meeting, the consultant and registrar were clear with parents about what needed to happen before Ivy could be discharged safely; they needed to know that Mum and Dad were able to meet all of Ivy's needs. Mum was on her phone during the meeting, however as she still responded, the professionals present did not challenge Mum or find this concerning.

120. After the meeting Mum and Dad were only able to spend about 10 minutes with Ivy, as the friend who had given them a lift needed to leave.

121. Immediately prior to Ivy's discharge, Mum stayed for four days in the parent's flat on the Neonatal Unit (NNU). All of Ivy's care was provided by Mum who was friendly with staff, and very confident with Ivy; no concerns were raised.

122. Ivy was discharged from the Neonatal Unit on Day 27 with the discharge paperwork completed during a 1.5-hour meeting. Safer sleep information in Czech by the Lullaby Trust was given in leaflet format and sent electronically.

123. Community Midwives usually provide antenatal care in a clinic; however, midwives went into the home.

124. It was recorded that Early Help was offered and was declined by the family.

125. The Health Visiting Service initially found the same issues that had needed to be addressed with the parents regarding caring for Leo, were also issues for Ivy. An interpreter was present in all conversations with Mum. Issues covered included safer sleeping, the temperature of the home being too hot, and preparing formula feeds. A joint visit was planned and the Healthy Child Practitioner and Health Visitor discussed beforehand that they may be able to complete a Multi-agency Referral Form (MARF) after the visit, however, there was not enough evidence for this as parents had addressed all issues. During the conversation with the reviewer the practitioner explained that they had an underlying concern that Mum's two older children in Czechia had been removed from her care. Mum gave no explanation as to why her older children were not in her care and said that she was able to have regular contact via video call with Sibling Two but had no contact with Sibling One.

126. The family were visited regularly at home by health professionals including the Neonatal Outreach Team and Health Visiting Service; interpretive services were routinely used.

127. Ivy and Leo were brought to all their routine appointments at the GP Practice; they were always dressed in clean clothes that fitted them and Mum was always prepared with bottles and nappies for them and snacks for Leo.

128. Mum did not attend her blood pressure review appointment, following Ivy's birth. As a result, the GP requested the receptionist contact Mum to arrange a further appointment. It is not known if an interpretive service was used.

129. All Mum's follow-up health appointments at the GP Practice were attended.

130. There were no concerns about the home environment or interactions between Mum and Dad, or with either parent, Ivy, or Leo.

131. Dad brought Leo to his 12-month development review where opportunities for Leo to socialise were discussed, and subsequently parents committed to taking Leo to three pre-school sessions a week which they would pay for.

132. There were professionals that were able to communicate effectively without using interpretive services; this included staff at the pre-school, and some staff members at the GP Practice.

133. During home visits, the Community Midwives and Neonatal Community Outreach Nurse encouraged Dad to support Mum as she was still recovering from pregnancy related health conditions and Ivy's birth and was very tired. Conversations about how to cope with a crying baby were had with Mum by professionals in the hospital and GP Practice. Parents had access to the ICON[5] (Infant Crying is Normal; Comforting Methods can help; It's Ok to Walk Away; Never, Ever Shake a Baby) programme online, although this is only available in English. Dad cared for Leo and Ivy when he returned home from his 12-hour shift. It is thought that Mum slept upstairs with the children and Dad slept downstairs on a two-seater sofa. When Ivy woke in the night Mum took her downstairs to Dad.

134. The practitioners' descriptions of Mum during home visits at this time can be summarised as being reticent and not inclined to talk or provide information.

135. Dad was described as the main caregiver when he was not at work and presented consistently as warm, friendly, and communicative to professionals and especially to Leo.

136. The Health Visitor gave an example of her vigilance following a visit in March 2023, as she noticed that Mum had a mark that looked like a love bite on her neck and spoke to her about it; Mum reassured the Health Visitor that it was nothing to worry about. The Health Visitor was confident that she would have noticed any new or unusual marks on Ivy.

Analysis

137. It is important that good practice demonstrated to ensure that Leo's needs were addressed in the safe discharge meeting is acknowledged and commended.

138. The reasons for Mum being reticent are not known; this could be because she was naturally quiet, did not feel comfortable sharing information, did not understand fully even when interpretive services were used, or was knowingly not sharing information specifically with regards to the reasons that Sibling One and Sibling Two were not living with her. A trauma informed approach to

[5] ICON - Babies cry you can cope - Advice and Support | ICON Home - ICON Cope

questioning, to understand what happened rather than why it happened, may have generated a different response. Alternatively, it may be the case that when a person conveys their lack of understanding of a language it can be used as a convenient reason to not engage which can support non-compliance.

139. Having the same Health Visitor for both Leo and Ivy is good evidence of family centred care as the family's context and history was already known. This enabled the Health Visitor to use her intuition; she had a gut feeling and was uncomfortable that Mum's two older children did not live with her. Robson (2017)[6] advises that, 'Such observations suggest that our intuitions are an essential part of our decision-making toolkit – that should be ignored at our peril.' More home visits than usual were carried out and despite asking tenacious questions about why the children did not live with her, Mum avoided answering them. It may have been beneficial for the Neonatal Community Outreach Nurse to conduct a joint visit with the Health Visitor as concerns could have then been shared.

140. Several professionals used interpretive services to communicate effectively because of Mum's assessed level of English. Agencies regularly use the translation service Language Line, where interpreters can be booked to attend appointments by phone or in person. Google translate was used on occasion if an interpreter was not available. Safer sleep information in Czech was provided in leaflet format and sent electronically. There is additional comprehensive information accessible online that is made available to parents with a newborn baby by the hospital. A hardcopy of this information is being developed in other languages; however, Czech is not one of the options that is currently being considered.

141. When a parent says that they are in regular contact with children who do not live with them, it is natural to accept what they are saying. It is now clear from information received by Czechia authorities that Mum was not in regular contact with Sibling Two. It is important that practitioners are professionally curious in these situations and show interest in Mum's relationship with the children that do not live with her.

142. It was clear that Dad was seen and spoken to. Dad understood and spoke English well, and whilst it is positive that he was seen by health professionals, what is not clear is if his circumstances were fully taken into consideration. Dad worked 12-hour shifts and was encouraged to help Mum as often as he could as she was tired and recovering from Ivy's birth. When Dad came home from work, he took over care of both children from Mum and often presented as the main caregiver. It is not known whether Dad was spoken to alone to ascertain his views, feelings and how he was coping, and if he was worried about his partner and how she was feeling.

Learning

143. Understanding bias is important to ensure that parents whose first language is not English receive as equitable a service as those parents whose first language is English, with 'Think Family' at the centre. Additionally, it's crucial to consider bias between parenting responsibilities. For example, if a mother was working full time and the main caregiver for the children at home and overnight, what would our response and approach to support be. It is important that support is available for both parents who are caring for a new baby.

[6] Robson (2017) Intuition: When is it right to trust your gut instincts? - BBC Worklife

Key Practice Episode 7 - Notifying Emergency Social Work Team (ESWT)

Key Lines of Enquiry:

- **Injury to Under 2 policy, Regional Child Protection Procedures for West Midlands**
- **Barriers to Effective Interpretation Services**

144. On the day that the non-accidental injuries were suspected, the GP phoned the Emergency Social Work Team (Out of hours) safeguarding number. The call was answered by an answering machine, but the author has not been able to clarify the content of the recorded message. The GP did not leave a message as it was after surgery hours.

145. When the paramedics arrived, they provided the GP with the number for their safeguarding team, and the GP made the call and spoke to them. Ivy was taken from the GP Practice into the ambulance. After assessing Ivy and finding that her response levels and muscle tone were not as expected, the paramedics made it clear that Ivy needed to be prioritised. One paramedic cuddled and fed Ivy 10mls of her formula and sang to her. Ivy was floppy, did not grip onto the paramedic's finger and could not support her own neck. Mum was outside the ambulance and seemed angry, saying she did not want to go to hospital as she was traumatised by Ivy's birth. Mum reluctantly went into the ambulance; throughout the journey to the hospital, she was tearful and faced away from Ivy who was in her car seat.

146. An x-ray confirmed that Ivy had fractures to her seventh rib on her left side and left clavicle. The Child Protection Medical concluded that the initial fractures were non-accidental and not consistent with any of the explanations given by either of Ivy's parents. Subsequently, specialist eye examinations were conducted and CT scans and skeletal surveys showed that Ivy's injuries were extensive and extremely serious. Ivy was found to have injuries that included significant bleeding behind both eyes, brain abnormalities, and fractures in her legs and arms.

147. After originally saying that she had not been drinking, Mum admitted that she had been drinking beer on the evening she took Ivy to the GP Practice. Mum also said that she had drank alcohol on special occasions and weekends throughout her pregnancy. It is worth noting that throughout Mum's pregnancy she maintained that she did not drink, and that Dad drank one or two beers each evening during the week, and five or six beers at the weekend.

148. During the police interview after the non-accidental injuries had been caused, Children's Social Care found that Mum responded in context before the interpreter had relayed what had been said.

Analysis

149. The General Practitioner at the GP Practice promptly recognised a safeguarding concern and immediately rang the Emergency Social Work Team, the GP did not leave an answerphone message but immediately called for an ambulance as there were clinical concerns for Ivy due to fluctuating vital signs. Including that Ivy looked pale, her oxygen saturation levels were fluctuating, and a fractured rib was suspected.

150. The Regional Child Protection Procedures Injuries in Babies and Children Under two years of age'[7] states that 'it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Services is made.' The responsibility to make the referral in this case

[7] Injuries in babies and children under 2 years of age - Regional Safeguarding Guidance West Midlands Procedures

was the General Practitioner at the GP Practice. It was not until later in the evening that Shrewsbury and Telford Hospital NHS Trust made the referral to the Emergency Social Work Team.

151. When the Emergency Social Work Team phone line was engaged, the 'Injuries in Babies and Children Under 2 Years of Age' procedure was not followed as the GP did not leave an answerphone message. It is recognised that children under 2 years of age are at an increased risk of serious physical abuse and are unable to communicate the history themselves; and that non-inflicted injuries in non-mobile infants are unusual. The author recognises that leaving a message for a number they may not have used before would make most professionals hesitant, especially considering the urgency to safeguard. It is recognised that in this instance the GP did everything possible to safeguard Ivy.

152. There are barriers for some agencies in using effective interpretation services. Interpretive services used in Children's Social Care have changed seemingly due to financial pressures, which means that all appointments need to be booked in advance. If an appointment is late or missed for any reason the interpreter needs to be rebooked. This inflexibility presents difficulties in using some interpretive services. 'Say Hi Translate' is a free app that enables a conversation in two languages to be translated immediately and sent by text message. Shropshire Council's firewalls/network security systems block the use of this app, which means that staff members who may need the instant access and flexibility of this service have had no option but to download this to their personal mobile phones.

Learning

153. When the Emergency Social Work team phone number is engaged, concerned staff should leave a message and try to phone again.

154. Information in the 'injuries in babies and children under 2 years of age' procedure needs to be embedded into the practice of all staff who may be working with children within this age group their parents and families.

155. Interpretive and translation solutions should be found and need to be flexible enough to provide effective ways to communicate with families, at the time it's needed.

Summary of Recommendations for improvement across Shropshire Safeguarding Community Partnership:

1) **Strengthen 'Think Family' approach** SSCP need assurance that staff are using the Think Family approach; staff should be confident and competent in their communication with parents whose first language is not English.
2) **Address and challenge bias** SSCP need assurance that all agencies are identifying and addressing bias, which means acknowledging that this may be present when parent's culture and first language are not English, and a commitment to ensuring that all families receive as equitable a service as those parents whose first language and culture is English.
3) **Referrals** SSCP need assurance that agencies have a focus on safeguarding being everyone's responsibility. Completion of referrals within Health Services (Shrewsbury and Telford Hospital NHS Trust) should be completed by the practitioners who have the concerns, or by those who are most familiar with the family (regardless of role). Support to complete and check through the referral should be available and given consistently to all staff members. The author recognises that the Multiagency Referral Form (MARF) was replaced by the online Children's Referral Portal in February 2026.
4) **Recording systems** SSCP need assurance that when Children's Social Care receive a referral, the Early Help Recording System should be routinely checked for information on all family members. The author recognises that the Multiagency Referral Form (MARF) was replaced by the online Children's Referral Portal in February 2026.
5) **Improve responses to injuries in under-2s** SSCP need assurance as to how the latest version of 'Injuries in babies and children under 2 years of age' has been understood and embedded into practice in GP Practices. The author recognises that the policy has been updated to Bruising in Babies and Children.
6) **Embed understanding of Escalation Policy** SSCP need assurance as to how awareness and use of Escalation Policy: Resolution of Professional Agreements is promoted.
7) **Strengthen interpretation and communication support** SSCP need assurance in relation to the flexibility and reliability of interpretive and translation services; this should be available during all episodes of contacts with parents. This assurance should include details of how communication style is agreed with the family and, how written information can be shared with parents in their own language from the outset.
8) **Embed understanding of Thresholds** SSCP need assurance that the most up to date versions of the Thresholds Document and any accompanying resources are embedded into practice.
9) **Conduct regular safeguarding audits** SSCP need assurance that regular staff audits are carried out to ensure that all staff are aware of safeguarding policies, procedures, processes, guidance documents and know how to make effective safeguarding referrals.
10) **Ensure coordinated support for families with financial or transport barriers** SSCP need assurance that 'Think family' is at the forefront in supporting parents with financial and transport difficulties to visit and stay with their newly born child in the Neonatal Unit. Ensure that family circumstances regarding work and financial commitments are fully understood and taken into consideration.
11) **Promote trauma-informed and professionally curious practice** SSCP need assurance that practitioners are working in a trauma informed way and are professionally curious in addressing issues of parent's seeming reluctance to engage with agencies.

David Shaw
Director of Children's Services
Shropshire Council

Emma Whitworth
Temporary Detective Superintendent
West Mercia Police

Vanessa Whately
Chief Nursing Officer
Integrated Care Board

Appendix 1
Immediate Learning Identified in the Rapid Review

Voice of the non-verbal child
All agencies to ensure that practitioners are aware of how to hear the voice of the non-verbal child, including documenting observations of the child's behaviour, presentation, home conditions, lived experience and attachment to their parents and siblings.

Feedback to referrers
When feeding back to referrers and any other agency involved with a child and family following a referral that has been outcomed as Early Help, Early Help should ensure that agencies are aware of the expectations of them that have been outlined in the rationale and decision-making with regards to providing further or on-going support to the child and family.

Financial support for families
Shropshire Safeguarding Community Partnership to re-advertise the support available via the Household Support Fund to agencies across the Partnership.

Use of Thresholds Guidance
All agencies safeguarding leads to ensure that their practitioners are aware of, make use of and reference the relevant parts of the Thresholds Guidance when making a referral to Children's Social Care to ensure improvement in the quality of child safeguarding referrals.

Professional Curiosity
All agencies to raise awareness of the importance of practitioners exercising professional curiosity and to offer learning opportunities on professional curiosity where possible.
Shropshire Safeguarding Community Partnership Business Unit to re-circulate the Professional Curiosity Guidance.
Shropshire Safeguarding Community Partnership Business Unit to arrange learning events for multi-agency practitioners on exercising professional curiosity.

Avoiding Unconscious Bias
All agencies to raise awareness of the issue of unconscious bias with practitioners to ensure that all children and families in need of help and support are provided with an equitable service, regardless of background, ethnicity, and any communication difficulties, (including any other special characteristics).

Use of Neglect Tools and Pathways
All agencies safeguarding leads to ensure that their practitioners are aware of the Neglect Tools and Pathways and that these tools are referred to and used in assessing risk in cases of child neglect and suspected child neglect.

Use of Escalation Policy
Agencies who have submitted a MARF and not happy with the outcome given by Compass, should check again that all information was provided in line with the Thresholds Guidance and if there remains a dispute then the agency should follow the Shropshire Safeguarding Community Partnership Escalation Policy.

Child Protection Medicals and Consent
Children's Social Care and Shrewsbury and Telford Hospitals Trust to develop and agree a shared Child Protection Medical Consent and Sedation Protocol. This should include information on who holds parental responsibility under each legal status to avoid confusion and delay in undertaking Child Protection Medicals and securing the necessary Order to protect the child.

Ensuring that Referrals and Assessments are Quality Assured and Submitted

Maternity Services to ensure that all referrals of child safeguarding concerns, Early Help assessments and supporting documentation is quality assured by the safeguarding lead midwives, and that records detail when and where referrals were sent and contain a copy of the documentation.

Appendix 2
Managers Briefing Contributions via MentiMeter (Anonymous)
Please share your thoughts on the circumstances shared and good practice…

- Cultural differences language barrier, Transport costs, Not able to do background checks in other countries.
- Good practice was evident by the level of home visits and home support they received. This shows that the practitioners identified the family needs.
- HV continuity known previously to family, home visit to arrange sibling development review, Weekly contacts to review needs led-service.
- Continuity of care. Maternity, HV's, going "over and above" normal response. More home visits. Care of family on delivery suite. Maternity reimbursement of transport funds."
- There was so many unknowns about the family's circumstance which led to barriers in safeguarding.
- Good-practice - appointments at home by health, GP referring in, weekly visits by health. Interpreter being used.
- There appears to be recognition of needs through the level of home-visiting.
- Practitioner going above and beyond. The same Health Visitor for both children showed continuity as she already knew the family before Ivy was born.
- Good practice GP referring in. Pregnancy home appts. Hand delivering letters. Mum having child vaccinated.
- Antenatal visits at home due to transport difficulties and midwifery concerns, needs led service.
- The language barrier was a huge issue.
- What was the barrier to getting information from the Mothers home country about the circumstances to her other children were not in her care.
- The fact that older children had been removed in another country was not able to be explored.
- Ivy cried for 3 hours during Leo's initial visit to pre-school that would have been concerning
- Why was Leo not able to stay in the flat?

Appendix 3
Managers Briefing Contributions via MentiMeter (Anonymous)
Please share any solutions and thoughts after discussing the key lines of enquiry...

- Staff are aware of policies and use of MARF etc. This is audited on a regular basis.
- Discussed the importance of taking the individual situation into account and consideration, there was a discrepancy between the way two hospital departments addressed the issues of the family.
- open discussions needed around families / children stopping in the neonatal flat? reasons why not are not clear is this historical.
- "Flexible approach to accommodation in Neonatal Unit family flats to support parents and siblings. Hard copies of threshold doc and referral forms on unit."
- The flat is too small for older children to stay in, it also leads to questions over save sleeping for the older children and how many children could stay? So is the flat fit for purpose?
- Staff aware of thresholds and policy. Signposting for travel to be discussed in hospital.
- There needs to be a clear understanding and review as to what the criteria is for use of the Neonate flat. Who ultimately says no and why. Justification?
- Curious as to how early help, or child in need assessments are discussed with parents. I understand they are consent led but in this situation it would have given the family support and may have included financial help with travel.
- Some people have trouble taking to others in English without the difficultly of a language barrier. Wariness of talking in public as opposed to in an official place eg GP.
- Financial constraints of families need to be taken into account access to funds, social services input if deemed at need and extra needs.
- All safeguarding contact information on Trust intranet. Injuries to baby video and all safeguarding training offered is emailed to all maternity and NNU staff regularly.
- Who is signposting to help with travel costs? Is claiming back really a help if people cannot afford to pay and claimback?
- Parents whose first language not English - need to use interpreters as they may understand some English but it is different if you need to discuss processes and investigations.
- The child safeguarding video needs to be shared across the workforce and signposting to the under 2's policy.
- Dad was visible but the uncles/ cousins were more invisible. We know little about their role in the children's care.
- Use of language and expectations for men/ partners by practitioners , important to establish own needs and if could affect wider family but difficult if not present at visits due to work commitments.
- Did the nursery staff recognise Ivy's crying for 3 hours?
- Recognition of language barrier should preclude individuals from thinking they have successfully conversed. It is only safe to use an interpreter to allow contextual understanding.
- Seen men; unmet needs of partner, what were they? How do we ask? Level of unconscious bias by health and social care practitioners?
- Notes made from conversations without an interpreter cannot be deemed reliable.
- Interpreters: use language live face to face or by phone. Staff more experienced seem to be able to communicate more effectively.
- Contextual understanding of Dad's life is very important in determining whether he is positively involved or cannot be involved through life pressures such as work.
- Safeguarding supervision: was offered and accepted at the time and on-going to learn individually and in groups.

- When a concern is raised in relation to a foreign national should "culture" be excluded through use of external groups to advise on whether things are "culturally" relevant.

Further verbal contributions from the group included.

- How important that the SSCP Escalation policy is used.
- Non-compliance - Recognition that language is often the first thing to go when parents do not want to share information or communicate.

Appendix 4
Managers Briefing contributions via MentiMeter (anonymous)
What are you taking away from today, was it helpful, what could be done differently at future events?:

- Useful even though had very little to do with the case. Need to look at transport to / from hospital and what is given out to parents.
- Was very helpful to hear the other agencies input and what they doing to support the family.
- It was very helpful and i was reassured non blaming, however disappointing some services did not have representation and should have been seen as a priority.
- Very useful, safe space. Gained learning via reflecting on a very sad case and so to receive feedback that both children are well.
- It was very useful, I will be taking away that all our staff need to watch the Thresholds video.
- It was helpful to reflect with other services and share information and views.
- Yes very interesting...I recognise the importance of acting on the learning opportunities after this meeting before something else is a priority.
- This is the first time I have been involved in this process. I will be taking some away to discuss with my team.