Central Bedfordshire
Safeguarding Children Partnership

Child Safeguarding Practice Review

Baby Euan

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1.0 Introduction and Background to this Child Safeguarding Practice Review

1.1 Baby Euan died when he was eight months old at the beginning of December 2021. His father called '999' on that morning reporting that Baby Euan appeared to be struggling to breathe. Ambulance crews attended and Baby Euan was transported to hospital. Despite CPR and treatment, he was pronounced dead. On examination, Baby Euan had several unexplained injuries. The post-mortem confirmed injuries that were believed to be non-accidental including broken ribs, fractured skull, torn stomach, and frenulum. Both father and mother were arrested for the murder of Baby Euan and a criminal investigation is currently ongoing.

1.2 An initial information sharing meeting took place and as a result of this it was found that the family, as well as being resident in Central Bedfordshire before, and at the time of death, had also been resident in Enfield and Lewisham and Baby Euan had been born at North Middlesex University Hospital NHS Trust (North Mid). Further information was requested from those two areas following an initial Rapid Review meeting. A second review meeting was held on the 7th March 2022. This case was further discussed at the Central Bedfordshire Safeguarding Children Partnership (CBSCP) Case Review Group on 12th May and with reference to the requirements as set out in Chapter 4 of 'Working Together to Safeguard Children' (2018), the group decided that the threshold was met to commission a Local Child Safeguarding Practice Review (LCSPR) in respect of Baby Euan.

1.3 The Partnership appointed a panel of local safeguarding leads and also appointed an independent lead reviewer Dr Russell Wate QPM to assist the panel with the review and to produce a report on behalf of the panel and the CBSCB.

1.4 A timeframe for the review was agreed as September 2020 to December 2021; this period covers confirmation of pregnancy until Baby Euan's death.

1.5 It was felt that the review should examine this timeframe using four key practice time periods:

- Pre-pregnancy timescale with a rationale to examine mother and father's history.
- Known pregnancy period of September 2020-April 2021 in Enfield and Central Bedfordshire.
- Time in Central Bedfordshire, January 2021 until October 2021, and in Lewisham October 2021 onwards.
- Return to Central Bedfordshire and the death of Baby Euan, November to December 2021.

1.6 The case review group, the panel and discussions with the lead reviewer also established key learning themes for the review to focus on.

- Voice and vulnerability of Baby Euan
- Transient -reluctant to engage families, including Information sharing
- Domestic Abuse- Coercive Control-Invisible Males
- 'Intersectional analysis' into race, disability, and health conditions.

1.7 Individual Management Reviews (IMR) were requested and completed by agencies in all three areas. The IMRs included critical analysis and reflection of engagement with Baby Euan and his family, identifying learning and recommendations both for the review but also in their individual agency. Existing chronologies were reviewed as part of the IMR process and updated in the IMR as required.

1.8 An extremely well attended practitioner event was held with front line practitioners involved in the case. This included practitioners from agencies in the other Local Authority areas and local agencies. The practitioner event was very helpful to the panel and the author in helping them to develop the learning and to compile this report.

2.0 Analysis of Learning Themes

Voice and vulnerability of Baby Euan

2.1 This section outlines Baby Euan's life including whilst he was developing and growing in the womb, and highlights his vulnerabilities as seen through agency and practitioners reports.

2.2 Baby Euan's mother's pregnancy is confirmed by North Middlesex University Hospital NHS Trust (North Mid) on the 3rd of September 2020. The mother has Type 2 Diabetes and is clinically obese.

2.3 Due to the diabetes and the high body mass index (BMI) the mother's antenatal care was delivered mainly by North Mid diabetic team. The pregnancy for Baby Euan was regarded as clinically 'high risk' due to the mother's co-morbidities. The North Mid IMR author's review of records and discussion with the diabetic midwife states that the mother's engagement with the diabetic team was not what they would have expected. It is documented that she had poor compliance with medication for her diabetes prior to pregnancy and during pregnancy. Baby Euan's mother required more than normal antenatal appointments due to her complex medical conditions.

2.4 In January 2021 the diabetic midwife raised her concerns with the safeguarding midwife and made a referral to Enfield social care for non-engagement with antenatal care (as per North Mid hospital child protection policy). The concerns were heightened as the mother had moved out of the local area during her pregnancy. The mother told the diabetic midwife that although she had been living in the Borough of Enfield with a friend at the beginning of the pregnancy, she had now moved in with the father of the baby in Central Bedfordshire. Even though she had moved out of area, she still wanted to deliver at North Mid as she 'knew the hospital'.

2.5 It was felt though that this would impact on her ability to attend all her appointments. Outcome of this referral was 'no further action' as she now resided out of Borough. This 'no further action' decision will be commented on in the next section of this report.

2.6 The mother is registered with the same GP practice between 22nd December 2020 and the 15th June 2021; however, they had no record of her pregnancy. This is something that is normal practice in some areas for example Bedfordshire but should happen elsewhere with maternity units informing GP practices. North Mid are already in the process of considering this as learning from this review. The diabetic midwife did believe that the GP was notified of their involvement antenatally.

2.7 Baby Euan was born at the beginning of April 2021 by emergency caesarean section at 37 weeks gestation. Baby Euan required resuscitation at birth as he was born in a poor condition. He was transferred firstly to North Mid Neonatal Intensive Care Unit (NICU), Baby Euan was then transferred out to the Homerton hospital NICU on the first day of life for 'cooling' (cooling of the head/brain to prevent any further brain injury) as per national guidelines.

2.8 This review is unable to fully evidence that the mother's poor antenatal care, alongside her own health needs prior to pregnancy, may have impacted on Baby Euan's growth and development in – utero. However, discussion by the North Mid IMR author with the medical and midwifery team drew a conclusion that due to the high-risk co-morbidities of mother's own health, that improved compliance with her antenatal care and her own health needs prior to, and during the pregnancy, may have improved the outcome for Baby Euan at the point of delivery.

2.9 An internal rapid review was undertaken by North Mid maternity risk team as per Trust and national guidelines for a neonate baby requiring brain cooling. North Mid declared a Serious Incident (SI). An independent investigation by the Healthcare Safety Investigation Branch (HSIB) was undertaken in September 2021. This investigation was in accordance with the Department of Health and Social Care criteria (Maternity Case Directions, 2018), taken from 'Each Baby Counts and MBRRACE-UK'. No safeguarding concerns or recommendations were identified by the investigation.

2.10 In 2014, the Court of Appeal ruled that an unborn child could not be considered as a 'person' at the time the injury was caused because they had not been born. The case that brought this ruling was where a seven-year-old girl, known as CP, and her guardians failed in their attempt to sue her mother for the daughter's foetal-alcohol-spectrum disorder caused by her mother's heavy drinking during her pregnancy. The risks are recognised and advice is given against it, but the advice is not enforceable, and the child has to live - if they survive - with the consequences of the mother's irresponsible but not illegal actions.

2.11 Whilst acknowledging this decision by the Court of Appeal, professionals need to be aware the evidence of how a mother cares for herself in pregnancy is an indication of how they might care for their baby following birth. It is fair to say that the quality of Baby Euan's developing life within the womb was not optimum. Good practice was shown by the diabetes midwives who sought safeguarding advice and made a referral to their local children social services department. There are numerous cases of babies, who at birth are either taken into care, placed on a CP register, or subjected to a CIN plan. These cases are often when the mother is extremely young, a habitual drug user, misuses alcohol or DA is a strong feature. These cases though could be extended to include other health conditions, as is the case for Baby Euan, and a multi-agency safeguarding discussion would be good practice.

2.12 On the 18th April 2021, Baby Euan is discharged home to Central Bedfordshire; North Mid contact Bedford Hospital Trust (BHT) to advise them that the family are living local to Bedford and requesting follow up as Baby Euan and parents living locally to them. No safeguarding concerns are identified in discharge records. GP letters were sent at the point of discharge of the mother and then at point of discharge for Baby Euan. This is the first contact that the Bedford hospital had in relation to Baby Euan.

2.13 A verbal handover between the North Mid and Cambridgeshire Community Services (CCS) took place on the 19th of April which included a summary of Baby Euan's stay in hospital, the reasons for this and the discharge home on mixed feeding (breast and formula).

2.14 The father contacts a midwife on the 23rd April 2021 stating that Baby Euan had been unwell since birth and had a tongue tie but was feeding ok. The CCS Health Visitor and Speech & Language therapist (SALT) at North Mid have a phone conversation about Baby Euan who had been diagnosed with Grade 1 mild neonatal encephalopathy. Due to assertive pressure from the mother and father, Baby Euan had been discharged home before a feeding assessment could take place. The mother had been offered a referral to Bedfordshire SALT Team for a feeding assessment but this had been declined by parents as Baby Euan's tongue tie was not impacting on breast feeding. The tongue tie release referral is made on 27th April 2021 at the new birth visit.

2.15 On the 27th April 2021, Baby Euan was seen as part of the mandated contacts with families with new babies for the 0-5 service. A planned (arranged) health visitor home visit was undertaken and discussion about the need for Baby Euan's tongue tie to be released (a minor procedure) was held with the parents. The midwife had completed a referral for this. Father's name (given wrongly) is recorded on the electronic records, ethnicity is recorded in the parent held Child Health Record (red book). There was a referral following this appointment on the 27th April by the health visitor to the SALT team for the baby to be seen at the Child Development Centre for initial assessment of dysphagia (swallowing function).

2.16 Baby Euan is seen at Bedford Hospital Trust (BHT) for release of tongue tie on the 28th April 2021 by a specialist midwife and discharged from the service.

2.17 An assessment was completed at the new birth visit, but Baby Euan was not then seen again by the health visitor due to the father making a verbal complaint about the health visitor. He stated that the health visitor had not completed the red book correctly. After a number of attempts the Team Leader was able to get in contact with father of Baby Euan by phone. The father stated that the ethnicity of baby and mobile contact details for parents were entered incorrectly. The parents stated that they could weigh Baby Euan themselves and did not require health visitor input. It was agreed between the Team Leader and father that the red book would be collected and errors corrected. Baby Euan was not brought for SALT appointment, the father reported to the follow up made by a SALT professional that Baby Euan was now feeding well with no problems since the tongue tie release.

2.18 During the telephone discussions with father (not with mother) by the Team Leader regarding father's complaint, and again during a telephone discussion following father's request for a call back to support with the Sure Start forms, baby's wellbeing was considered, but there is a lack of focus on the lived experience of Baby Euan as there was no potential for visual interaction, assessment of the parent/child relationship, or their development. All reports were reliant on father's reporting of his wellbeing.

2.19 The Team manager who is a trained HV offered to carry out a visit but this was refused by the father.

2.20 Baby Euan attended Lister Children's Emergency Department accompanied by both parents. Mother and father reported that Baby Euan has been projectile vomiting for three days. This was after every feed so they had brought him in for review due to their concerns

surrounding projectile vomiting. A full clinical assessment and examination took place, no injuries or bruising was noted to Baby Euan. Records state that the parents came across as anxious and pushed for examinations not deemed as necessary. Hospital recorded no safeguarding concerns but noted that it is unusual for parents that pushed, for example for an ultrasound scan, not to return for any follow up appointments, including for the hypoxic-ischemic encephalopathy found at birth. The HV was notified.

2.21 When Baby Euan was not brought to a virtual appointment with a BHT paediatrician a letter was sent to their Central Bedfordshire GP advising them of the missed appointment and plan to offer another.

2.22 Baby Euan is seen when he is 12 weeks old for the 6-8 week GP post birth check by their GP surgery in Central Bedfordshire with his mother. The father joined the appointment later via Mum's telephone. The GP was concerned about father's behaviour during this interaction. The GP stated at the practitioner event that it just felt to them that the interaction was unusual, because mother kept the phone close to her ear throughout the rest of the appointment, which covered the parents requesting for individual vaccinations to be given for Baby Euan. It was noted that mother was attentive and Baby Euan's development was normal, although he had eczema and reflux.

2.23 One of three vaccines were accepted for Baby Euan at this appointment. Mother reported that she wished to spread out the vaccinations as Baby Euan had had a difficult start. The next immunisations were rescheduled, and the father was encouraged to attend to ask questions. Baby Euan was not subsequently brought for his vaccinations.

2.24 The CCS IMR states that vaccine refusal, even when rational reasons are given, may be much more of a red flag than previously suspected and has been reflected on by all team members involved in the process. They are already discussing such cases at safeguarding meetings and will continue to do so. This should be seen as a risk for other agencies to take note of.

2.25 Based on the GP concerns related to lack of immunisations, possible coercive control, the HV Team Leader sought safeguarding supervision and there is documentation that suggests that Baby Euan's lived experience was considered, as regards to their long- term health needs and reports from father only. In this case a safeguarding chronology was completed but there was a lack of clear analysis which focused on the lived experience of the child following the GP concerns raised at the liaison meetings.

2.26 Whilst Baby Euan was living in Lewisham the family never engaged with the HV there.

2.27 At 4.14am on the 11th November 2021, a neighbour of Baby Euan and his parents in Central Bedfordshire called Bedfordshire Police reporting hearing arguing, thuds and a baby crying. On attendance, both parents were spoken to separately, they both stated there was no argument, they are dealing with a teething baby. They state that the neighbour is intolerant of the noise and has banged on walls previously. There are no signs of concern noted by the officers and the log is closed. Baby Euan was not seen and no PPN was submitted. Further comment will be made in a later section of this report which considers DA.

2.28 In 2011 Ofsted published a thematic report , 'The voice of the child: Learning from Serious Case Reviews.' There were five main messages with regard to the voice of the child within this report.

• In too many cases the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings

• Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute

• Parents and carers prevented professionals from seeing and listening to the child

• Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.

• Agencies did not interpret their findings well enough to protect the child[1]*.*

2.29 In the case of Baby Euan, the findings from this study are relevant. He was not seen frequently enough. The parents prevented professionals from seeing Baby Euan by not bringing him to health appointments, and following the complaint, the refusal to allow a HV to visit and be actively involved in Baby Euan's life. Agencies, although rightly highlighting concerns, did not interpret their findings well enough.

Transient-hard to engage families including Information sharing

2.30 In this case there is evidence of the transient movement of the mother and then Baby Euan and the father between three different Local Authority areas. Some of these movements were unknown to professionals and agencies in those areas in which the family were now living, or when they had left their area.

2.31 The period between the Enfield Social Care referral and Baby Euan's birth at North Mid was subject to scrutiny at the Case Review Group meetings because from the information provided to them it was unclear where the parents were living and which services were being accessed. Information provided following the meetings from the mother's health records identified that North Mid recorded a move to Central Bedfordshire on 24th January 2021 and that mother planned to continue care and deliver at North Mid. As this information was not shared with agencies in Central Bedfordshire at the time of the move, the parents and the then unborn Baby Euan remained unknown to services within Bedfordshire until 18th April 2021, when Baby Euan is then discharged home to Central Bedfordshire. It was also noted that fathers' details were not recorded on North Mid and Homerton discharge summary paperwork. It was stated at the practitioner event that this was the first time the mother's GP found out that she had even been pregnant. However, this is not wholly accurate as there had been conversations antenatally by the diabetic midwife with the GP surgery and when the mother was discharged prior to Baby Euan notification had been sent to the GP surgery. When a mother books her pregnancy directly with midwifery services it would be good practice for their GP practice to be informed of this. GP surgeries to ensure their records reflect this.

2.32 When the mother moved out of the Enfield area during the antenatal period, this did not have direct impact on the care North Mid provided as teams made every effort to engage with her. However, discussions have been held by them as part of this review as to whether the referral made to Enfield social care should have been sent to Central Bedfordshire social

[1] report OFSTED. (2011). The voice of the child: Learning from Serious Case Reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/526981/The_voice_of_the_child.pdf.

care given that the mother was now living in that area. It is felt by the review author notification to Central Bedfordshire should have been made by North Mid.

2.33 A mother has a choice as to where she would like to receive antenatal care. The pregnancy was clinically high risk due to the mother's co-morbidities. When the mother informed staff that they had moved out of area, the diabetic team discussed with her on several occasions about transferring her midwifery care to her local hospital. The mother did not want to do this, stating that she knew North Mid well and wished to deliver her baby at the hospital.

2.34 It was felt by the NUMH IMR author that because there were no high-risk safeguarding concerns identified, apart from poor attendance to appointments, it would not be expected for midwives to notify the local maternity services in Bedfordshire. They will only transfer care if the mother requests it and in this case the midwife did encourage the mother to transfer her care to a local hospital to where she was residing but the mother refused. This non-notification though conflicts with the fact that they submitted a referral to Enfield CSC and as such had safeguarding concerns, so this should have been sent to CSC where the mother was now residing.

2.35 On 10th May 2021, following the call from the father, when he was unhappy about the new birth visit, records show a CCS team leader made six attempts to contact him before they spoke on 13th May.

2.36 This, and other efforts of the CCS health visiting service to build engagement with Baby Euan's parents was evident. However, a referral to Children's Services due to the concerns emerging from professionals, including the parents' decision not to access follow-up health care for Baby Euan following his birth difficulties, being hard to contact, and them declining routine vaccinations may have if a referral deemed to meet threshold supported relevant historical information about the father being secured and support being offered to the family.

2.37 There had been minimal contact with Bedford Hospital prior to Baby Euan's death. When informed that the family were moving to Lewisham (October 2021), BHT completed a case review for transfer which included a summary of Baby Euan's birth difficulties, absence of immunisations, concerns about father's controlling behaviour, and need for the nine- month developmental review. This meant the new GP in Lewisham would have had relevant health and safeguarding information to support practice.

2.38 The challenge around this case was trying to determine where Baby Euan and his parents were living. The family were understood to have moved to Lewisham in October 2021; professionals were unaware of the subsequent return to Central Bedfordshire. This view was supported by the professionals at the practitioner workshop.

2.39 When at the Lister Hospital, appointment requested for an ultrasound scan for Baby Euan. There were discussions between consultant paediatrician and parents regarding this not being necessary in view of the clinical presentation, and there were no clinical surgical concerns or medical concerns which would warrant this. In view of these observations the consultant paediatrician completed an information sharing form detailing that there were no current safeguarding concerns raised during the admission but requested for information to be shared with the health visiting service to offer some follow up support as it was felt there could be some parental anxiety surrounding Baby Euan's health. It was noted that there was

an incongruence between this noted parental concern but declined for paediatric assessment for support. An outpatient ultrasound appointment was provided for reassurance to the parents. This was not attended.

2.40 On 10th September 2021 Baby Euan was due to be seen in a virtual outpatient appointment with the paediatrician, however, he was not brought. The paediatrician attempted to make telephone contact with the family but was unsuccessful.

2.41The 'Not Brought to Appointments' pathway is currently being reviewed in line with new ways of working following the pandemic. This will pick up children not brought to virtual appointments. This is however generic learning and not just learning identified as a result of this case.

2.42 The sharing of information in respect of mother not attending appointments might have been beneficial for local services to have known, particularly as this resulted in a referral to MASH in London. This information would have then fed into the decision making around Baby Euan when he wasn't brought to his first appointment with the paediatrician.

2.43 Learning has been identified in relation to the transfer in / out process which needs to be updated and ensure robust verbal information handover between areas.

Domestic Abuse- Coercive Control-Invisible Males

2.45 Information shared with the review by the Lewisham MASH identified that the father was known to their services as a child between 2004-2008.

2.46 Further police checks show that the father has a PNC record of arrests between 2012 and 2020. These relate to offences of harassment, stalking and assault, and appear to be domestic related involving his sister and previous partners. All matters were No Further Action, and he has no convictions or cautions.

2.47 Although the following described incident occurred after the death of Baby Euan it is important that it is included in this section as it might be an indication of what occurred within the household whilst Baby Euan was alive.

2.48 On the 22nd February 2022 Baby Euan's mother attended the hospital emergency department. She had a head injury, nosebleed and injured hand caused by an assault which she states has been perpetrated by her partner (the father of Baby Euan). She asked the ED staff to contact the police for her. The mother then refused to wait to be seen by the medical team or police. Records show no MARAC referral was made by ED staff. Trust wide notification has now been made as a result of this incident, informing staff that they can make referrals to MARAC based on professional judgement, when consent is not gained due to extenuating circumstances.

2.49 On the 9th of March 2022 the mother again made contact again with the hospital requesting her attendance notes to be amended to indicate that she was not the victim of domestic abuse and violence, and that she denied asking anyone to call the police. No records were altered on her behalf.

2.50 When the North Mid IMR author interviewed the midwife who delivered Baby Euan, they discussed in more detail if she had any concerns regarding domestic abuse and coercive controlling behaviour. On specific questioning she said that although she did not have any

concerns regarding their relationship but that both parents were verbally aggressive and passive aggressive at different points of the labour towards her. The father, at one point, was particularly verbally aggressive towards the midwife when the emergency caesarean section was required as it was evident that Baby Euan was deteriorating clinically. The midwife reports that the situation was very uncomfortable for her.

2.51 On further reflection, the IMR author and the midwife discussed controlling and coercive behaviour and although the midwife felt that there was none in this case during the contact she had, it is something to consider for future practice when families are extremely challenging during labour and delivery.

2.52 On the 27th April 2021 - A planned (arranged) health visitor home visit was undertaken. The HV stated at the practitioner event that the father gave a false name and did not answer her request for his date of birth. Because of this the correct details of father were not known and could not be located on the NHS Spine. The GP was not able to provide this information either. Of note, the name initially given by father was not similar in any way to the name that he is known by, which was disclosed by police at the rapid review meeting. The fact that the service had been given the wrong name was significant and did not allow for health to undertake any assessment of risk, need or support required.

2.53 The father subsequently made the complaint against the HV and thereby took control of not letting the HV into his home.

2.54 At 12 weeks old, Baby Euan was taken to the GP surgery by his mother for the 6-8 week GP post birth check. The father joined the appointment via mother's phone. The GP felt concern about the father's behaviour during this interaction as she felt that there were indictors of controlling behaviour to mother. The mother kept the phone close to her ear throughout the later part of the appointment and as a result there was a parental request for individual vaccinations for Baby Euan. He was subsequently not brought for the vaccinations. The GP at the practitioner event stated that although she couldn't state categorically it was coercive controlling behaviour but the whole situation was one which she felt uneasy with. Hence why she shared this with HV at subsequent meetings.

2.55 This sharing of information took place at a GP liaison meeting and a health visitor was further informed that when the father had asked for forms to be signed by a GP, he was aggressive and accused staff at the GP surgery of being racist. Father had not given his name to the GP. The health visitor took advice from Team Leader following this liaison meeting. Safeguarding supervision was then sought by the Team Leader and a decision was made to begin compiling a chronology, to register the father into the S1 unit and review his records. However, father's details were not known and therefore GP was tasked to seek this information and add this, if they knew it. The GP did not have, and was not able to obtain this information.

2.56 There was a strong feeling at the practitioner event that more awareness raising needs to take place with frontline staff as to what constitutes coercive and controlling behaviour and how this affects children who live in these households.

2.57 Coercive control is not primarily a crime of violence, but it is firstly and foremost what the acknowledged international expert on the topic, Stark (2007) describes as a liberty crime.

Stark provides a detailed breakdown of the behaviours that comprise coercive control, some of which perfectly fits the actions and behaviour of the father in this case:

> *'Intimidation (including threats, surveillance, stalking, degradation and shaming), Isolation (including from family, friends and the world outside the home); and Control (including control of family resources and 'micromanagement' of everyday life').'*[2]

2.58 In relation to the concerns of coercive control behaviour to mother by father identified by the GP and Health Visitors, along with declined follow up medical visits, the rapid review meeting considered whether there should have been a safeguarding referral at this point. This would have offered an opportunity to view past concerns, the father's history, and police record, use of aliases, and to explore the lived experience of Baby Euan and whether the use of the Domestic Violence Disclosure Scheme (DVDS)[3] should be considered.

2.59 The review author posed to the delegates at the practitioner event the subject of the father being an invisible male. He suggested to them that the father was visible to agencies and although he was at times aggressive and controlling of professionals and the mother, he did engage with professionals. The unanimous feelings of the practitioners at the event was though, that he was invisible, as no correct name or date of birth was known for him and no knowledge of his background was known in order for him to be understood as a risk to Baby Euan and the mother.

2.60 In the early hours of the 11th November 2021, a neighbour of Baby Euan and his parents in Central Bedfordshire calls Bedfordshire Police reporting arguing, thuds and a baby crying. On attendance, both parents are spoken to separately, they both state there is no argument, they are dealing with a teething baby, walking, talking, and watching TV, they state the neighbour is intolerant of the noise and has banged on walls previously. There are no signs of concern noted by the officers and the log is closed. It is not believed that Baby Euan was seen by officers and no contact was made with the neighbour to consider triangulating the information. No PPN or DASH assessment was submitted by officers. The incident log was closed, *'no domestic, no offences. There was no evidence of a domestic dispute or any other offences. Will be child making noise which the neighbour does not like*.'

2.61 Bedfordshire Police have for this review recognised this is a missed opportunity. Neighbours were not visited, which might have offered further information on the family and insight into Baby Euan's lived experience. The Case Review Group considered that the neighbours may not have wanted the police to wake them up or provide indicators that they had made a complaint to the police at that time of night. However, it would have been beneficial to make follow up enquiries with the neighbours, either by phone or a visit during the day. At this point, Baby Euan and his family were not known to health services to be back in Central Bedfordshire. Bedfordshire Police are currently developing training around 'Voice of the Child' to further develop knowledge and skills. It has been identified within Bedfordshire Police, that officers attending domestic incidents are not checking children, unsure of their powers and how to have difficult conversations with parents.

2.62 Further learning totally relevant to this call from the neighbour is highlighted in the national review into the deaths of Arthur Labinjo-Hughes and Star Hobson- Child Protection

[2] Stark, E., Coercive control. The entrapment of women in personal life. (U.S.A: Oxford University Press, 2007).
[3] Also known as Clare's Law

in England. Within the report it highlights that *'All Safeguarding Partners should assure themselves that: Referrals are not deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager. Indeed, the Panel believes that the use of such language has many attendant risks and would therefore discourage its usage as a professional conclusion.'*[4]

2.63 Although Baby Euan was very young it is important to learn from this case and consider the impact on children in homes where there is domestic abuse and/ or coercive control. The Domestic Abuse Act 2021 sets out that children are victims of domestic abuse that is perpetrated against their parent or carer. Katz (2016) in her article about children's experiences of coercive control states *'Children in coercive control-based domestic violence contexts may live with narrow space for action, reduced 'voice' within the family, disempowerment and erosion of their confidence'* [5].

2.64 The child safeguarding practice review panel briefing (September 2022) on Multi-agency safeguarding and domestic abuse, states that *'There appeared to be an assumption that simply naming 'domestic abuse' as a concern for a child is enough for all practitioners to understand the situation and respond appropriately. This is an overly simplistic, optimistic and, at times, dangerous assumption that leads to potentially avoidable harm to children and non-abusing parents.' Statutory and voluntary sector services working with children and adults require detailed understanding of abusers' use of controlling and coercive behaviour.'*[6]

2.65 The attendees at the practitioner event and the review author agrees with this statement that this understanding is needed and required by practitioners.

'Intersectional analysis' into race, disability, and health conditions.

2.66 The Child Safeguarding Practice Review Panel guidance for safeguarding partners that was published in September 2022 states that:

> *'Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. It is important to consider the potential to learn from issues of 'intersectionality' at each stage of the process – particularly when considering the usefulness of an LCSPR*[7]*.'*

2.67 This Intersectional analysis has been a key part of this CSPR and highlighted as a theme for partners to consider in their IMRs, at the practitioner event and in panel meetings. It was felt that race, disability, and health conditions did play a part in this case. Using this intersectional approach has helped this report to more than simply recognise diversity but to try to understand the characteristics of the three individuals involved.

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[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf

[5] Katz E (2016) Beyond the physical incident model: how children living with domestic violence are harmed by and resist regimes of coercive control. Child abuse review volume 25 46-59 (2016)

[6] Child Safeguarding Practice Review Panel (CSPRP) (2022) Multi-agency Safeguarding and domestic abuse. https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

[7] Child Safeguarding Practice Review Panel (CSPRP) (2022) Guidance for Safeguarding Partners https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf

2.68 A panel discussion took place in relation to whether asking parents about their faith which also was relevant in this case was appropriate. It was felt yes if the purpose was to gain better understanding of child's lived experience. It could be integral to understanding the child's experience and practitioners should ask is there cultural or religious practices which they need to be aware of that affects the child, so that they are able to work alongside that family better.

2.69 As part of the paediatric assessment for the ED attendance, the father's details and demographics were taken as part of the social history and understanding who cares for Baby Euan. This is in line with the Hospital procedures and relevant documentation was kept reflecting this.

2.70 What didn't happen was the collection of data and demographics surrounding Baby Euan's ethnicity, this was missing from the clinical records. It is an expectation this information would be collected as part of the clinical assessment and booking in process. While this information would not have changed the assessment/outcome of the clinical assessment of Baby Euan, this information should be routinely collected.

2.71 There are improvements being made to the collection of ethnicity information for all children and young people attending E&N Hertfordshire NHS Trust. This involves an action for a meeting to take place with the Equality & Diversity Team & Digital team to explore digital options to supporting improvements.

2.72 The father made a complaint of racism against health visiting staff, he stated that in his view the health visitor had not been culturally sensitive and had made an inaccurate recording of Baby Euan's ethnicity, gender, and parental contact details. The Team Manager reported in their rapid review interview that they had been struck by father's emotional account of their child's birth and their experience of negativity from others. He was reported to have little trust in the National Health Service. The health visitor at the practitioner event stated they had spent two hours at the address on this visit and felt at the time no issues other than the discussion about father's name and date of birth and a discussion about the BCG vaccine. Father's verbal complaint included the health visitor approach to the discussion about BCG, in his view, lacked some cultural sensitivity.

2.73 The Rapid Review discussions considered whether this was a tactic to intimidate staff who were curious about missed appointments and baby having no name or whether there was a case to answer. On investigation, the allegation relating to a mistake in recording the child's ethnicity was followed up by a manager and corrected. This mistake may have reduced the family's willingness to engage with services. The father was wary about engaging with services which may be down to his ethnicity and must be taken into account by professionals. One of the practitioners at the event suggested as a consideration, did the father himself, due to his race and ethnicity feel marginalised, and the complaints were his way of trying to regain control.

2.74 Parental refusal of universal services (health visiting, vaccinations) is a choice. It is not known if there were related religious or cultural beliefs informing this decision. Equally, a request to spread out vaccines as Baby Euan had a 'difficult start' is a reasonable concern from the family. However, practitioners should be encouraged to explore concerns or reluctance with parents and there was no evidence that this occurred.

2.75 The allegation of racism could be interpreted as the father putting up barriers to not let the HV in, but as the Rapid Review states that it is important for professionals to understand the negative outcomes and experiences for BAME groups which are evidenced in research and the lived experience of BAME people. An example of trying to do this is in The NHS Long Term plan '*commits to ensuring that by 2024, three-quarters of pregnant BAME women will receive care from the same midwife before, during and after they give birth. This is proven to help reduce pre-term births, hospital admissions, the need for intervention during labour and to improve women's experience of care.'* [8]

2.76 It is noted that at the mother's registration for the pregnancy for Baby Euan, the information recorded her ethnicity as Black Caribbean and shared a diagnosis of Type 2 Diabetes. There were no language barriers recorded. Religion is recorded as Christian for both parents. The midwife present during labour reported that she was aware that the father was speaking to their pastor when difficult decisions were needed from the parents.

2.77 Bedfordshire Police identified Ritual Abuse as a line of enquiry for their criminal investigation. This was due to certain items found on their examination of the home address. The Rapid Review reflected on their records; agreeing that this was not predictable within the information held by agencies and is not discussed further within this report.

2.78 In relation to learning from this review for cultural competency and sensitivity, the CCS will be supporting exploration for both internal and external learning and development. The Trust has pledged to become an anti-racist organisation and is actively implementing objectives to work towards and embed.

2.79 Although the fundamental circumstances of the Child Q CSPR are not relevant to this review, there is though, key learning in relation to race that the local partnership should take account of.

> *'The full reasons behind why racism continues to feature in professional safeguarding practice are without doubt wide-ranging and complex. The CHSCP should expedite its work on developing an anti-racist charter and practical guides that support the eradicating of racism, discrimination and injustice across its local safeguarding arrangements[9].'*

3.0 Conclusion

3.1 In the Child Safeguarding Practice Review panels 2020 Annual report,[10] 'Patterns in practice, key messages and 2021 workplan.' the report makes the following comments:

> *'From our analysis we have highlighted six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are amongst the most urgent, and also the most difficult. Underpinning all of them is the importance of effective leadership and culture – dimensions which are too often left unexplored in the case reviews that we see. We expect*

[8] https://www.england.nhs.uk/2020/06/nhs-boosts-support-for-pregnant-black-and-ethnic-minority-women/
[9] https://chscp.org.uk/wp-content/uploads/2022/03/Child-Q-PUBLISHED-14-March-22.pdf
[10] https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2020

these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system.'

'Six key practice themes to make a difference

1. Understanding what the child's daily life is like

2. Working with families where their engagement is reluctant and sporadic

3. Critical thinking and challenge

4. Responding to changing risk and need

5. Sharing information in a timely and appropriate way

6. Organisational leadership and culture for good outcomes.'

3.2 There are three key pieces of learning from this annual report that are clearly evident in this review for Baby Euan and have been explored in the analysis sections of this report. They are for professionals to understand what the **child's daily life was like, working with families where their engagement is reluctant and sporadic,** particularly relevant when the family, and father in particular, was stopping health visits or Baby Euan being taken to health visits, and directly related to this point is where this happens **sharing information in a timely and appropriate way,** this was even more relevant where the family resided in three different local authority areas**.**

3.3 The other two areas of learning involve the theme of **intersectionality,** highly relevant in this case due to mother's health and the families race and ethnicity and finally **domestic abuse.** The rapid review group also reflected on links to national reviews including 'Non-Accidental Injury in under 1s' and 'The Myth of Invisible Men' as Baby Euan was eight months old when he died. The father has a police record relating to domestic incidents and a complex history including social care involvement. As a partnership, Central Bedfordshire have completed two Rapid Reviews in relation to the non-accidental Injuries to babies, alongside reviews completed in neighbouring authority areas. Pan Bedfordshire and local work is underway to ensure best practice and service development in respect of safeguarding infants. This is overseen by the Pan Bedfordshire Non-Accidental Injury working group.

3.4 In discussion with Central Bedfordshire neighbouring partnerships, they are considering the impact of parental choice to decline universal health services; whilst it is a parent's right to make this decision, they will consider what this may mean for unborn/young babies especially where concerns have already been raised. This has been raised at the Pan Bedfordshire Learning, Improvement and Training Group to support practice development.

3.5 Although controlling and coercive behaviour is now embedded within domestic abuse definitions, it appears to be the least understood aspect of the overall domestic abuse and safeguarding legislation and an area where all professionals need to think wider and seek to explore individuals with greater curiosity. Front-line practitioners in particular need to be more alert to the signs and symptoms of these behaviours and be able to highlight possible triggers and subtle inferences and make appropriate referrals.

4.0 Recommendations

4.1 This CSPR has identified learning and made some recommendations, as detailed below, and the implementation of these will assist the CBSCP to deal more effectively with similar circumstances in the future, resulting in the improved safety and welfare of children.

Recommendation 1 The Central Bedfordshire Safeguarding Children Partnership (CBSCP) should share this review report with the Enfield and Lewisham Safeguarding Children Partnerships for them to consider if there is any learning that they would wish to consider actioning within their area.
Recommendation 2 The CBSCP should seek assurance from all agencies that they always include the voice and lived experience of a child in their actions and assessments. This includes children that are babies, who are unable to communicate verbally. This could be widened to include the mothers and fathers voice and their lived experience. Also, voice and views of the wider family who know the child and parents should be considered if possible.
Recommendation 3 The CBSCP should seek assurance from partners to ensure that they are pursuing alternative ways of engaging families when there is resistance to bring a child to a health appointment. In particular those families who decline universal services where there are only known low level concerns. (Paradoxically in this case the family did reach out for health care but did not attend follow up appointments, so this should be borne in mind as well.)
Recommendation 4 i) The CBSCP should re-issue the Department for Education Information sharing guidance (2018). In particular emphasising how important it is for agencies to notify other areas when they have transient and mobile families that transfer to them. ii) a) The CBSCP should seek assurance from maternity services that when mothers book their pregnancy directly with them, that they send notifications with consent to, where known, the mothers and if they know the fathers/male carers details and they consent to their GP practices. b) That maternity services, where a pregnancy is regarded as clinically 'high risk' due to the mothers co-morbidities or other risk factors and they fail to manage adequately these risks, that they share their concerns with children social care. iii) The CBSCP should encourage health visiting services to ensure a verbal handover takes place when children and their families move to another area and to seek this verbal handover when these children and families transfer into their area.
Recommendation 5 The CBSCP need to raise professionals awareness, knowledge and understanding of: i) the Domestic Violence Disclosure Scheme, Domestic Violence Protection Notices and Domestic Violence Protection Orders. ii) To ensure that front-line staff can recognise the signs and symptoms of coercive and controlling behaviour as a form of domestic abuse. iii) The fact that household domestic abuse is always harmful to children. (Each agency to support this by also delivering agency specific guidance.)

iv) Seek assurance from Bedfordshire Police that frontline staff are ensuring that children being seen/spoken to when attending domestic incidents.
Recommendation 6 The CBSCP to ensure that their partners understand what the meaning of intersectionality is and that they are embedding this into their agencies procedures and actions of their frontline practitioners.

Appendix A

Child Safeguarding Practice Review: Terms of Reference

Baby Euan

Subject of Review: The subject of this review will be known as Baby Euan.

Reason for Review: Euan, aged 8 months old, died in December 2021. The post-mortem confirmed a number of non-accidental injuries. Central Bedfordshire Case Review Group completed a Rapid Review, identifying areas of learning. This Child Safeguarding Practice Review will bring together practitioners to further explore themes of mobile families, culture and ethnicity, domestic abuse and the voice and lived experience of the child.

Independent Reviewer: Dr Russell Wate QPM

Dr Russell Wate QPM is a retired senior police detective, experienced in the investigation of homicide and in particular child death. He has contributed to a number of national reviews, inspections and inquiries, as well as being nationally experienced in all aspects of safeguarding children. Russell is part of the National Panel's pool of reviewers and has been involved in a number of their published reviews. He has carried out a large number of Child Safeguarding Practice Reviews and has also been an independent chair and scrutineer for Safeguarding Children Partnerships. Dr Russell Wate is independent of any agency within Central Bedfordshire.

Timeframe to be covered by the review: September 2020- December 2021.

This period covers confirmation of pregnancy to Euan's death. Agencies are invited to further consider significant and relevant contacts or events outside of this timeline.

Agencies involved:

- Central Bedfordshire Children's Services
- Enfield Children's Services
- Lewisham Children's Services
- Cambridgeshire Community Services

- Bedfordshire Police
- Bedford Hospital Trust
- North Middlesex University Hospital NHS Trust
- Homerton Hospital
- Lister Hospital
- Lewisham & Greenwich NHS Trust
- Bedfordshire, Luton & Milton Keynes Integrated Care Board (BLMK ICB)
- South East London Clinical Commissioning Group
- East London Foundation Trust
- Saffron Health Centre, Biggleswade
- The Vale Surgery, Lewisham
- Forest Hill Health Visiting
- Safeguarding Children Partnerships for Lewisham and Enfield

Key areas of focus: In responding to our Rapid Review, the National Panel noted 'the helpful focus on ritual abuse but thought that the consideration could have extended into a more intersectional analysis into race, disability, and health conditions. We also questioned whether it would have been relevant to consider the role of the father given previous incidents related to assault, stalking, as well as coercive and controlling behaviour.'

We will bring together practitioners, knowledgeable stakeholders and panel members to explore learning from key time periods and learning themes. The impact of COVID will be explored as a golden thread throughout the themes.

Time periods

- Pre-pregnancy; agencies may share relevant information and learning prior to the pregnancy.
- Pregnancy (Sept 2020-April 2021)
- Periods of residence in Central Bedfordshire (April– Oct 2021) and London Borough (Oct 2021 onwards)
- Return to Central Bedfordshire and death of Baby Euan (November- December 2021)

Learning themes

- Voice of the Child
- Mobile Families

- Domestic Abuse/ Coercive Control
- Invisible/ Hidden Males
- Culture and Ethnicity, including a focus on intersectional analysis into race, disability, and health conditions.

Timescales for completion: 22nd June- 22nd December 2022

Written Documents to be requested:

- Individual Management Reviews (IMR) to be completed. Reviews to include critical analysis and reflection of engagement with Euan and his family, identifying learning and recommendations to take forward.
- Chronologies: existing chronologies will be reviewed as part of the IMR process and updated as required.

Practitioner learning event: Once all information has been received and reviewed a panel meeting will be held to review all information and identify key learning themes before holding a practitioner event.

Process for engaging family: TBC- Criminal Investigation in progress.