SERIOUS CASE REVIEW

ISABELLA

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1. Introduction

Initiation of the Serious Case Review

1.1. This Serious Case Review (SCR) was commissioned in September 2019 by Bury Safeguarding Children Board (BSCB). The matter under review is the unexpected tragic death of a young child (Child Isabella[1]).

1.2. Isabella had complex medical needs and global developmental delay. At the time of death Isabella was supported by a Child in Need (CIN) plan. When Isabella was 14 months old, her Mother found her unresponsive at the home address. Isabella was transported to hospital by ambulance under respiratory arrest but sadly died after attempts to resuscitate failed.

1.3. The BSCB concluded that the circumstances of this case meet the criteria for a SCR as per statutory guidance[2].

1.4. In 2018, the government announced that all local authorities would be required to replace their Local Safeguarding Children Boards with a team of Safeguarding Partners, who will work as a group to strengthen the child protection and safeguarding system. Consequently, on 30th September 2019 the BSCB was replaced by the Bury Integrated Safeguarding Partnership (BISP) and will be referred to as this thereafter throughout this report.

Methodology and Agency Involvement

1.5. The review was managed by a review panel (known as the Panel) which included representation from relevant organisations within Health, Children's Social Care (CSC), the Police and BISP. Allison Sandiford, an independent reviewer (the Reviewer) was commissioned to work with the Panel and to undertake the Review.

1.6. Individual report templates were distributed to agencies which requested a timeline of significant events and consideration and analysis of their involvement with Isabella and family. Following completion of the reports the timelines were merged and carefully analysed by the Reviewer. Key practitioners, managers and safeguarding leads then attended a one-day Learning Workshop, facilitated by the Reviewer, which provided the opportunity for individuals to discuss the detail of agency practice. The reports and discussions formed the foundation of this report. The Panel then reconvened to consider a draft report and all members made an invaluable contribution to the process and learning of the Review.

1.7. The Panel convened on a further occasion to consider recommendations and how learning could be shared with relevant practitioners and agencies. A final draft report was shared electronically and considered by all in advance of the extraordinary meeting with the BISP Strategy Group in February 2020 where the Review was presented.

The Purpose of this Review

1.8. The purpose of this Review is to consider what lessons can be learned to guide better future practice. This Review is understanding of the increasing pressures placed upon agencies that too often results in overwhelming workloads for very capable individuals. It is therefore necessary to reiterate that it is not the purpose of this Review to scrutinise the actions of, or apportion blame to, agencies or individuals.

[1] It is important to protect the identity of the child and family; the name Isabella has been chosen for the review and is not the child's name.
[2] Working Together to Safeguard Children, 2015, HM Government

1.9. Nor is it the purpose of this Review to make a judgment as to whether Isabella's death was predictable or preventable.

1.10. The Review process has unavoidably been worked with the benefit of hindsight, but the report has attempted to minimise any influence of outcome bias.

Period under Review

1.11. The Review period commences from when the pregnancy becomes known and ends with the tragic death of Isabella.

The Review sought to understand the following Key Lines

1.12. Whether there was enough assessment of, and whether concluded assessments had considered the pre-existing vulnerabilities of parents such as;

Mother's young age

Parents' own childhood experiences

Any history of domestic abuse and/or sexual abuse

1.13. Whether practitioners were confident of Mother's ability to meet the health needs of Isabella and whether a sufficient support package was in place.

1.14. Whether there was enough knowledge of and involvement of Father and whether his information was shared and communicated effectively between workers/agencies.

1.15. Whether the case was managed effectually at Child in Need and whether the plan was maintained, reviewed and progressed as necessary, taking all of the needs of Isabella into consideration.

1.16. Whether the multi-agency meetings were clarified and focused, and whether communication regarding the management of risk was effective, in particular with regards to any non-engagement from parents.

1.17. Whether consideration was given to the effect a new baby would have on parents' ability to manage the needs of Isabella and whether there was any new subsequent impact on risk.

Parallel Processes

1.18. The Review, although an independent process undertaken on behalf of BISP, was thoughtful of the ongoing Sudden and Unexpected Deaths in Childhood (SUDC) procedure in relation to Child Isabella's death.

Family Involvement

1.19. In line with the principles laid down in Working Together, parents were invited to contribute to the Review. Their contributions are included in section 3 of this document.

2. Brief Synopsis of Events

Background

2.1. Prior to Isabella, both parents had been known to CSC. Mother's parents (hereafter referred to as maternal grandmother (MGM) and maternal grandfather (MGF)) separated when Mother was young, but she maintained contact with both parents and her siblings. Professional records report a lack of structure, guidance and boundaries for Mother within her childhood which accumulated in her becoming subject to a Child Protection Plan[3] (CPP) for a period of time. There were also concerns for Mother in respect of Child Sexual Exploitation (CSE) and these increased when her relationship with Father became known when she was 16 and he was 21. Mother undertook some work around CSE and over time the risk was thought to have lessened as it appeared that the relationship had ended. However, the concerns, coupled with a dip in home conditions at MGM's address, resulted in Mother becoming recognised as a CIN.

2.2. As a child Father lived with his parents (hereafter referred to as paternal grandmother (PGM) and paternal grandfather (PGF)) and siblings.

Pregnancy

2.3. Mother moved out of the area to live with her grandparents around the same time that she discovered she was pregnant. She engaged with midwifery services and a pre-birth assessment. Father did not attend midwifery appointments and his engagement with the assessment was minimal. As a result of the assessment CSC offered Mother support but she did not consent and as there was no statutory role for CSC, the case was closed. The assessment recognised issues in relation to parent's relationship when Father was under the influence of alcohol. With the exception of PGM, the paternal family were unaware of the pregnancy. The assessment reported that Mother had no intention to live with Father and that she wished to remain with her grandparents in a supportive environment.

2.4. In the last trimester of the pregnancy, a verbal domestic incident occurred between parents whilst Father was under the influence of alcohol.

Birth

2.5. Isabella was born prematurely and admitted to the Neonatal Intensive Care Unit (NICU). Mother was discharged from hospital 4 days later, but Isabella remained for just under 13 weeks.

Health

2.6. During her lifetime Isabella was under the care of several consultants whose expertise lay in different areas of medicine. Appointments were frequent and attendance of Isabella was needed at a variety of appointments in several locations across 3 different hospitals. It is acknowledged that Isabella's health needs were so great that she would require additional intervention and care, above and beyond what is expected for a new-born and that if her health was not monitored regularly, she would be at risk of becoming very ill quickly. Subsequently the health information submitted for this review was extensive and this report is not inclusive of all of the professional medical involvement.

2.7. The Review acknowledges that it was Mother who cared for Isabella on a daily basis and that Isabella's needs would have made this a demanding job. The involvement that Isabella required from a range of professionals would have proved difficult for any parent to coordinate and manage. Furthermore, it is acknowledged that the medical care was disjointed across a variety of locations and this would have been an added burden for Mother due to financial circumstances and limited support from Father and extended family.

[3] Child Protection Plan – A multi-agency plan created in situations where a child has been deemed as suffering, or likely to suffer, significant harm.

Discharge

2.8. During Isabella's time in hospital there were instances reported of irregular visiting from Mother and a lack of clean clothes and nappies being provided but education for Mother regarding medication and safe care was ongoing. Prior to discharge Mother had a period of 'rooming-in'[4] during which time it was recorded that Mother had asked for Isabella to be returned to the unit as she was tired and couldn't cope with her. It was noted that Mother managed much better when MGM accompanied her rooming-in, but that Father had appeared disinterested. The concerns were shared at the discharge planning meetings and a competency folder was made and given to Mother upon discharge so that all of the information could be shared with the Outreach Team[5].

2.9. Upon discharge, Mother had decided to leave her Grandparents address and had returned to live with her father (MGF). Father continued to live elsewhere.

Home

2.10. During the timeframe under review following Isabella's discharge from hospital, the chronology and agency reports reveal a developing picture of inconsistent and sporadic engagement with professionals by Mother. Many health appointments were either cancelled or not attended and strategy meetings[6] were convened as a consequence.

2.11. The Health Visitor (HV) worked hard to co-ordinate appointments in an attempt to monitor and improve Mother's engagement with services but by December 2018 professionals had deemed that Isabella was a CIN. The CIN plan centred around Isabella's health needs but Mother's engagement remained sporadic and health appointments continued to be missed resulting in CSC having a case discussion with a Child Protection Conference Chair who advised that the case should continue at CIN but be escalated if non-engagement continued.

2.12. Around the same time that CIN commenced Mother discovered that she was pregnant again.

2.13. A number of concerns were reported by professionals over the following months including an occasion whereby Mother had attended the GP for a routine visit regarding her own health needs and the GP observed Isabella to be so unwell that an ambulance was called. Isabella was admitted into hospital and during this admittance, staff at the hospital shared concerns about Mother's ability to manage Isabella's needs. There were also 2 separate safeguarding referrals made by North West Ambulance Service (NWAS) due to the home environment at MGF's address and a lack of support for Mother from Father and extended family. However, on a positive note a Family Support Worker (FSW) was appointed to work with Mother and Mother appeared to work well with her, putting appointments into a diary to create order and addressing housing and financial needs. But by May 2019 concerns regarding missed health appointments were high again and a strategy meeting convened where it was decided that it was necessary to escalate the case to an Initial Child Protection Conference (ICPC). Following discussion with a Conference Chair a conference was provisionally booked but the case never progressed.

2.14. In July 2019 Mother gave birth to Isabella's sibling.

[4] 'Rooming-in' means that mother and baby remain in hospital but are unsupervised in a room separate from the Neonatal intensive care unit. Mother would be expected to carry out all cares.

[5] The Outreach Service aims to support parents and carers with the care of their children to provide support for the families within the home environment and within their local communities

[6] Strategy meetings are convened under section 47 of the Children Act 1989 where there is reasonable cause to suspect a child is suffering, or likely to suffer, significant harm.

Response to Being Unwell

2.15. In August 2019 Mother called an ambulance after finding Isabella unresponsive. The ambulance crew transported Isabella to hospital under respiratory arrest. Following further cardiac arrests, Isabella sadly died after all attempts at resuscitation had failed.

2.16. Mother reported that Isabella had been poorly for 2-3 days and had been vomiting.

3. Family Views

3.1. Mother met with the Reviewer and provided her experience of the support and services received by Isabella and herself. Her contribution has proven invaluable and the Reviewer would like to offer Mother and all of Isabella's family sincere condolences.

3.2. BISP has contacted Father and invited him to meet with the Reviewer and contribute to the Review but has not received any response.

3.3. It is clear from discussions with Mother that Isabella was very much loved. Mother was happy to be pregnant and understood the initial reasons for CSC becoming involved and conducting the pre-birth assessment. She admitted that she was wary of Social Workers (SW's) due to her own past experiences of them when she was younger and that of others whom she had spoken to.

3.4. Mother had mixed emotions about the time that Isabella spent in hospital following her birth. Mother said that some of the staff were very helpful and nice, but others didn't explain things very well and she felt as if they were looking down their noses at her. Mother said that sometimes staff would offer to help her with Isabella but when she accepted help it would later be used against her with staff reporting that she couldn't manage on her own. She also said that she would have appreciated doctors and nurses spending more time with her explaining the condition and why it might have happened. This question still remains unanswered.

3.5. Mother was pleased when Isabella was allowed to come home and overall, she was happy with the support that she got from professionals that supplemented the help that she got from her parents and Isabella's father. However, as time went on there were instances when professionals would contradict one another with their instructions regarding medication and care and Mother found this confusing. She talked of different medical practitioners stating different dosages for some of Isabella's medication and of times when she had asked for Isabella to be admitted to hospital due to sickness, as instructed, but was told not to attend. Mother said she felt able to phone hospitals for advice and often did, but there were some occasions when she felt as if professionals were talking about her behind her back; she found comments about not bonding and not meeting Isabella's health needs hurtful, and in her opinion, untrue. Mother also remembered that one consultant had accused her of not giving Isabella her medication when she had, and she had found this to be very upsetting.

3.6. Mother admitted that she did miss some of Isabella's health appointments but felt that she always had a valid reason for doing so. There were times when either she or Isabella was too unwell to travel and other times when appointments clashed. Transport was sometimes a problem and she had been told to call an ambulance which she understood to mean calling 999, and she wasn't comfortable doing this when it wasn't an emergency.

3.7. Mother didn't really have any particular memories of the CIN plan. However, she remembered that she was unhappy when she heard that Isabella was going to be subject to a Child Protection Conference. Mother felt that this was unfair as she hadn't had a SW for many weeks at this time and the FSW had also ceased her visits.

3.8. When Mother discovered that she was pregnant again she was happy. She said that she has always wanted to have a family and she is at her happiest when at home with the children. She was not worried about caring for 2 children and managing their needs.

3.9. In summary Mother was happy with much of the support that she and Isabella received but felt as if there were times when she received conflicting information and times when she wasn't kept in the loop. For example, she didn't receive the results of an MRI scan that Isabella had undergone for 6 months, by which time Isabella had passed. There were also problems with professionals not always keeping their own records up to date with medication and Mother was frustrated with the many changes of SW.

4. Practitioners' Views / Actions

The following observations and considerations have come from agency reports and the Practitioners who attended the learning workshop.

4.1. Practitioners all agreed that the cornerstone of this case was the recognition of any medical neglect. Medical neglect can result if a carer fails to ensure that a child in their care is receiving adequate medical care. According to a clinical report by the American Academy of Paediatrics[7] the following factors are considered necessary for the diagnosis of medical neglect:

- A child is harmed or is at risk of harm because of lack of health care.
- The recommended health care offers significant net benefit to the child.
- The anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over nontreatment.
- It can be demonstrated that access to health care is available and not used, and
- The caregiver understands the medical advice given.

It was the collective task of the professionals involved with Isabella to assess whether medical neglect was a factor and how best to safeguard her. CIN was a correct environment to consider this after initial concerns had been raised. Professionals needed to first, wholly understand Isabella's needs and second, establish the efforts that Mother had made to meet these needs whilst taking into consideration, her means (financial, physical and emotional) to do so. This required a good working relationship between Mother and practitioners with a good level of honesty and communication that could only be achieved by overcoming any distrust Mother may have had of agency support.

4.2. As medical neglect was discussed at the learning workshop the importance of having an accurate recording system of non-attended medical appointments became clear. As did the importance of parents and carers understanding that the onus of attendance was on them. An article in The British Journal of General Practice[8] has made two suggestions regarding non-attendances of paediatric appointments that addresses both of these points; The first suggestion is that it is probably no longer appropriate to use the term 'Did Not Attend' (DNA) when describing a child's non-attendance at a clinic because it is not a child's responsibility to attend clinic (it is their parent's responsibility to take them). It would therefore be more appropriate to say that the child 'Was Not Brought' to an appointment. This method of recording is already being utilised within the Bury area but not everyone at the workshop was aware of it, despite an expectation of staff who are mandatorily required to attend the safeguarding training course to cascade it to other staff. The second suggestion discusses the importance of GP practices to have policies and procedures in place that clarify what they should do if a child is not brought to an appointment. Such a non-attendance should not only be coded correctly but also trigger an appropriate response, perhaps a follow-up phone call from a receptionist or GP. Of course, this guidance should also apply to hospitals who should be clear on what action to take if a child is not brought. Health practitioners confirmed that there is such a policy in place within the acute setting involved with Isabella. This policy states that if a child has not been brought to an appointment or has had appointments repeatedly cancelled or re-arranged, then the Consultant should review the case notes. Whether the Consultant decides that the child can be discharged or that a further hospital appointment is required, the Secretary should be asked to write to the Choose and Book System and copies of this letter should be sent to the GP, person(s) with parental responsibility and community health services. Effectively the policy means that the GP, community health services and Mother should all have been aware of all of the missed appointments.

4.3. It has been confirmed to the Review that all of the GP practices in the area are expected to follow up any child who has not been brought to an appointment. However, the GP practice in this case did not have a robust process in place at the time of Isabella's care. This gap had already been identified and addressed in September 2019 and it became expected that from that time forward a named GP for Safeguarding within the practice would review all of the children subject to CSC who were not brought to an appointment and either

[7] Recognizing and Responding to Medical Neglect by Carole Jenny, MD, MBA, and the Committee on Child Abuse and Neglect

[8] Child not Brought to Appointment by Jeremy Gibson and Jenny Evennett. British Journal of General Practice 2017; 67 (662): 397

the safeguarding GP or another member of staff would follow up with the parents/carers as to why the child was not brought, or review the clinic/hospital letter received to ascertain the future plan of care. However, it is noted that this system relies heavily upon the acute settings following their policy accurately and consistently communicating the missed appointment to the GP. Any omission of this will result in the GP not becoming aware of all of the missed appointments and frustrate their process.

4.4. There was much discussion at the workshop about CSC; what the perception was across social care teams during the timeline of this review, and the subsequent effect that this had on the workings of the case. It was considered that the situation at the time was not conducive to effective practice. Representatives from CSC explained that one team had found itself in an indeterminate state when their manager left and simultaneously there were a number of vacant roles across other teams. The situation was described as unusually chaotic. It was explained that as a result a 'project team' had been established using agency workers and this team was allocated cases to relieve other SW's. However, it was still necessary for practitioners to prioritise work and this is very difficult to do without allowing any cases to drift. The situation also highlighted that when so many people leave their roles simultaneously it is very difficult to conduct formal handovers that follow protocol, and CSC is aware that this needs to improve.

4.5. During the course of this Review similar concerns have been identified by practitioners that have arisen in recent SCR's examining practice in the area. Most notably these include:

- A lack of professional curiosity about fathers – it was agreed that all of the assessments should have included consultation with both parents.
- A lack of professional challenge between practitioners and agencies – practitioners discussed a lack of professional challenge when multi-agency meetings did not copiously address issues or there was disagreement regarding actions and assessments.
- A lack of focus on the child – the CIN plan focussed on Mother's abilities to attend appointments as opposed to the effect of missed appointments on Isabella.
- The lack of a pre-birth assessment – a pre-birth assessment should have been undertaken regarding Mother's second pregnancy given that a sibling was subject to CIN due to safeguarding concerns.
- A disregard of Think Family – practitioners forgot to Think Family and consider the needs of all household members upon learning of the second pregnancy.

This would suggest that learning and recommendations from previous SCR's have not been embedded effectively into current practice and may benefit from being revisited.

5. Analysis of the Key Lines of Enquiry

The analysis is derived from the practitioners who attended the learning workshop, the family and discussions with the Panel. The analysis of practice in no way seeks to apportion blame to professionals but seeks to understand what can be learnt to support professionals to develop better future safeguarding of children.

Whether there was enough assessment of, and whether concluded assessments had considered the pre-existing vulnerabilities of parents.

5.1. Isabella was initially subject to a pre-birth assessment. This assessment was completed by a neighbouring CSC team as at the time Mother was staying with her grandparents. As in accordance with procedure, the assessment was initiated by Bury CSC due to the previous concerns around CSE, Mother's relationship with Father and poor home conditions at MGM's address. Information was appropriately transferred between bordering authorities and Bury CSC conveyed that Mother had been subject to a CIN plan that had recently been closed in January 2018 when safeguarding concerns had been reduced.

5.2. Mother's history is clear within the assessment. Her young age is given consideration and it is concluded that although she is mature for her age, she will require support when the baby is born. The assessment acknowledges that she has this support by means of her grandparents who were seen as offering a stable environment. However, the assessment is optimistic and offers no consideration to the event that Mother could return to the care of her own parents with the baby following the birth. Given that there is reference to CSC having had substantial involvement with Mother and her family previously and that she was subject to child protection whilst in their care, the absence of this consideration is a large omission and will have had a significant impact on the level of risk concluded.

5.3. The assessment focuses largely on Mother's ability to parent as it becomes known that Father will not be living with Mother and the baby following the birth. However, it is important for professionals to preserve an open-minded curiosity when completing pre-birth assessments and include Fathers in all situations where possible. The assessment records that Father did not engage well - there was only one meeting effected with him despite several attempts. Importantly this assessment had cited concerns about Mother and Father's relationship at the beginning and as such Father and the relationship should have remained high priority with Father's avoidance to engage only serving to increase concerns. His poor engagement obstructed any understanding of his ability to parent and what support he may offer. There was some successful discussion with PGM who informed of cultural differences proving problematic but there is little knowledge of Father's personal experiences of being parented himself. The assessment does consider some domestic incidents that have occurred between Father and his first wife and it is noted that although Father acknowledged that they provided cause for concern, he was reluctant to discuss them. Mother said that things were different in their relationship, yet a concerning incident did occur whilst the assessment was being completed. Reassuringly Mother called the police to report the incident with Father, but Father had left prior to officers attending. The DASH[9] was completed and a referral was correctly sent to the MASH[10] covering the area where Mother was residing, but Mother declined offers of further support stating that she was happy and fine within the relationship. She was advised to consider Clare's Law but there is no evidence of this ever happening, neither is there evidence of the police speaking directly with Father. Although this incident is referred to within the pre-birth assessment it lacks consideration of the risks that a further incident could present to baby and only includes parent's acknowledgement that this is not an ideal environment and that contact should be limited when Father has had a drink.

5.4. The pre-birth assessment by nature of Isabella's health needs being unknown pre-birth could not take into consideration Mother's ability to parent a baby with considerable health needs.

[9] The Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model is to assist the police and partner agencies across the UK to identify and assess risk

[10] The Multi-Agency Safeguarding Hub (MASH) is a single point of contact for safeguarding concerns bringing together professionals from services.

5.5. Following the birth, it was good practice for the nursing staff to arrange a discharge planning meeting in respect of Isabella and good practice for the hospital to initiate a C&F[11] assessment. This assessment noted the current home conditions with MGF (where Mother was now residing) to be good enough and reported that Mother was meeting Isabella's basic needs. It was learned that Mother had taken Isabella to stay overnight at MGM's address and given the previous associated risks at this address, this decision was discussed, and advice was given that Isabella did not stay there. Mother engaged with the assessment and said that she was happier now Isabella was home and she was managing well. The SW observed positive attachment and emotional warmth from Mother towards Isabella. Mother made it clear during the course of the assessment that she would not work with the Local Authority on a voluntary level and thus it was concluded that a multi-agency strategy meeting was required to allow professionals to consider up to date information and decide whether it was safe enough to close the case or whether the threshold was met for an a Initial Child Protection Conference to convene. There is verification of managerial oversight at this time which agreed with the conclusion to close the case. However, given the history of the parenting provided to Mother herself as a child; the consideration that Mother was still a child by nature of being 17 years old; and considering that Mother was now reliant on her parents to assist her to parent a child with complex health needs, it is difficult to see how the case could be closed in the absence of a parenting assessment or risk assessment in respect of Father and the other significant adults living within the same address. A refusal by anyone to engage with the assessments should have been seen as further cause for concern to be considered alongside Mother's ability to manage significant health needs whilst heavily reliant on the support of her parents, which had not yet been tested. Whilst it was acknowledged that Mother had engaged well with some health professionals, it remained that she had already cancelled appointments with the HV and failed to attend some health appointments. Which when coupled with the concerns raised by the hospital at discharge, is further concern as to whether she was able to manage the needs of Isabella in her current environment.

5.6. Within months a second C&F assessment commenced due to concerns that Isabella's health needs were not being met. Mother had now turned 18 but the assessment rightfully still references her age and experience as an underlying factor. Mother now agreed to work voluntarily with CSC at CIN.

5.7. Both of the C&F assessments that were undertaken with the knowledge of Isabella's health needs, overlooked the need to consider how, and if, Mother had come to terms with the diagnosis. A parents emotional response is an important component regarding the ability to understand and process the needs of a child with complex needs, and it is reasonable to assume that Mother's emotional response may have been exacerbated by the fact that she herself was of a young age and that this was her first child. Appropriately both assessments do refer to the challenges faced by Mother within her own upbringing but omit to consider any depth of consideration into how her experiences could impact upon her ability to parent. Research[12] has proven that women who have experienced neglect within their childhoods *are more than twice as likely as other women to experience depression, more frequently have a teenage pregnancy, and are more likely to be in adult relationships characterised by domestic violence*[13]. Sadly, these matters have a cumulative effect on a young mother who as a consequence may then be less responsive towards her own child. This alone raises the chances of neglect occurring for a child but given Isabella's complex needs the chances become even higher. With regards to Father, both of the C&F assessments refer to him and acknowledge that he isn't able to offer much positive support yet neither consider how this, and the domestic incidents that occur between Mother and Father, may further impact Mother's ability to meet Isabella's needs and/or how it may affect Mother's emotional health which is crucial to her parenting.

5.8. A combination of the pre-existing vulnerabilities of parents that were known to professionals all identify as risk factors for child neglect. These include parental history of neglect, parental characteristics of young age and low income, family disorganisation and domestic violence. Couple these with Isabella's young age and chronic physical illness and it is very apparent that much further research was required.

[11] A Child and Family (C&F) Assessment addresses the most important aspects of the needs of a child / young person, and the capacity of his or her parents or care givers to respond appropriately to these needs within the wider family and community context

[12] Neglect: research evidence to inform practice Dr Patricia Moran, Action for Children Consultancy Services

[13] Bifulco and Moran, 1989, Wednesday's Child: Research into Women's Experience of Neglect and Abuse in Childhood and Adult Depression

Learning:

- Ongoing consideration should be given as to how professionals engage with fathers. If a father has not engaged, it should be clearly recorded that he remains an unassessed risk.
- The effect of significant events in a parent's life should be considered when assessing their ability to parent.
- If a parent does not consent to Local Authority support at CIN, careful consideration should be given to escalating the protection provided.

Whether practitioners were confident of Mother's ability to meet the health needs of Isabella and whether a sufficient support package was in place.

5.9. It is clear from professionals' meetings that health practitioners had some early concerns regarding the capacity of Mother to care for Isabella. These concerns were alleviated by means of a referral to CSC and the use of a competency folder clearly identifying Isabella's medical needs for Mother to share with the Outreach team. In addition, all follow-up appointments were made prior to discharge to ensure continuity of care and there was a sick-day plan which stated what to do in the event of Isabella becoming acutely unwell. There is reassurance of Mother's abilities when sometime later, consultants at Northern Care Alliance recorded that Mother presented as aware of Isabella's health needs at appointments and was able to articulate changes and challenges that had arisen since their last meeting. Their report also evidenced that Mother had reassured some professionals that she had support in the form of MGM and MGM's attendance at many health appointments backed that this was the case. Mother also presented the idea that Father was supportive when she attended these appointments. This information was taken at face value by professionals.

5.10. The HV saw Isabella and Mother most frequently and as the extent of the care required for Isabella became apparent and the limitations of Father's and extended family support became clear, she supported Mother with extensive home visits that were over and above what would usually be provided. The HV tried to assist with the organisation of the health appointments and was able to monitor Mother's engagement with health services to an extent. Subsequently she referred to CSC with concerns that arose. Consequent strategy meetings recognised that Mother was struggling to attend appointments and manage the health needs of Isabella, and this raised concerns. The struggle that Mother had is comprehensible - Horwath[14] has found that children who have complex needs are vulnerable to medical neglect - the *medical demands can place strain on carers, particularly those living in poverty and without support systems.* Horwath's findings coupled with the growing concerns of practitioners involved with Isabella, would strongly suggest that an updated assessment of Mother's capability, with contributions being required from all involved professionals, was an essential exercise. However, there is no evidence of such an assessment being undertaken. This assessment could have sought to explore underlying issues regarding Mother's understanding of the importance of health appointments and any frustrations she had about the care Isabella was receiving. When the FSW was introduced to Mother in March 2019 Isabella's diagnosis was discussed. It is clear from the discussion that Mother rejected the notion that Isabella was subject to a disability. This point is worthy of further analysis as it would suggest that the impact of Isabella's needs and the circumstances surrounding her health still hadn't ever been fully determined with Mother. On hearing Isabella 's diagnosis Mother would have likely experienced grief and a host of other emotions and if she didn't immediately experience a sense of bereavement for the loss of the type of life she had envisaged her and her child living, research suggests that it is predictable that she would have eventually. An article written in 2003, Supporting Parents' Adaptation to Their Child with Special Needs[15] looked at how a parent's adaptation to their child's condition can serve as a crucial focus when intervening to improve functioning. It states that *'In addition to the stress associated with the extra physical demands of raising a child with a chronic condition, parents experience psychological stress and disappointment when their child does not meet their hopes and expectations for a healthy child. From this perspective, many parents go through a process of grieving, although most appear to recover. We believe this recovery is the process of updating, rebuilding, and replacing the hopes and expectations they had prior to their child's birth*

[14] Horwath, J., Child Neglect: Identification & Assessment, 2007, Palgrave

[15] Building New Dreams. Supporting Parents' Adaptation to Their Child with Special Needs by Douglas Barnett, PhD; Melissa Clements, PhD; Melissa Kaplan-Estrin, PhD; Janice Fialka, MSW, ACSW. Infants and Young Children Vol. 16, No. 3, pp. 184–200 2003 Lippincott Williams & Wilkins, Inc.

with the realities of their child's actual prognosis'. There is no evidence that this was ever considered post Isabella's birth or that this issue was given attention when planning support. Yet this was important as this state of mind may have had a direct link to the sporadic attendance of health appointments by means of an unconscious denial of their importance.

5.11. It is irrefutable that any health plan would have proved more effective if one person had been designated to be a lead professional. Despite many agencies and professionals being involved with Isabella there was no suitable lead person identified to co-ordinate appointments and their locations. The HV was initially tasked at the discharge meeting but professionals in attendance at the workshop all agreed that the expertise required was beyond the capabilities of the HV role. A suitable candidate for this holistic role would have been a nurse from the Children's Community Nursing Team (CCNT) but Mother had refused their support when it had been offered when Isabella was initially discharged home. A further opportunity to engage Mother with this team was sadly missed when, following Isabella suffering a period of illness, Mother did consent to a referral. The referral requested contact be made with Mother and stated that Mother had said that she was struggling at home. Unfortunately, this referral was not actioned due to human error possibly caused by staff shortages, but it should be noted that Mother had always been given open access to CCNT and could have been pro-active in utilising their support that was available to her at any time.

5.12. Lancashire NHS Foundation Trust have recognised the importance of having a lead professional and have developed a role of 'Safeguarding Health Practitioner' (SHP) within one of their localities. These roles are filled by trained nurses who have experience of undertaking holistic assessments and multi-agency working. The SHP's undertake joint work with CSC to assess and support complex health needs and will attend multi-agency meeting (including CIN meetings), undertake home visits and work directly with families whilst liaising with other health professionals.

5.13. It is reasonable to conclude that the support package offered to Mother may have been advantageous to some people finding themselves in her situation. However, Mother clearly struggled to accept help from professionals, and it is not clear how much this was explored with her. Professionals at the workshop discussed Mother's frequent reassurances that she could cope and her reluctance to accept that by definition of her age alone[16] she may require support. Becoming a mother produces considerable challenges for everyone as a number of physical and emotional changes take place *including the reorganisation of identity, roles and responsibilities*[17]. For young mothers, the challenges of becoming a parent are particularly heightened and often take place within the background of disadvantage and adverse childhood experiences[18]. Professionals who have worked closely with Mother report her to be a very proud person who is eager to prove her capabilities. If you consider some of the negative attitudes' society displays against young mothers, any young mother's fear of being judged or criticised is understandable. In 2018 Action for Children commissioned researchers from the Institute for Policy Research, University of Bath to carry out a literature review and analysis to find out more about the difficulties young parents can face[19]. As part of the project they held focus groups and interviews with 21 young parents. When asked why she was reluctant to admit that she needed any support, one expectant mother aged 19, replied: 'They think that you're young so you're not going to do very well, so there's a lot of pressure to prove everyone wrong.' With this in mind a deeper exploration as to why Mother didn't want to accept help may have helped professionals to create a more suitable support package that maintained a sense of autonomy for Mother over the decisions to be made regarding her child.

Learning:

- When there is a large group of professionals involved with a child it is important for there to be a confirmed lead professional who is able to take a holistic view.
- Children who have complex health needs are particularly vulnerable to neglect and require close and regular monitoring by a skilled lead practitioner. The Clinical Commissioning Group (CCG) must give consideration to

[16] Reports tend to use the term 'young parent' to denote any person aged under 25 years who is expecting a baby or has a child
[17] Knox, 2014; Slade et al., 2005 as cited in Young Mums Together Mental Health Foundation
[18] Hillis et al., 2004 as cited in Young Mums Together Mental Health Foundation
[19] https://www.rip.org.uk/news-and-views/blog/young-parents/

the absence of such a professional and consider the creation of a position similar to that discussed at 5.12 to assist a family to co-ordinate the health chronology.

- Parents or carers of children with complex health needs who are themselves subject to vulnerabilities, including by means of young age, may benefit from a professional assisting them to steer the professional system.
- Practitioners need to consider how to communicate what support is available to parents without any social discrimination and respond to parents who do not feel able to accept support in a positive and understanding way.

Whether there was enough knowledge of and involvement of father and whether his information was shared and communicated effectively between workers/agencies

5.14. There has been a lack of consideration about the role of Father throughout this case and the extent of his care and contact with Isabella is unclear. This could be attributed to a lack of professional curiosity, but it is also a factor that Father is difficult to engage and is described by many professionals as being quiet. He is vague in his responses to questions and has been known to say that he cannot recall details such as names and addresses, which has an effect of frustrating further checks.

5.15. Some history of Father was obtained by the SW during the pre-birth assessment and it became known that he had previously been married and that there had been domestic violence within that relationship. By this time Mother had provided his name to midwifery although it appears that he did not attend any of the appointments. There is some mention of Father attending the NICU and rooming-in to support Mother whilst Isabella was in hospital but no evidence of him being involved in the care. There is no evidence of Father being involved in the CIN process.

5.16. Following the birth of Isabella, Father was subject to a Pre-Sentence Report. The National Probation Service (NPS) made safeguarding enquiries with Children's Services but at this time Mother and Isabella had not returned to the Bury area and the pre-birth assessment in the neighbouring authority had concluded and closed. NPS were therefore told that Isabella was not open to CSC. However, the author of the pre-sentence report being compiled at the time reported that all elements of safeguarding relating to his partner and children would require investigation by his offending manager. For reasons that this Review has been unable to establish, this did not happen. During an assessment 8 months later Father disclosed Isabella during a discussion and it was explained to him that due to the concerns of domestic abuse in his previous relationship, CSC would be contacted, and information would be requested from the police regarding the domestic callouts. Father was described as being uncomfortable about this. It appears that, possibly due to a long-term sickness absence of a staff member, these enquiries were not completed, and a safeguarding referral was not completed.

5.17. All of this lack of information seeking is despite the fact that only 18 months prior to Isabella being born, the relationship between Mother and Father gave professionals cause for concern; a couple of weeks after Mother's 16th birthday professionals had been concerned that she may be at risk of CSE after a member of the public reported her as presenting as intoxicated in a fast food outlet at 02:45 hours. She was with another young female and an older Asian male whom she later admitted to being Father although she initially said that they were just friends. At this time Father was 21 years old and it was decided that structured work looking at CSE and grooming would prove beneficial to Mother. Mother had initially been assessed as being at high risk of CSE but following sporadic engagement with a social worker and some work being completed, the risk was declared to have reduced - It had been 6 months since the reported incident and Mother was reported to be spending more time at home; had ended the relationship with Father; and had changed her associates. There is nothing in any of the reports provided to the Review that indicates that when Mother presented as pregnant any consideration was given to the previous exploitation concerns within parents' relationship. The information would have been available from several sources (the police would have had the CSE concerns on record as would Mother's CIN meeting minutes and CSC would have had a copy of the CSE risk measurement tool) and should have been shared with other agencies during the assessments. Had this information been shared, professionals would have had reason to consider the power balance between Mother and Father's relationship and any associated risks posed to Isabella as a result.

Learning:

- Professionals must include fathers in all assessments and show additional curiosity when a person attempts to avoid engagement.
- Information about avoidant behaviour should be shared with all other professionals involved.
- Historic information from all agencies should be considered and there should be no assumptions about what is known by those involved.

Whether the case was managed effectually at Child in Need and whether the plan was maintained, reviewed and progressed as necessary, taking all of the needs of Isabella into consideration.

5.18. Mother has often declined support from agencies and some practitioners who have worked with Mother have struggled to gain her confidence. There appears to have been a distrust of professionals that has created barriers to how effective any support could be. Mother's subsequent perceived lack of engagement has been a continual source of concern and was a contributing factor to the decision for the case to be held at CIN. However, even when engagement with professionals and attendance at health appointments still did not improve enough, reasons provided by Mother regarding missed appointments were readily accepted. In addition, requests to cancel CIN meetings were respected when in fact, the meetings could have convened in Mother's absence. Continuing with the meetings regardless would have assisted professionals to collate failed appointments and would assist in '*evidencing the issue by giving an over-view of co-operation levels and reasons for failed appointments'* as is instructed within the Greater Manchester Procedure for managing non-engagement[20]. It would also have ensured that meetings had continued to convene within procedural expectations. Eventually the continual non-engagement did correctly lead to further strategy meetings and consideration of a Child Protection Conference. However, the real question should be 'why' Mother did not prioritise attendance of CIN meetings. It is possible that the meetings lacked enough impact, and this was discussed when the Reviewer met with her. It was concluded that she may have been more likely to attend if the meeting had offered her a practical solution to her problems such as assisting her to record and plan all of Isabella's health appointments forthcoming within the next review period and consider transport options. This would have also provided an opportunity for professionals to see what the appointment schedule looked like and become aware of any duplications or opportunities to bundle appointments together by location. This type of planning could have proved effective in helping Mother to gain trust in the professionals around her and start to value their support. The transparency of such a piece of work would also have exampled Mother's abilities and engagement providing a clearer path towards any escalation of support.

5.19. It is undeniable that case management proved complex largely due to the substantial number of health appointments and that organisation of these was complicated by Mother's limited engagement. To address the engagement, meetings were often held at Mother's address as this clearly made it easier for her to attend. Still, it also would have been beneficial to hold at least a fraction of the meetings at hospitals to assist Consultants to attend. Their opinion and expertise regarding the impact of missed appointments for Isabella was crucial in exemplifying any harm Isabella was at risk of suffering and their explanations may have helped Mother to understand the importance of engagement.

5.20. Everyone in attendance at the practitioner's workshop agreed that there were elements of drift within the CIN process regarding professional involvement. Records indicate that there was at least one occasion where the HV had not been invited to attend (established to be due to an error in the recording of an email address) and the GP was not included in the process. This inconsistent or non-attendance of key professionals rendered it impossible to obtain a full comprehension of how many health appointments had been missed and without this complete information it was impossible to assess or manage Mother's capacity and ability to improve attendance. A successful plan depends greatly upon the professionals having a clear view of individual review periods and the situation overall - and being reactive.

[20] ttps://greatermanchesterscb.proceduresonline.com/chapters/p_deal_uncooperative_fam.html

5.21. The following points indicate that the CIN plan was not proving robust enough to address the current circumstances:

- Health appointments continued to be missed but there is nothing in the reports that evidences sufficient understanding by Mother or the professionals regarding the subsequent harm that could result as a direct consequence and was avoidable.
- CIN meetings were being cancelled upon the request of Mother.
- A further domestic incident was reported suggesting that relationship work was not effective.
- 2 referrals made by NWAS reported ongoing concerns for Mother's need for more support.

5.22. With the above in mind it would have been beneficial to utilise the Graded Care Profile 2 Tool to objectively measure the quality of care afforded to Isabella in terms of Mother's commitment. This would have assisted professionals to identify the support required for Isabella and develop the working relationship with Mother.

5.23. It is unanimous within the reports gathered for this review and the discussions had at the learning workshop, that the escalation decision to convene an ICPC was appropriate based on statutory guidance[21]. There developed a common consensus that Isabella was at risk of suffering significant harm[22] if her health needs were not met and this decision recognised that the complex health needs of Isabella should not alter the threshold for escalation of intervention. The first documented recognition of this appears the month after Isabella was discharged from hospital; Police records note that an officer had a strategy discussion with CSC after the HV had raised significant concerns regarding Isabella not being brought to vital health appointments. It is recorded that the discussion concluded that *should Mother DNA on any of Isabella's health appointments then it should be escalated to ICPC.* This did not happen immediately but within weeks it had been decided that a CIN plan would be implemented and when concerns remained 2 months later, CSC did have a case discussion with a Child Protection Conference Chair. The advice at this time was to remain at CIN and escalate if non-engagement continued. It was at a strategy meeting 4 months later that the decision to escalate was further concluded and as a result an ICPC was agreed to be booked within timescales. However, due to staff absences this decision was not shared with the necessary administration staff and the meeting was not actioned. Subsequently no invitations were sent to any agencies and professionals remained in the dark as to why the case had not progressed. Discussion was had amongst practitioners at the workshop as to why no other professional had raised any concerns regarding this lapse. It became clear that agencies often allow CSC to take the lead stance on a case and there is a presumption that CSC will have completed certain tasks and addressed the concerns raised within a multi-agency forum. It is important to re-iterate here that any practitioner with serious concerns that a child's welfare is not being adequately safeguarded should request that a conference be convened[23]. This was not done in this case, and neither were any concerns escalated to supervision. Use of an escalation policy is not a personal attack on another agency or a colleague but a method to initiate a professional question mark and reflect upon multi-agency work and decision making. The fact that all the professionals at the workshop had been in agreement that the decision to proceed to ICPC was correct, would indicate that this absence of curiosity regarding why the case was not progressed, was not due to any uncertainty about how best to manage the interests of Isabella. It was in fact established to be a reflection, in some cases, as to how confident a practitioner is about discussing such concerns with their supervision. Attendees at the practitioners workshop discussed this in detail and concluded that practitioners should feel comfortable taking a case to supervision that they feel anxious about but often a one-to-one with a manager can feel like a scrutiny of how well you are performing within your role as opposed to a discussion of options. The importance of good quality supervision is evident here and reflective support is essential in such a situation to ensure that practitioners feel able to challenge if a plan is not escalated.

[21] Working Together to Safeguard Children, 2018, HM Government

[22] The Children Act 1989 describes the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children.

[23] Working Together to Safeguard Children, 2018, HM Government

Learning:

- If a parent or carer continually cancels meetings, professionals should consider convening in their absence to assess risk and reflect upon the impact on the child when parent's engagement is not good enough.
- Meetings need to involve all relevant agencies and all professionals must remain alert to any drift of a plan and be empowered to challenge a plan that is not working.
- Professionals who have made a referral or agreed to an escalation of safeguarding have a statutory duty to follow up their concerns if they are not satisfied with a response and should escalate their concerns in the event that they remain dissatisfied.
- It is important for professionals to remember to use and to feel confident within the escalation process if they feel that a decision or action is not in the best interest of the child.
- The Graded Care Profile 2 assessment tool is already used by social workers in the area and all practitioners should remember to give it due consideration.
- Professional thought processes and decisions must be recorded to support case management in the event of long-term sickness or changeover of staff.
- CSC should not be viewed as the prime agency.

Whether the multi-agency meetings were clarified and focused, and whether communication regarding the management of risk was effective, in particular with regards to any non-engagement from parents.

5.24. In addition to the CIN meetings there have been a number of other multi-agency meetings that have convened throughout this case including strategy meetings and discharge planning meetings. A number of issues have been identified with both their content and in the case of CIN, their frequency.

5.25. The purpose of multi-agency meetings is to present and examine facts and consider subsequent risks to the child. There is no evidence to suggest that in this case, this has always been thorough and practitioners at the workshop did not consider that meetings had always addressed the risk factors that arose from missed health appointments. There was a lack of analysis of any potential impact, for example there is no evidence of discussion as to how the missed appointments could impact Isabella by creating a life-threatening situation to occur that was otherwise potentially avoidable. The overriding focus has been primarily upon Mother's reasons for non-attendance.

5.26. The meetings were always chaired by experienced SW's and there was good representative of agencies overall, but it is clear that on occasions key professionals have not been invited to meetings or received any feedback. There is for example, no record of the paediatricians having any minutes or actions from multi agency meetings despite them raising concerns about missed appointments. However, this Review does recognise that professionals all have a responsibility to chase the results of referrals that have been made by themselves. The GP reported to be unaware of meetings and the HV was missed from at least one strategy meeting even though she had vital information about health appointments not attended and a good knowledge of Mother's parenting. It was discussed in the practitioner workshop that an automatic notification of multi-agency meetings to all agencies, regardless of their involvement, could assist with the issue of professionals being missed from invites or unaware of meetings.

5.27. Over all the meetings do appear to have lacked clarity and this, although wholly recognised by professionals, has gone uncontested. Professional challenge is crucial, and anyone involved in a multi-agency meeting should feel confident to challenge another professional if they consider that concerns have not been addressed. No such challenge is recorded within this case.

Learning:

- Professionals should be confident to challenge and ask questions if a meeting has not addressed the concerns.
- Professionals who feel that there has been a loss of focus on a child should be professionally curious and able to seek reflective supervision and support to assist with a timely response to any decline in a child's situation.
- Any practitioner receiving professional challenge should not be offended.
- Professionals should chase the results of the referrals they have made.

Whether consideration was given to the effect a new baby would have on parent's ability to manage the needs of Isabella and whether there was any new subsequent impact on risk.

5.28. Upon learning of Mother's pregnancy CSC should have completed a pre-birth assessment but this was overlooked in a flurry of changing social workers and heavy caseloads. In addition the midwifery team involved with the care of this pregnancy, made an assumption that there were no safeguarding concerns for the older sibling (Isabella),likely presuming that the CIN plan was regarding Isabella's health needs as opposed to safeguarding, and therefore did not make any referrals. There was no other reason for midwifery to make a referral and seek out other agencies at this time as baby was developing well and Mother was attending all of her ante-natal appointments. This has affected a disjointed approach and has resulted in a definite split down the agencies working with Mother, with some being completely focussed on Isabella and some being wholly centred on unborn baby. No agency appears to have had focus on both and the Think Family approach which promotes the importance of a whole-family attitude appears to have been lost.

5.29. As the pregnancy has developed CIN meetings have diminished due to Mother cancelling, social workers leaving, and the case not being immediately reassigned. The last CIN meeting convened when Mother was approximately 6 months pregnant. A strategy meeting occurred the following month and this concluded that both Isabella and unborn baby would be considered at ICPC. The reasons for this meeting not convening have been discussed previously within this report at 5.23 but had the meeting occurred, a conversation would have been had regarding the safeguarding of both Isabella and the unborn baby. And this would have included any effect that the introduction of a new-born into the family might have had.

Learning:

- The Think Family approach must be considered in all situations.

6. Good Practice Identified

Many examples of good practice have become apparent during the course of undertaking this review. The following list is not exhaustive.

6.1. The professionals who have completed reports and participated in this review have done so with extraordinary openness, transparency and honesty. All discussion that transpired during the course of the workshop was conducted with respect and opinions and reflections were communicated in a non-disparaging manner.

6.2. The HV has demonstrated an excellent commitment to supporting Mother and Isabella whilst maintaining good communication with other practitioners and agencies. Likewise, the FSW worked well to develop a good relationship with Mother and utilised pragmatic and practical methods of assistance.

6.3. Upon becoming aware of Mother and Isabella's situation, Housing obtained temporary accommodation promptly and efficiently in an attempt to minimise disruption and reduce any emotional stress.

6.4. The Paediatrician recognised that Mother would benefit from support to manage Isabella's health care early in the process and raised concerns with the relevant agencies.

6.5. The NWAS was expeditious in raising their concerns and making the appropriate referrals.

6.6. There was a good understanding of medical neglect by some practitioners who attended the workshop and they shared their knowledge and discussed the matter in a helpful and informative manner.

7. Recommendations

In order to promote the learning from this case, the review identified the following actions for BISP and its member agencies:

7.1. BISP to review the supervision arrangements within partner agencies, in line with the agencies' individual roles and competencies, and to be assured of compliance by utilising feedback from supervisors, supervisees and people who use services. BISP should reconsider the use of a multi-agency practice forum to reflect upon group supervision and explore complex multi-agency decisions.

Proposed Outcome: *BISP will be confident of the multi-agency decision making process and professionals will be empowered to seek supervision and support as necessitated.*

7.2. BISP to ensure that the language change – 'Was Not Brought' is reinforced across partner agencies and make certain that practitioners are trained to realise 'medical neglect' and recognise missed appointments as an indicator.

Proposed Outcome: *The universal use of the language term will emphasise a parents/carers responsibility to take a child in their care to health appointments and will deliver a clearer marker to identify neglect.*

7.3. BISP to confirm that all partner agencies have a rigorous and thorough system in place regarding the management of handing over cases to other practitioners, and verify that each agency has reviewed their system to ensure that teams are managed most effectively and have an inbuilt resilience to cover, in particular, cases of extreme absences. Agencies must be seen to consider introducing new measures, such as a buddy system or business continuity plan, to mitigate the instances of absences.

Proposed Outcome: *Disruption to service users subject to a change of worker will be minimal and the support provided will be uninterrupted.*

7.4. Given the detection of similar concerns raised in previous SCR's, BISP should seek reassurance that previous learning is embedded within the working environment. BISP must complete their future Serious Case Review learning within reasonable timescales and quality assure practice to evidence that supervision is satisfied that learning has been effective and is being applied.

Proposed Outcome: *BISP will be confident that learning from reviews is embedded and proving effective.*

7.5. The CCG to consider establishing a role within Bury similar to the 'Safeguarding Health Practitioner' role which has been successfully introduced to a locality within Lancashire Refer to 5.12.

Proposed Outcome: *Trained nurses will work jointly with CSC to assess and support complex health needs and work directly with families whilst liaising with other professionals.*

7.6. Where a child is diagnosed with complex medical conditions, the CCG should consider appointing a Lead Practitioner to facilitate and support all carer(s) in understanding the condition, and the importance of responding to symptoms promptly and attending all appointments.

Proposed Outcome: *All carers will be supported to develop a better understanding of a child's health condition and their treatment plan.*